

"All HIV-negative pregnant and breastfeeding women should be considered eligible for PrEP."

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National HIV Technical Advisor
MOH – Zambia

Advancing HIV Prevention and PrEP
for Pregnant and Breastfeeding Women
Nairobi, Kenya | April 22-24, 2026



HIV
Impact Network for
Vertical Transmission
Elimination



Meet Chanda.

She is every woman in every ANC queue in every country.

Chanda is 28. Six months pregnant with her third baby. Well educated mid-level career women in Lusaka, Zambia. She has been waiting on a wooden bench since 7 a.m.

A nurse hands her a pill, perhaps 2 150mls jabs of Lenacapravir subcutaneously in the abdomen . No questions. No conversation. Just: "Everyone gets this now. Take it every day."

Chanda walks home with a pill bottle she does not understand, for a risk she was never asked about, maybe doesn't even have; to take in front of a mother-in-law who will assume she has HIV.

Ask yourself:

Is that the care you would want for:

- ***Your sister***
- ***Yourself***
- ***Your daughter?***

why don't you ask her first?

Not Every Mother, Not Every Time.

Ask Her First

Universal eligibility is not the same as universal benefit. Good HIV prevention is targeted, informed, and earns a woman's consent — not presumed on her behalf.

Debate Prepared from: Hamoonga et al. (2023, 2024) · Nelson et al. (2023) · Beima-Sofie et al. (2019)



We Oppose the Motion

OUR POSITION

PrEP should be offered as part of a risk-informed, woman-centred conversation — not administered as a default to every pregnant woman who walks in

We will show that:

- **Universal offer does not produce universal uptake**
- **Evidence and ethics both favour targeting**
- **Women themselves want informed choice**

THE PROPOSITION

Offer PrEP to all pregnant and breastfeeding women universally — no risk screening — treating every woman as eligible by default

Rationale usually given:

- **Avoid missing at-risk women**
- **Reduce stigma of being "risk-assessed"**
- **Simplify provider workflow**

Why We Oppose the Motion

01

The Evidence

- Actual uptake is low
- Most women do not perceive themselves at risk
- Universal offer does not overcome the real barriers

02

The Practicality

- Clinics are overstretched, ART-trained staff scarce, continuation poor
- A blanket policy wastes the resources real at-risk women need at a time are talking sustainability

03

The Ethics

Good prevention respects a woman's autonomy, weighs maternal–fetal trade-offs, and does not medicalise pregnancy by default.

The Evidence

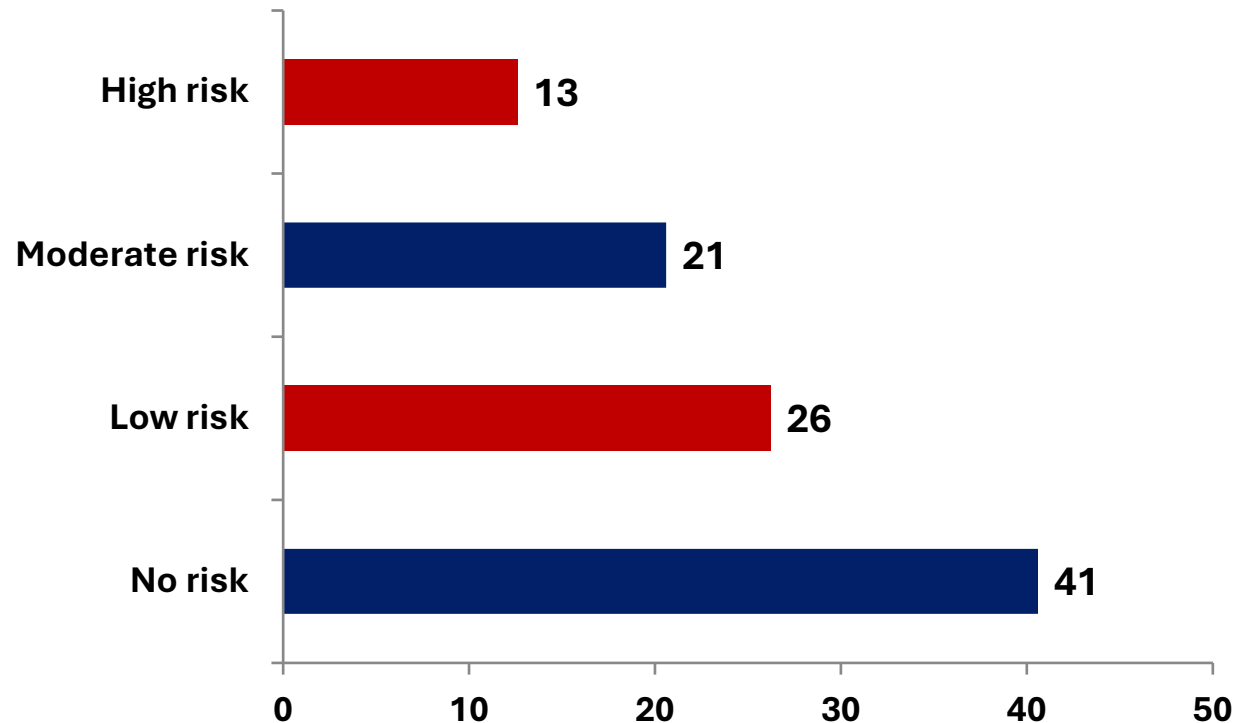


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Most women don't see themselves as at risk — and screening respects that.

Self-reported HIV risk perception

Lusaka DCE, n = 389 pregnant / breastfeeding women



Source: Hamoonga et al., 2024 (Table 2)

Two-thirds say "no risk" or "low risk"

Handing PrEP to every woman ignores this.

- Most women at presentation self-assess as not at meaningful risk of HIV.
- Initiating PrEP in someone who does not feel at risk predicts poor adherence and early discontinuation.
- Risk-based screening is not gatekeeping — it is the conversation in which a woman learns what PrEP is, whether she is in fact at risk, and chooses.
- Without that conversation, "offering PrEP to everyone" becomes a box-tick that neither informs nor protects.

Evidence from the field

PREP UPTAKE IN PBFW–Lusaka, Chilanga, Chongwe, Kafue, Luangwa & Rufunsa

Constituency	ANC						Postnatal/Breastfeeding (Delivery-24 months)						PREP_NEW TOTAL
	#. HIV negatives in ANC	screened for Prep	Number at substantial risk	#initiated	% Screened	% Initiated	#. HIV negatives Postnatal/Breastfeeding	screened for Prep	Number at substantial risk	#initiated	% Screened	% Initiated	
Chawama Constituency	119	119	12	9	100%	75%	251	251	6	3	100%	50%	12
Munali Constituency	201	201	58	45	100%	78%	72	72	5	5	100%	100%	50
Mandevu Constituency	391	390	16	11	100%	69%	302	262	15	13	87%	87%	24
Kanyama Constituency	358	358	25	23	100%	92%	327	327	6	6	100%	100%	29
Matero Constituency	301	301	29	25	100%	86%	291	291	3	2	100%	67%	27
Kabwata Constituency	111	111	6	4	100%	67%	201	201	6	4	100%	67%	8
Lusaka Central Constituency	69	69	4	2	100%	50%	57	57	6	2	100%	33%	4
Chilanga District	140	140	53	53	100%	100%	54	54	0	0	100%		53
Chongwe District	131	130	20	20	99%	100%	140	140	10	6	100%	60%	26
Kafue District	129	129	37	36	100%	97%	92	92	7	5	100%	71%	41
Luangwa District	22	22	8	6	100%	75%	39	36	4	0	92%	0%	6
Rufunsa District	81	72	28	5	89%	18%	121	121	2	1	100%	50%	6
Provincial Total	2053	2042	296	239	99%	81%	1947	1904	70	47	98%	67%	286

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Risk screening is possible

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PrEP eligibility is low at 10%

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Risk screening is possible

PrEP eligibility is low at 10%

PrEP uptake is high when you screen

Practicality

Universal PrEP among PBFW is just not Practical



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A universal policy meets an overstretched system – and both lose.

Strained HRH

Only 42% of nurses and 37% of midwives in the Cape Town integration study were ART trained, the cadre required to prescribe PrEP. Universal offer collides with a bottleneck we already have.

Long queues, long travel

In the Zambian DCE, waiting time and travel time were the strongest negative predictors of PrEP choice. Adding everyone to the PrEP queue lengthens the queue and drives the truly at-risk away.

Continuation collapses fast

41% of pregnant and 25% of breastfeeding women continued PrEP at 3 months. Initiating women who were never at substantial risk inflates these denominators and masks real failure to retain those who need it.

Stigma has a real cost

Women report being mistaken for ART users; partners disapprove. Putting every woman on PrEP — including those not at risk — spreads that stigma across the whole antenatal population without a matching benefit.

Take the case of the Zambian VTP Program Cascade

Estimates New Infections among PBFW = **2,114** (0.25% incidence). *Spectrum 2025*

- 850,000 HIV negative PBFW annually
- Cost of Lenacapravir \$69.6 per year
- Total cost for Universal PrEP for PBFW for 24 months = **\$118,320,000**

Estimates Positive Infants New Infections from PBFW = **1424** (52% of infected infants). *Spectrum 2025*

- 850,000 HIV negative PBFW annually
- Eligible PBFW for PrEP at 30% =255,000
- Cost of Lenacapravir \$69.6 per year
- Total cost for targeted (eligibility based) PrEP for PBF for 24 months = **\$35,486,000 (3 fold cheaper)**

In the era of sustainability and reducing resource envelope, the choice is obvious

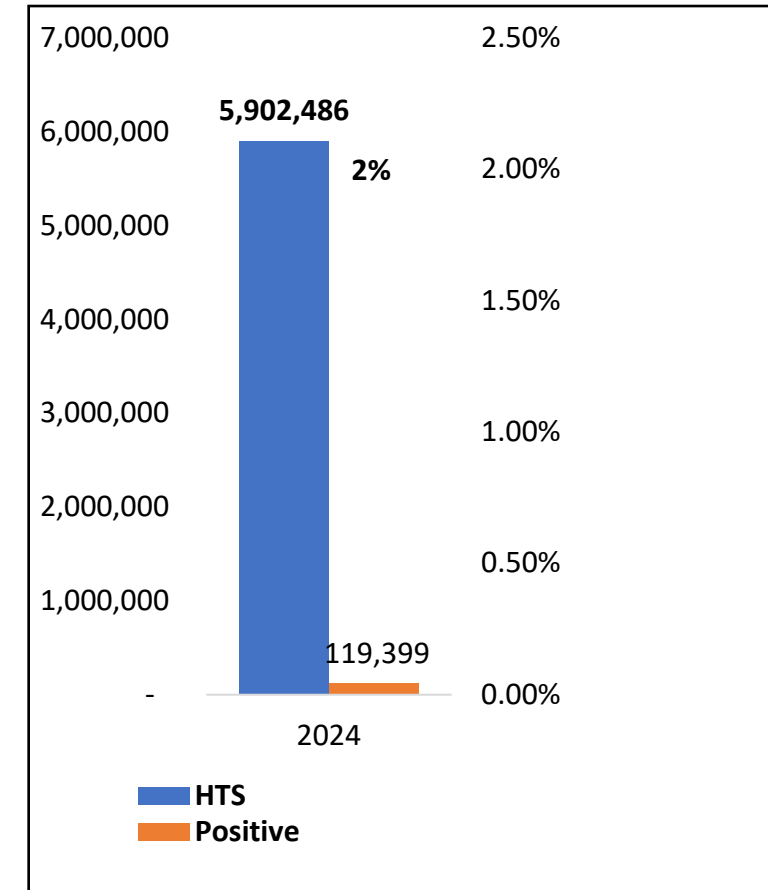
HIV Positivity Among PFW lower than General Population

(Zambia program data from HMIS)

HIV re-tests	2022	2023	2024	2025
HIV re-test in (ANC, L&D, PNC)	103,322	231,152	424,257	465,364
HIV re-test positive (ANC, L&D, PNC)	1,634	1,641	1,659	1,356
% HIV re-test positive (ANC, L&D, PNC)	1.58%	0.71%	0.39%	0.29%
other data elements				
2022	2023	2024	2025	
Antenatal Care First Contacts	783,047	813,026	822,599	860,229.1
Known HIV+ at first antenatal visit	41,747	40,859	42,057	41,318
% KP at first contact	5.33%	5.03%	5.11%	4.80%
Initial test in ANC	624,741	716,457	784,363	810,603
Testing positive on initial ANC test	13,184	12,294	12,750	12,739
% testing positive on initial HIV test in ANC	2.11%	1.72%	1.63%	1.57%

Routine data positivity in ANC

- Program data show PFW incidence of **~0.3–0.6 per 100 person-years** — well below WHO's 3 per 100 threshold for PrEP, compared to **3-10%** in high-risk individuals
- Universal PrEP would require treating **300–600 women** to prevent one infection, at cost per infection averted: **~\$20,000–50,000**; at roughly 5–10× the cost per infection averted of targeted PrEP.



Routine data positivity in general population

Most of PFW may not be at risk of HIV and preventing the few that are must be targeted and cost-effective

*Jones HS et al. (2024), Lancet Global Health

Ethics



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The evidence base is still being built. Universal rollout outruns it.

Pregnant women were excluded from PrEP trials. Clinical and policy experts have relied on triangulating animal data, registries and post-market surveillance — not randomised evidence — to justify use in pregnancy

Target where benefit is clearest

Experts in that study agreed that the severity of the woman's risk justifies the uncertainty — moderate risk does not. Screening is how we concentrate a still-imperfect evidence base where it helps most.

Respect the woman's informed choice

Autonomy is not served by default enrolment. It is served by giving a woman the facts about her risk, the medication, and the uncertainty — and letting her decide.

Pregnancy is not the time to presume

When two lives are affected and data are incomplete, the ethical default is not "give more" — it is "explain, screen, and target".

Listen to what women ask for.

Their preferences contradict the logic of a "give-to-all" policy.

"I would not take it if my husband disapproved."

Married, pregnant — Hamoonga 2023

"I fear my baby might be born prematurely because of taking PrEP."

Single, pregnant — Hamoonga 2023

"People will think I am sick — that I am taking ARVs."

Married, breastfeeding — Hamoonga 2023

"I can forget. I already forget family-planning pills. What would make me remember PrEP?"

Married, breastfeeding — Hamoonga 2023

Women are telling us they want information, partner dialogue, and meaningful choice — not an automatic prescription.

The myths we have heard.

Three arguments we expect — and why they don't carry the motion.

THEY SAY

"Risk screening misses at-risk women."

WE REPLY

True of a bad screening tool — not of screening itself. The answer is a better conversation (partner status, condom use, IPV, STIs), not abolishing the conversation. Universal provision without dialogue misses the same women because they never recognize or accept their risk.

THEY SAY

"Screening creates stigma."

WE REPLY

The qualitative data show stigma attaches to being seen taking the pill, not to being asked about risk. Scaling PrEP to everyone spreads that stigma across the entire antenatal population. A private, respectful risk conversation does the opposite.

THEY SAY

"Women can't assess their own risk."

WE REPLY

Then help them — that is what counselling is for. Treating women as unable to participate in the decision is paternalism in a new dress, and it is exactly what the clinical ethicists in Beima-Sofie et al. warned against: making decisions for pregnant women rather than with them.

What we support instead.

Opposing the motion is not opposing PrEP. It is opposing its misuse.

01

Universal screening, targeted offer

Every woman is asked about risk. Those who are at substantial risk are counselled and offered PrEP. Those who are not get honest information, not a prescription.

02

Repeat HIV testing, not one-off enrolment

Risk changes across pregnancy and lactation. Three-monthly testing for breastfeeding women — still poorly implemented — catches new risk better than putting everyone on PrEP at booking.

03

Invest in what actually drives uptake

Multi-month dispensing, provider attitude, shorter waits, partner engagement, community education. The DCE evidence shows these — not universal default — move the needle.

04

Keep building the evidence

Support safety registries and inclusion of pregnant women in research, so that future expansion rests on data rather than on the hope that scaling harder will solve what targeting could solve better.

In closing: Prevention should reach the woman who needs it, not be handed to every woman regardless.

The evidence does not support universal uptake only universal offer.

Women themselves want information, not a default prescription.

Ethics, safety and scarce clinical capacity all favor targeting.

Risk-based screening is the conversation in which good prevention begins.

Proposing this motion is proposing a lazy man's approach, we need to still do the hard and correct work, we need to promote precision prevention.

ONE LAST THING

Before you vote,

Back to Chanda

Picture her face.

She is your recipient of care. Your sister. Your neighbour. Maybe one day she is you.

*Do we hand her a pill —
or do we hand her a choice?*

***Vote with her.
Vote to ask her first***



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Thank You!

