TAC Electronic Newsletter

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We must improve the maternal health and prevention of mother-to-child transmission programme

As we approach World AIDS Day a key goal must be to improve maternal health and prevention of mother-to-child HIV transmission (PMTCT). The PMTCT programme is the litmus test of the South African government's commitment to implementing the HIV/AIDS National Strategic Plan (NSP). On Monday and Tuesday delegates at a *National Civil Society Conference on Implementing the National Strategic Plan on HIV and AIDS* committed to mass mobilisation and public education to inform pregnant women to participate in the PMTCT programme.

Below, please find:

- Briefing on the current state of the PMTCT programme and what needs to be done to improve it.
- Statement released today by Government Communication and Information Service (GCIS) following a plenary meeting of the South African National AIDS Council (SANAC) yesterday.
    - It commits government to announcing the new PMTCT protocol in two weeks.
    - The Department of Health has indicated that it is implementing strategies to improve accreditation of antiretroviral sites. Currently the process is too slow and treatment is frequently unavailable in primary care health facilities where it is most needed.

Maternal health and mother-to-child HIV transmission: ongoing crises

?*Antiretrovirals prevented my child from getting HIV ... When she was six weeks old, a PCR test was done to check if she was HIV-positive or not. She tested HIV-negative and that was good news to me.? - Phindile Madonsela*

"We need everyone to realise that PMTCT is not a programme only for children, but for mothers and children - with the spin-off of reducing transmission to babies." - Dr Ashraf Coovadia, quoted in the Argus, 27 November 2007.

South Africa's prevention of mother-to-child HIV transmission (PMTCT) programme has saved tens of thousands of children dying from AIDS and helped many pregnant women access life-saving antiretroviral treatment to restore their own health. The programme has been particularly successful at primary health care level in Khayelitsha, Cape Town, where the vertical transmission rate has fallen to below 4%. Yet the countrywide programme remains inadequately implemented.

About 38,000 children are born with HIV in South Africa each year. A further 26,000 children are estimated to be infected through breastfeeding. Therefore, more than 6% of infants born each year will become infected with HIV by their first birthday. The effect of this is apparent in important health indicators such as the under-5 mortality rate, which has increased from 65 deaths per 1000 births in 1990 to 75 deaths per 1000 births in 2006.1 The health indicators for pregnant women are also disturbing, with maternal mortality increasing between 1997 and 2004 due to the HIV epidemic.2

The state must implement critical improvements to the PMTCT programme to reverse these trends. As yet unpublished evidence from the Western Cape indicates that the implementation of a reasonably effective PMTCT programme coupled with treatment of pregnant women has resulted in a reduction in child mortality.[3] Our challenge is to emulate this in the rest of the country as well as further improve the Western Cape programme.

Key to improving PMTCT are (1) increasing take-up of the programme, (2) upgrading the single-dose nevirapine regimen, (3) ensuring women with low CD4 counts or AIDS are placed on highly active antiretroviral treatment (HAART) and (4) appropriately monitoring and evaluating the programme on a regular basis.

This summary of the PMTCT programme draws on three key documents:

- Chapter 4 of *District Health Barometer 2005/06* produced by Health Systems Trust (HST).[4]
- *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011* (NSP), which describes the goals of the PMTCT programme and a set of indicators that can measure progress towards those goals.
- Draft version of the *Policy Guideline for the Implementation of Prevention of Mother-to-Child Transmission of HIV* (Draft Policy Guideline).[5]

The National Strategic Plan's Commitments on PMTCT

The NSP describes two main objectives for PMTCT. The first is to broaden existing PMTCT services to include other related services and target groups, and the second is to scale up coverage and improve quality of these services to reduce transmission to less than 5%.

The interventions to broaden existing PMTCT services include programmes to reduce the percentage of unwanted pregnancies, HIV prevention programmes for uninfected pregnant women and responsible fatherhood programmes, among others. Interventions intended to address the second objective of scaled up coverage and improved quality include increasing the proportion of public sector antenatal services providing PMTCT, the development of a policy and guidelines on counselling and testing in pregnancy, and providing CD4 testing of all pregnant women so that those with CD4 counts less than 200 can be offered HAART.

The *Treatment, Care, and Support* priority area of the NSP seeks to address the special needs of children and pregnant women by: (1) decreasing HIV-related maternal mortality through woman-specific programmes; (2) determining the HIV status of infants, children, and adolescents as early as possible; and (3) providing a comprehensive package of services to HIV-affected, -infected, and -exposed children and adolescents.

Key indicators of the NSP are to

- increase the proportion of pregnant women tested for HIV, through provider-initiated testing, to 95% by 2011,
- increase the proportion of HIV-positive women who receive PMTCT services to 95% by 2011 and

- conduct CD4 testing on HIV-positive pregnant women in 85% of primary care facilities by 2011.

Current status of PMTCT and what needs to be done

Monitoring and Evaluation (M&E)

The quality of M&E of the PMTCT programme is poor. Key statistics of the programme are only available from a Ministry of Health press statement of 12 March 2007[6], the HST District Health Barometer identified above and a table in a 2007 treasury report[7]. The HST report describes some of the data problems encountered, particularly in the Eastern Cape:

The data available from the Eastern Cape districts was generally of poor quality. At one end of the spectrum there was no data at all from Chris Hani and Amathole, whilst at the other end Alfred Nzo and O.R. Tambo had over 140% of pregnant mothers tested. ... Clearly there is inadequate monitoring of this priority programme by managers throughout the Eastern Cape. (page 45)

About testing rates, the report states:

[T]he Western Cape did not have data available in 2004 so no comparisons can be made. The changes in Alfred Nzo and O.R. Tambo [Eastern Cape] are obviously the results of poor quality data.

The NSP commits to measuring annually the percentage of pregnant women tested for HIV, percentage of HIV-positive women who receive antiretrovirals to reduce the risk of transmission, the percentage of children born to HIV-positive women and the percentage of children born to HIV-positive women who receive PCR tests. The mechanisms to do this accurately and annually are not in place but need to be implemented urgently.

Uptake and Reach

The complete PMTCT package is reaching far too few pregnant women. The HST report explains:

For a PMTCT programme to be successful pregnant women must follow several sequential steps:

- *attend an antenatal clinic equipped to offer VCT;*
- *accept pre-test counselling and HIV testing;*
- *receive their test results;*
- *[accept a CD4 count and get the results;]*
- *accept ARV prophylaxis for themselves and their babies;*

- *correctly receive and administer therapy;*
- *receive infant feeding counselling and make an appropriate infant feeding choice;*
- *participate in postpartum follow up care.*

At each step, losses occur which decrease the overall effectiveness of the programme (page 44 ? step in brackets added)

According to statistics obtained from the Ministry of Health statement and the HST report, more than 90% of government clinics (3382 of 3663) are currently providing PMTCT services. Of the approximately 800,000 public sector births in South Africa in 2006, about 580,880 pregnant women were offered PMTCT services. From the antenatal survey, we can estimate that about 168,000 (i.e. 29%) were HIV-positive last year. Yet only 74,052 women received nevirapine prophylaxis i.e. less than half the eligible women. Of this amount, the subset of babies who were tested for HIV was just 19,758. About 18% tested positive.

This means that of the approximately 800,000 public sector births, we know the HIV status of less than 3% of infants. And of these, the results are poor ? far above the 5% transmission rate target.

The HST report demonstrates that the Western Cape province is doing well, with about a 75% take-up rate. The report states ?This clearly shows that where a programme is prioritised it can achieve significant results quickly.?

Treatment for women

The PMTCT programme is an opportunity to reduce maternal mortality and to ensure women with AIDS access treatment. This opportunity is not being used in most facilities. Though the NSP and the Draft Policy Guideline recommend HAART for women with CD4 counts less than 200 or who are clinically indicated, we should consider changing the PMTCT guidelines to offer HAART to pregnant women with CD4 counts less than 350. The Draft Policy Guideline does present evidence that this could be beneficial for PMTCT. This would also put South Africa in line with several other countries including Lesotho, whose PMTCT Protocol is expected to be adopted shortly.

For this to succeed, facilities offering PMTCT should be providing HAART or be able to refer patients to convenient nearby primary health facilities offering HAART.

Prophylaxis regimen

Outside of the Western Cape and some tertiary institutions, single dose nevirapine is currently used throughout the country. Transmission rates using single-dose nevirapine are over 8% at best and usually much higher, as the results of the countrywide programme released by the Department of Health described above indicate. But with dual prophylaxis regimens or even HAART for all pregnant women, transmission can be reduced to 5% or even lower.

The HST report provides this important insight:

The low uptake of nevirapine highlights the importance of moving away from an ?all or nothing? PMTCT regimen where a single dose of nevirapine is taken or nothing. Consideration should be given to adopting a dual or triple drug regimen for this programme which, based on daily doses opposed to a once off dose, is likely to lead to higher adherence and coverage. A dual dose has been successfully piloted in the Western Cape with promising results in the reduction of mother to child transmission of HIV.

The Draft Policy Guideline recommends a *minimum* of two antiretrovirals commencing at 28 weeks or as soon thereafter as possible for women who are not yet eligible for treatment. If single-dose nevirapine is part of the new regimen, a ?cover the tail? postpartum regimen of AZT and lamivudine is necessary to reduce nevirapine resistance.

Infant feeding

Women should continue to be offered a choice between breastfeeding and the use of paediatric formula milk. However, there is emerging evidence that women who breastfeed and take HAART are unlikely to transmit HIV to their child.8 While this has not yet been confirmed in a clinical trial, it is sufficiently compelling that until there is more definitive evidence, women who choose to exclusively breastfeed should be offered HAART. This recommendation is not explicitly made in the Draft Policy Guideline, but consideration should be given to adding it.

Women who choose to exclusively formula feed should be supplied formula milk for free for six months. This recommendation is made in the current version of the Draft Policy Guideline.

Counselling on infant feeding needs to be standardised and designed to empower pregnant women to make an informed choice.

Diagnosis

Polymerase Chain Reaction (PCR) testing can be used as soon as six weeks after birth to determine infant HIV-status both with high sensitivity and high specificity. However, a number of factors prevent its wider use, including the cost of the tests themselves, the cost of the automated blotting paper needed to conduct the tests, and the complexity of conducting the test in laboratories with limited infrastructure. The CHER study has shown that infant mortality can be reduced significantly by placing HIV-infected children on HAART early, i.e. as soon as possible after their status is known.9

While PCR testing is taking place in many facilities, there is inadequate monitoring and evaluation of this critical aspect of the PMTCT programme to determine whether or not it is being implemented widely and effectively. The M&E component of the PMTCT programme must measure uptake of PCR testing.

1 Department of Health. 2007. *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011.* http://www.tac.org.za/documents/NSP-Draft10-2007-2011.pdf
Actuarial Society of South Africa. 2005. *ASSA2003 Summary Statistics.* *http://www.assa.org.za/applications/cms/documents/file_build.asp?id=100000112*

2 TAC. 2006. *Understanding the Confidential Enquiry into Maternal Deaths: A TAC briefing* . http://www.tac.org.za/documents/AnalysisOfMaternalDeaths.pdf

3 Personal communication with David Bourne.

4 Barron P., Day C., Monticelli F., et al. 2006. *District Health Barometer 2005/06. Health Systems Trust. Technical Report.* http://www.hst.org.za/publications/701.

5 Still unpublished and in draft format at the time of writing.

6 Ministry of Health. 2007. *100% coverage for Prevention of Mother to Child Transmission of HIV*. http://www.doh.gov.za/docs/pr/2007/pr0312a.html

7 National Treasury. 2007 (September). Intergovernmental Review. Table 3.17.

8 Clayden, P. 2007. *Very low transmission rates among breastfeeding women receiving ART*. HIV Treatment Bulletin Volume 8 Number 8/9 August/September 2007. http://www.i-base.info/htb/v8/htb8-8-9/Very.html

9 NIAID. 2007. Questions and Answers: Children with HIV Early Antiretroviral Therapy (CHER) Study: Treating HIV-Infected Infants Early Helps Them Live Longer South African Clinical Trial Modified Because of Initial Data. http://www3.niaid.nih.gov/news/QA/CHER_QA.htm.

[END OF PMTCT BRIEFING]

SANAC statement issued by GCIS

29 November 2007
To All media and Editors

For Immediate release

COMMUNIQUÉ

The South African National AIDS Council (SANAC) held its second meeting chaired by the Deputy President Phumzile Mlambo-Ngcuka in her capacity as chair of SANAC. The meeting was also attended by the deputy chair Mr Mark Heywood, members of the Inter-Ministerial Committee, including Ministers of Education Naledi Pandor and Public Service and Administration, Geraldine Fraser Molaketi, as well as the Deputy Minister of Social Development Jean Sawson-Jacobs and representatives of civil society organisations dealing with HIV and AIDS.

The meeting received progress reports on the implementation of the National Strategic Plan on HIV and AIDS 2007-2011 from business, civil society and government sectors constituting SANAC. The sectors reported progress on the implementation of programmes and mobilisation for active participation in their sectors. In particular campaigns to encourage people to test for HIV and know their HIV status, as well as campaigns to popularise the NSP are becoming widespread. ,

Some sectors reported meetings with various Provincial AIDS Councils. The faith based sector has extended participation in implementing the NSP to a wider range of faiths. Similarly, the business sector reported good progress on the implementation of the NSP including the sharing of good practice with respect to support to employees and their families and advances towards closer working relationships with the medical aid companies in plans to extend access to treatment.

Government?s report highlighted the intervention programmes within the public sector ranging from employee assistance programmes to grants in support of child-headed families and vulnerable children. The presentation included a report on budgetary allocations for various aspects of the NSP.

The Deputy President highlighted the working relationship with the house of traditional leaders who were critical in ensuring that the HIV intervention programmes were effective and are known to even more communities in South

Africa. Ms Mlambo-Ngcuka indicated the need for SANAC to heighten messages linking HIV and AIDS with the 16 Days of Activism Against Women and Child Abuse campaign and called on all men to stand up, march and join the campaign.

Civil society raised concerns regarding the slow accreditation of health facilities that offer ARV treatment and the need for an improved treatment regime for the prevention of mother to child HIV transmission. The Department of Health indicated that it was implementing strategies to improve accreditation. A new protocol on PMTCT will be announced within two weeks.

At the end of the meeting the deputy chairperson of SANAC, Mr Mark Heywood remarked that the SANAC meeting was an indication that the partnerships for the prevention and treatment of HIV were becoming more focused, targeted and effective. In his view SANAC was ?beginning to play an important role in guiding the implementation of the NSP, advising the government and highlighting shortcomings with implementation.?

Much still needs to be done. In particular the meeting noted:
that mass communication of the NSP?s key activities needs to be undertaken
that there needs to be better coordination and improved collaboration concerning Monitoring and Evaluation, and Research.

The next meeting of the SANAC Programme Implementation Committee will look at these issues and is scheduled for the 06th of December 2007.

The meeting was also briefed on the plans for the national celebrations of the World AIDS Day due to take place in Mahwelereng in Limpopo with provincial events around the country.

Issued by GCIS on behalf of SANAC

Thabang Chiloane on 082 888 8783 (The Presidency),

[END OF GCIS SANAC STATEMENT]

- Prevention of Mother-to-Child Transmission

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