Poor PMTCT programme: ALP letter on behalf of TAC to Minister of Health

By *moderator*
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ALP letter on behalf of TAC to Minister of Health

27 September 2007

Dr Manto Tshabalala-Msimang
Minister of Health
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Dear Dr Tshabalala-Msimang

RE: REVISION OF NATIONAL TREATMENT GUIDELINES TO PREVENT MOTHER TO CHILD TRANSMISSION AND IMPROVEMENT OF MATERNAL AND PAEDIATRIC HEALTH SERVICES

1.We refer to our letters dated 6 August 2007 and 30 August 2007 on behalf of the Treatment Action Campaign (?TAC?), the Southern African HIV Clinicians? Society and a group of concerned clinicians, paediatricians and obstetricians in South Africa.

2. We have not received a written response to either letter.

3. We are advised that at the South African National Aids Council (SANAC) plenary session held on 10 September 2007, the Department of Health committed itself to revising the national treatment guidelines to prevent mother-to-

child transmission (PMTCT). The revision would, at the very least, be in line with the World Health Organisation (WHO) guidelines, which recommend administering dual or triple drug regimen, which is significantly more effective in reducing the rate of transmission of HIV from mother to child than the currently implemented single-dose regimen of Nevirapine (NVP). It is also important that this is located in a comprehensive programme that encourages knowledge of HIV status and treatment for the mother where this is indicated.

4. We are further advised that the Department of Health informed the SANAC meeting that the revision of the treatment guidelines would require the approval of the National Health Council (NHC), and that this is due to take place in November 2007.

5. A further consultation meeting was held between various clinicians, paediatricians and obstetricians in South Africa and the Department of Health on 11 September 2007. Again, the Department of Health committed itself to revising the treatment guidelines.

6. In the light of recent developments we request:

6.1. A date for implementation of the revised guideline, given that this has been a long-awaited policy change; and

6.2. Confirmation that the national Department of Health will not prevent provinces and health facilities that are in a position to implement a revised regimen from doing so. As you know, doctors and paediatricians around the country have expressed their capacity and willingness to implement immediately, and that the Western Cape province is already doing so. A memorandum setting out this capacity was drafted by several paediatricians and doctors and, we are advised, submitted to the Department of Health. We attach a copy of the memorandum for ease of reference

7. We look forward to a written response by 5 October 2007.

Yours faithfully

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[END OF LETTER]

Poor mother-to-child transmission prevention programme puts lives at risks

by Nosisa Mhlathi

Edited version of article published in City Press (2 September 2007) and Cape Times (6 September 2007)

By Nosisa Mhlathi

Nomandla is a 29-year-old woman from Khayelitsha, Cape Town. She tested HIV-positive in October 1999. She was very scared; she knew her results even before she was tested because her son had already tested positive. Nomandla felt depressed that she had transmitted the virus to him. She felt that she had committed a sin. Almost every day her child was in and out of hospital. She endured the pain of watching him suffer in his fight for life. She wonders if things would have been different if she had had access to the mother-to-child transmission prevention programme that was implemented in Khayelitsha when her son was born. Nomandla's story is typical even today.

Tens of thousands of infants contract HIV every year because the mother-to-child transmission prevention programme is poorly implemented. It is also poorly monitored, so statistics released by the government must be treated with caution. But taking them at face value, between 60 and 70% of pregnant women attending antenatal clinics in 2006 were offered mother-to-child transmission prevention services. This is already too low, but it gets much worse. Of the approximately 600 000 women offered the programme, we would expect about 175 000 to be HIV-positive. Yet fewer than 75 000 - less than half - actually received the anti-retroviral medicines that reduce the risk of HIV transmission. And it gets worse still. Of these 75 000 births, only about 20 000 infants were actually tested for HIV and about 25% tested HIV-positive.

A further problem is that a single-dose nevirapine anti-retroviral regimen is implemented in eight of the nine provinces. Even though it is regarded as sub-optimal internationally and locally, if the drug AZT were added to it, the transmission rates could be brought down from 12 to 25% (depending on various factors) to about 5 to 10%. The Western Cape programme has to its credit for several years now implemented this dual prophylaxis regimen. Healthcare workers here have consequently reported lower transmission rates and reduced infant mortality.

Healthcare workers in Gauteng and KwaZulu-Natal have indicated they have the capacity to implement dual therapy immediately, but cannot do so without authorisation from the national Department of Health.
A year has passed since the International Aids Conference in Toronto, where the World Health Organisation (WHO) published updated guidelines for prevention of mother-to-child transmission in resource-limited settings, including the introduction of dual therapy. The HIV National Strategic Plan endorsed by cabinet on May 3 states "there is overwhelming evidence that better efficacy is achieved with dual therapy in (mother-to-child transmission prevention). A dual therapy regime is also known to be highly cost-effective." The Medical Research Council and the Southern African HIV Clinicians' Society also recommend this improved drug regimen. The money saved on HIV treatment for infected babies more than compensates for the extra cost of the second drug.

We are also losing an important opportunity in our mother-to-child transmission prevention programme to identify women who have Aids and need to go on to highly active anti-retroviral treatment (which involves three drugs taken daily for life) in order to restore their health.

Several organisations have written to the government to ask when dual therapy will be implemented. So far the

government's only response has been a press statement on July 31 explaining that work is being done by the Department of Health to improve the current guidelines. Why is it taking so long and why can the national department simply not give provincial departments the go-ahead to implement dual therapy and other improvements to the programme?

It is true that some scientific questions remain unanswered. For example, paediatricians are unsure how to handle the complex problem of infant feeding. Breast milk is healthier than formula milk, but breastfeeding also increases the risk of HIV transmission. So across the country, paediatricians recommend different feeding strategies to HIV-positive mothers. But there is unanimity that the single-dose nevirapine regimen must be upgraded to at least dual therapy. The delay in implementing it is unnecessary and therefore the Treatment Action Campaign (TAC) has threatened court action against the Minister of Health. This would also help restore our confidence in the health department and show that the government is serious about implementing the National Strategic Plan.
We prefer not to litigate. But the long delays suggest there is no political will to improve mother-to-child transmission prevention. The consequence of this is that many more HIV-infected babies and many mothers die unnecessarily.

- Prevention of Mother-to-Child Transmission

- Prevention of Mother-to-Child Transmission
