Published on *Treatment Action Campaign* (http://tac.org.za/community)

A response to minister of health on mother to child transmission

By *moderator*
Created *2007/09/11 - 12:00am*
11 September, 2007 - 00:00 ? moderator

The Minister of Health has made statements to the media that the Department of Health has long been prepared to implement dual therapy regimens in all the provinces in South Africa, but has been prohibited by the 2001 Constitutional Court judgment in Minister of Health and Others v TAC and Others. She states that the judgment limited the Department of Health to implementing only 'monotherapy' nevirapine (NVP) to mothers with HIV to reduce mother-to-child transmission. This is a gross distortion of the truth.

The facts are as follows:

- The case before the Constitutional Court became necessary because of the unwillingness of the Department of Health to provide treatment for PMTCT in the public sector. At the time the use of single dose NVP was recommended by the WHO and approved for this purpose by South Africa's own regulatory authorities.

- The decision to use single-dose NVP as opposed to AZT or other more effective regimens was taken by the Department of Health when it initiated 18 PMTCT pilot sites before the case. But it refused to extend the programme beyond these pilot sites. Single-dose nevirapine was the cheapest regimen available and this probably informed the state's decision. (See the extract below from a speech by the Minister of Health to the National Assembly on 16 November 1999.)

- Despite the fact that a number of public health facilities were ready to roll out PMTCT, and had the necessary resources, the Department actively prevented them from doing so. It was in these circumstances that the Department was ordered to provide treatment for PMTCT and to avoid unnecessary infections.

- In its order the Constitutional Court expressly stated:
  "The orders made . . . do not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods become available to it for the prevention of mother to child transmission of HIV."
  It is obvious, therefore, that the Court in no way contemplated that its judgment should be read as limiting the ability of the Department to improve and update the treatment guideline for PMTCT.

- In the face of this judgment, and constant pressure at least since July 2004 from health care workers, scientists and activists to update the PMTCT regimen so that it offers better protection for the mother and child, the Department refused to do so. (See newsletter of 15 July 2004 .)

- As a last resort, on 6 August 2007, the AIDS Law Project wrote to the Minister on behalf of a group of concerned health care workers, the Southern African HIV/AIDS Clinicians' Society and the Treatment Action Campaign demanding that the treatment regimen be updated in line with local and international expert recommendations. Although these recommendations were published over a year ago, only the Western Cape province has been implementing a dual therapy regimen. It has seen a reduction of its mother-to- child HIV infection rate to around 8%. This regimen is not implemented in other provinces around South Africa.

We welcome yesterday's announcement by the Department of Health at SANAC of the imminent approval of dual therapy as a minimum treatment regimen for PMTCT. We call for the urgent and proper implementation of this policy.

For more information contact:

Heather Mangwiro (011) 356 4117 or

Adila Hassim (011) 356 4116

Nosisa Mhlathi (021) 788 3507

Extract from speech by the Minister of Health to Parliament =96 We are not responsible for the errors in the text.

From

http://www.info.gov.za/speeches/1999/0001131124a1002.htm

The fifth clinical trial was done, both with AZT, and with a new drug called Nivirapine The trial was done as a joint Uganda/United States study.

The drugs were given to the women once during labour and delivery and the babies were given one dose within three days of being born.

The final results of the study have not been published yet, but in the interim analysis, the team looked at 308 women who had taken AZT and 310 who had taken Nivirapine, and the Nivirapine was markedly more effective. Nivirapine was also safer, less expensive and more practical than AZT or any other drug tested so far, in preventing MTCT. Nevertheless, Nivirapine is still not registered in Uganda for mass administration for the prevention of MTCT.

In terms of affordability, the cost of the short course of AZT, as given in the Thai study that showed a 50% reduction in transmission, would be approximately R400 per mother. The cost of Nivirapine, by comparison, would be approximately R30 per mother and child.

This will mean that many countries that could not adopt drug strategies that involved AZT, because of the cost, could now adopt a strategy with Nivirapine, that could lower the rate of MTCT.

Comparative studies are currently underway in South Africa to look at Nivirapine as compared to the short course in AZT (the Thai Trial) and the short course in AZT plus 3TC (the PETRA Trial). The findings of these cost-effectiveness studies are expected in March 2000.

- Manto Tshabalala-Msimang
- Prevention of Mother-to-Child Transmission

- Manto Tshabalala-Msimang
- Prevention of Mother-to-Child Transmission

Source URL (retrieved on *2017/05/24 - 8:09am*): http://tac.org.za/community/node/2139