Department of Health Announces New PMTCT Guidelines

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Some progress, but serious problems remain

The TAC welcomes the Department of Health?s announcement on Friday 25 January of a new national protocol for the Prevention-of-Mother-to-Child-Transmission of HIV (PMTCT). Central to the new policy is the introduction of dual-antiretroviral prophylaxis, consisting of nevirapine plus AZT, for preventing mother-to-child-transmission of HIV rather than the single-dose nevirapine regimen recommended in the Department?s 2003 PMTCT protocol. Pregnant women enrolled in PMTCT programmes will now receive AZT from 28 weeks of pregnancy until labour and a single dose of nevirapine during labour. Infants will be given a single dose of nevirapine after birth and short course of AZT for seven days. Other key features of government?s revised PMTCT policy guidelines include:

- Routinely offered HIV testing for pregnant women. All pregnant women attending antenatal care clinics will now be offered voluntary counselling and testing (VCT) on their first visit. Those women who test HIV-negative will be offered a follow-up test at 34 weeks pregnancy. Those who test HIV-positive will be offered a CD4 count and viral load test at the time of their HIV positive diagnosis.

- The initiation onto antiretroviral therapy of all HIV positive expecting mothers with CD4 counts of 200 cells/mm3 and below.

- The routine testing of infants for HIV in order to establish the effectiveness of the new PMTCT interventions. Babies will be tested for HIV at six weeks using PCR testing and will also receive an antibody test at 18 months.

The revised PMTCT protocol will help to reduce the number of unnecessary infant HIV infections thereby saving many lives. We call on all healthcare workers, provincial health officials and community organisations to implement these protocols.

However we regret that the Department of Health?s new protocol, while better than the 2003 one, is still out of sync with the World Health Organisation?s (WHO) strongest recommendations for the prevention-of-mother-to-child-transmission of HIV. Specifically, the revised protocol fails to include any mention of the antiretroviral drug lamivudine (aka 3TC), a safe, effective and inexpensive addition to AZT. The 2006 WHO guidelinesfor preventing HIV infection in infants recommend that lamivudine be administered to the mother, in conjunction with AZT, both during birth as an HIV prophylaxis as well as postpartum as a means of reducing the risk of nevirapine resistance.

Minister of Health Tshabalala-Msimang has on several occasions publicly expressed her concern about possible nevirapine resistance in women who have participated in PMTCT programmes. It therefore makes little sense that an effective, scientifically-proven method of reducing the likelihood of a mother developing resistance to nevirapine, a seven-day postpartum course of AZT and lamivudine (known as the ?cover-the-tail? strategy), has been actively decided against in the new national protocol. The 'cover-the-tail' strategy was strongly recommended by expert HIV

paediatricians who advised the Department of Health on the new protocol; we are disappointed that this well-founded recommendation has been ignored.

Another serious shortcoming in the new PMTCT policy guidelines is that pregnant women who test positive for HIV will only be started on antiretroviral therapy once their CD4 count has dropped to or below 200 cells/mm3. Once again this puts the new guidelines out of step with current international best practice. Compelling scientific evidence points to significant health advantages for pregnant women who initiate antiretroviral therapy at CD4 cell counts of 350 cells/mm3 rather than 200 cells/mm3. US and European treatment guidelines now recommend that all patients, including pregnant women, with a CD4 cell count of 350 cells/mm3 or below should start anti-HIV treatment. This was also recommended by expert HIV paediatricians who advised the Department of Health on the new protocol. Furthermore it should be noted that HIV is now the leading cause of maternal mortality, and that the third report of the Confidential Enquiries into Maternal Morality (2002-2004) found that non-pregnancy related infections caused nearly 40% of maternal deaths. Earlier access to treatment is a way of saving women?s lives. This is a priority.

One point in the Department's recent press statement which requires further clarification is a sentence regarding the prescription of the two drugs, AZT and nevirapine, to be used in the national PMTCT programme: "AZT and nevirapine are schedule 04 medicines and they therefore have to be prescribed by a medical officer". We hope that the term 'medical officer' as it is used by the Department of Health will not prevent nurses and midwives from being allowed to routinely and easily administer AZT and nevirapine for the purposes of PMTCT. Given the acute shortage of doctors in the public health sector, if nurses and midwives are prohibited from prescribing antiretroviral drugs the national PMTCT programme will face severe difficulty in reaching the targets set by the National Strategic Plan. This once again points to the need to urgently address the issue of task-shifting and amendments to scopes of practice and better training and conditions for nurses.

Critical to the success of the PMTCT programme is improved uptake. This requires a national community mobilization. The TAC will organize a national day of action to promote PMTCT services on 27 February. But we also welcome the decision of SANAC civil society sectors to organise a meeting to plan a national campaign in April for PMTCT scale-up, based on the National Strategic Plan outcomes and targets. We believe that such a campaign should promote testing; planned parenthood; reproductive choices; counselling; treatment for pregnant women; dual therapy and appropriate feeding strategies for infants including formula feed and exclusive breastfeeding. It should also plan scale-up strategies for testing and treatment of children and their fathers.

Civil society, health workers, faith organizations, political parties and organised labour will have to mobilise to ensure the PMTCT programme is properly implemented. We have a chance to save women?s lives and to begin to eliminate infant HIV infections.

- Prevention of Mother-to-Child Transmission

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