



African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR
GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF
MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

PMTCT COUNTRY REPORT

SOUTH AFRICA



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
AFASS	Acceptable, Feasible, Affordable, Sustainable and Safe
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
DHS	Demographic and Health Survey
PMTCT	Prevention of Mother To Child Transmission
HIV	Human Immunodeficiency Virus
HSRC	South African Human Sciences Research Council
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MS	Member State
NAC	National AIDS Council
NGO	Non Governmental Organisation
PEP	Post-exposure Prophylaxis
PFP	Project Focal Person
PICT, PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Postnatal Care
PSS	Psychosocial Support
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
TAC	Technical AIDS Committee
TOT	Training of Trainers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

ACKNOWLEDGEMENTS

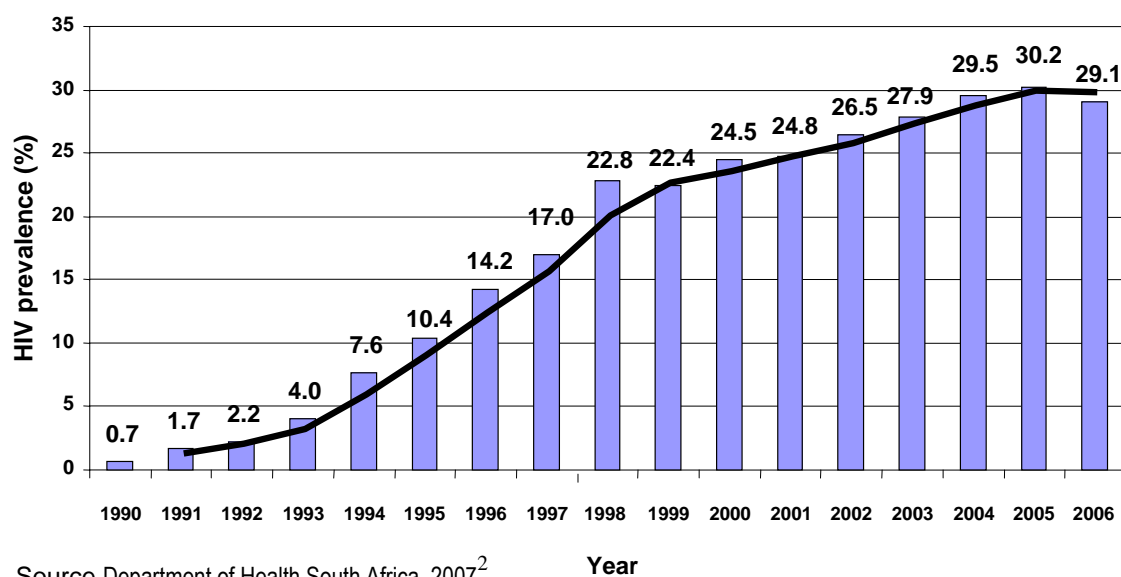
This report is based on information and support from many sources. Our thanks to the SADC secretariat for commissioning this project, and for supporting all its various phases. Thanks also to the various partners and the South African National authorities and officials who contributed to the design and successful implementation of the field work. Our gratitude also to the PMTCT project focal person for South Africa, Prof Geoff Setswe, for the substantial efforts he/she invested in conducting field work. This analysis was carried out by Prof John Seager (Monitoring and Evaluation Expert for the project) and Dr Njeri Wabiri (Project Director).

1. INTRODUCTION

1.1 HIV/AIDS and PMTCT in South Africa

Using data drawn for various sources, Rehle et al. (In press)¹ summarised the HIV and PMTCT situation in South Africa as follows. In South Africa, HIV prevalence surveillance among pregnant women attending public health clinics has been conducted on an annual basis since 1990 and served as the primary source for monitoring trends of HIV in the country (Figure 1). HIV prevalence data collected from the latest round of antenatal clinic surveillance suggest that HIV infection levels might be leveling off, with prevalence among pregnant women at 30% in 2005 and 29% in 2006 (Department of Health South Africa, 2007).

Figure 1: Antenatal HIV prevalence, South Africa 1990 - 2006²

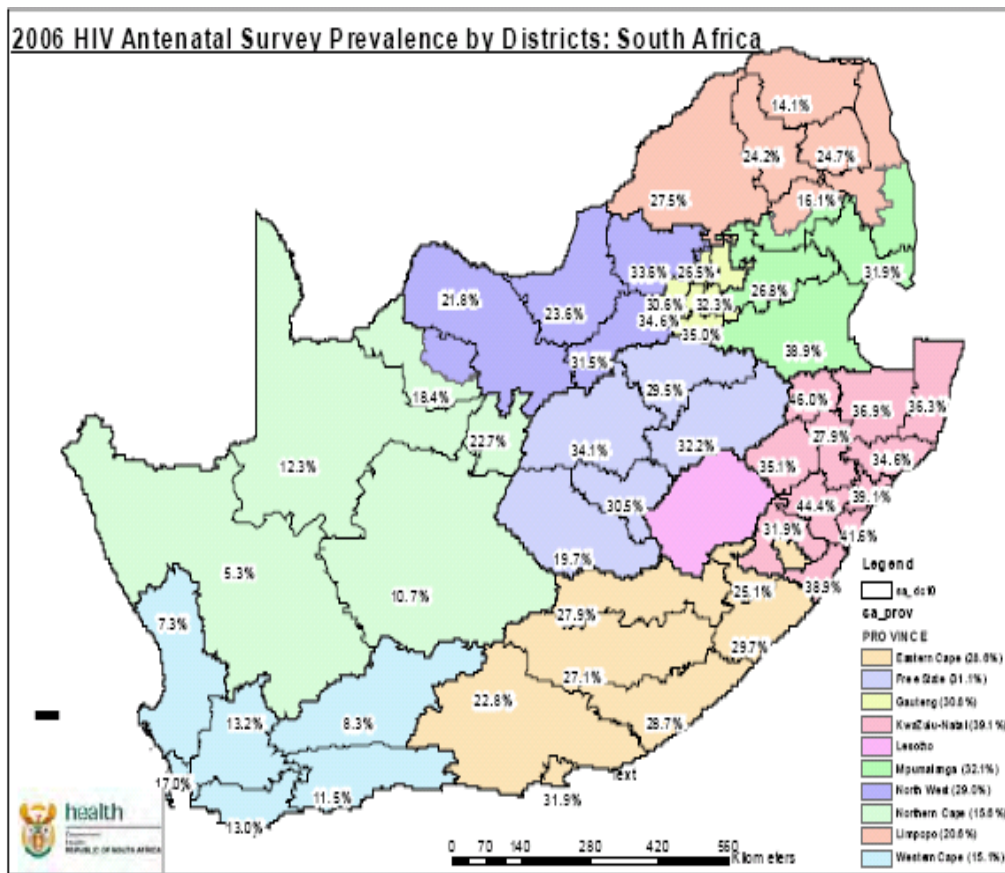


The HIV prevalence levels in antenatal clinic attendees vary considerably between provinces, from 15% in the Western Cape to 39% in the province of KwaZulu-Natal (Figure 2). The variations within provinces are equally wide, e.g., the district level prevalence for KwaZulu-Natal ranges from 27.9% in Umzinyathi to 46.0% in Amajuba (Department of Health South Africa, 2007).

¹ Rehle T, Simbayi L, Leclerc-Madlala, S, Shisana, O, Zungu, N, Seager, J, Peltzer K. In press. HIV/AIDS and Society. *It: The State of the Nation 2008*. Cape Town: HSRC Press.

² Department of Health South Africa (2007). *National HIV and syphilis antenatal prevalence survey, South Africa 2006* Pretoria: Department of Health South Africa.

Figure 2: Antenatal HIV prevalence by district, South Africa 2006



Source: Department of Health South Africa, 2007²

The most widely acknowledged shortcoming in South Africa's response to the HIV/AIDS epidemic has been the country's delay in availing treatment for the prevention of mother-to-child transmission (PMTCT) of HIV as well as antiretroviral therapy (ARV) for those with advanced HIV infection. The government began implementing the expanded PMTCT programme towards the end of 2002. It is estimated that by August 2005, PMTCT services were available to HIV-positive pregnant mothers at 2 525 sites nationwide. According to information collected during the current study, 86% of districts now offer PMTCT, although coverage varies substantially (48-100%) between districts and provinces (Section 3.2).

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for policies, protocols and guidelines for PMTCT in the SADC region.

To achieve this, the project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) - see appendix 1 - is reviewing and analysing policies, protocols and guidelines for PMTCT in each SADC member state (MS), in collaboration with the PMTCT national focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on PMTCT, and come up with best practices in implementation of PMTCT policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);

- review gender issues and consider how men and women are involved in PMTCT; and
- review and analyse proposed minimum standards for the PMTCT policies.

2. METHODOLOGY

The PMTCT national focal person in South Africa was tasked with three key responsibilities:

- 2.1: Identify policies, procedures and frameworks on PMTCT
- 2.2: Participate in the assessment of the policies, procedures and frameworks on PMTCT
- 2.3: Facilitate dialogues and stakeholders consultations on policies relating to PMTCT, including policy discussions on the development and implementation of policies, procedures and frameworks on PMTCT in the country.

A field guide, consisting of relevant tools and instructions for each of the task, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key stakeholders in the country. The field guide was piloted in one of the Member states in collaboration with SADC.

Policy discussions, facilitated by the PFP in collaboration with SAHARA team expert, were held with various key stakeholders in the country, including:

- government official(s) responsible for PMTCT policies, protocols and guidelines;
- civil society official(s) responsible for PMTCT policies, protocols and guidelines;
- representative(s) of international organizations responsible for PMTCT;
- representative(s) of private or informal sector responsible for PMTCT policies, protocols and guidelines; and
- others as appropriate.

The policy discussions were scheduled at the convenience of the respondents and conducted in the community or at an office where there was an undisturbed atmosphere. The PFP received direction and guidance from SAHARA project team on how to conduct policy discussions. Selected respondents were invited by letter or email to participate in the discussions, and included officials from the national AIDS council and national AIDS coordination programmes; PMTCT programmes and administrative staff; primary stakeholders, such as technical partners, donors and implementing agencies; and civil society.

3. FINDINGS

3.1 SWOT analysis of PMTCT in South Africa

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats in regard to the PMTCT programme in South Africa (details are in Appendices 2, 3, 4, 5, 6).

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • PMTCT policy drafted in 2001 • New PMTCT guidelines published February 2008 • PLWHA and disability sector involved in social mobilization plan for PMTCT • Wide consultation on policies and plans 	<ul style="list-style-type: none"> • PMTCT protocol does not (fully) match international best practice norms. • Men not sufficiently involved (but 'Men as Partners' programmes is addressing this) • Adolescent mothers not included in PMTCT planning • Inadequate human resources • Poor quality counselling • Infant formula supply problems • Inaccurate M&E
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Recent renewed political commitment • Accelerated PMTCT roll out launch (Mar/Apr 2009) • Change to PITC in ANC and maternity settings • PNC register piloted and ready to be printed 	

3.2 Analysis of PMTCT policies and protocols.

The first PMTCT policy was drafted in 2001. Revisions to this policy have been made in light of new research and new developments. The Department of Health published new guidelines for PMTCT in February 2008.³

The Department of Health has consulted widely in the development of the PMTCT accelerated roll-out plan. A Stakeholder Task Team was established and the plan was accepted by all key stakeholders. The government began implementing the expanded PMTCT programme towards the end of 2002. It is estimated that by August 2005, PMTCT services were available to HIV-positive pregnant mothers at 2 525 sites nationwide. According to information collected during the current study, 86% of districts now offer PMTCT, although coverage varies substantially (48-100%) between districts and provinces (Section 3.2).

Despite the overall availability of PMTCT, with around 2 525 sites nationwide accredited for PMTCT services experts estimate that only 51.7% of mothers identified as HIV positive receive treatment. The Western Cape was the first to roll out dual therapy regimens.

The strategic objectives of the accelerated PMTCT plan are to:

- 1) Increase proportion of pregnant women tested for HIV or having had a CD4 count test;
- 2) increase proportion of HIV-infected pregnant women receiving ARV dual prophylaxis to ideally > 4 weeks;
- 3) increase proportion of eligible HIV-infected pregnant women initiated on HAART;
- 4) increase proportion of HIV-exposed infants receiving dual prophylaxis;
- 5) increase proportion of HIV-exposed infants receiving a PCR test at 6 weeks; and
- 6) reduce proportion of infants with a positive PCR

³ National Department of Health. Policy and guidelines for the implementation of the PMTCT programme. February 2008. <http://www.doh.gov.za/docs/policy/pmtct-f.html>. Accessed 19/03/09

Integration of PMTCT into paediatric AIDS treatment and care activities

- PMTCT guidelines call for integrating PMTCT interventions into routine maternal and child health as well as general HIV care, treatment and support services.
- Respondents indicated that further integration of PMTCT into paediatric AIDS treatment and care activities is needed

CD4

- ART is provided for pregnant women with CD4 \leq 200

Infant and Infant feeding

- The guidelines state that infant feeding options should be discussed with mothers; exclusive formula feeding is recommended or exclusive breastfeeding if the AFASS criteria are not met.

Age of consent

- The age of consent in the new Child Care Act is 12 years

3.3 PMTCT policy gaps in South Africa

- Civil society has consistently called for the adoption of a new PMTCT protocol that meets international best practice norms and includes the submissions of the Department of Health Task Team.
- M&E of the PMTCT programme is not conducted by reputable national academic or research organizations.
- Management systems are not based on best practices and resources are not adequate to ensure PCR HIV testing is performed at 6 weeks and shortly after weaning.
- Inter-facility transfer of information has not been simplified and medication prescribed is not clearly noted on the relevant identification card.

3.4 PMTCT situation analysis in South Africa

See Appendix 3.

3.5 PMTCT approaches/ Models in South Africa

The package includes:

- primary HIV prevention programmes for women of child-bearing age;
- routine offer of voluntary HIV counselling and testing to pregnant women;
- safe infant feeding counselling and support;
- safe obstetric practices;
- single-dose nevirapine (sdNVP) to the mother and to the infant; as well as the provision of infant formula to women who choose this route and who will be able to do it safely, in an acceptable, feasible, affordable and sustainable manner.

Strategies to promote PMTCT uptake include:

- Political commitment, prioritising the program
- Community mobilization, through door to door campaigns or other serious district campaigns have been proposed. PMTCT is seen as a catalyst for wider service coverage and for the implementation of the national strategic plan (NSP)
- Increase effective coverage, holding institutions accountable to this and watching the impacts of greater emphasis of provincial care
- Move to Provider Initiated Counselling and Testing

- Increase staffing for the programme
- Integration of services

3.6 Key PMTCT policy discussion issues

See details in Appendix 6

Some of the bottlenecks in the implementation and scaling up of PMTCT include:

- (a) Data challenges in facilities
- (b) Incorporation of family planning into VCT (training)
- (c) Inclusion of unintended consequences
- (d) Prevention of vertical transition (early booking of mothers)
- (e) Maternity records silent on HIV status of mothers - thus no ARVs are dispensed during labour
- (f) HAART system for pregnant women; and
- (g) that CD4 counts are not being properly documented (filed).

Other challenges include:

- Too few people are willing to be tested, hence testing rates remain low despite availability of testing sites
- Poor Nevirapine administration rates
- Poor transfer of information
- Poor data quality that makes programme assessment difficult
- No widespread campaigns or agreement on the message to send out
- Community involvement is lacking
- PMTCT is not seen as a priority by healthcare facilities, in part due to competing demands
- PMTCT is a poorly resourced programme, compared to others such as ARV rollout.

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

- Provision of dual therapy
- Counselling on infant feeding
- Good basic antenatal services across SADC
- Good strong referral system that involves the referring health professional, patient and receiving health professional.
- Age of consent:
 - The age of consent in the new Child Care Act is 12 years

Performance Monitoring and Evaluation of the PMTCT programme

- All districts (not only priority districts for accelerated PMTCT plan) should conduct appraisal of current status of PMTCT
- Institute a PMTCT barometer to evaluate the level of performance on PMTCT in the districts
- Standardize data collection tools, strengthen M&E systems and improve the quality of District Health Information System (DHIS) data;
- Introduce Excellence award for the best performing district for PMTCT;
- Develop training packages and check lists, posters etc. for community-based delivery packages

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF PMTCT POLICIES, PROTOCOLS AND GUIDELINES

Prongs	Indicator
1: Primary prevention of HIV infection among women of childbearing age	
1.1 [Health education]	Y
1.2 [HIV testing and counselling]	Y
1.3 [Couple HIV counselling & testing]	?
1.4 [Safer sex practices including dual protection (condom promotion)]	?
2: Preventing unintended pregnancies among women living with HIV	
2.1 [Family planning]	
2.2 [HIV testing and counselling]	Y
2.3 [Safer sex practices including dual protection (condom promotion)]	?
3: Preventing HIV transmission from a woman living with HIV to her infant	
[Quality antenatal and delivery care]	
3.1 [HIV testing and counselling]	Y (PI)
3.2 [Retesting in late pregnancy]	Y
3.3 [HIV pre-test counselling]	Y
3.4 [Post-HIV test counselling]	Y
3.6 [Male involvement]	Y
3.7 [Gender-based violence; stigma]	Y
3.8 [Involvement of PLHIV]	?
3.9 [Clinical (staging) and immunological assessment of pregnant women]	Y
3.10 [ART for pregnant women eligible for treatment]	Y (≤ 200)
3.11 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y (Dual)
3.12 [Safer obstetric practices]	Y
3.13 [Infant feeding counselling and support]	Y
4: Providing appropriate treatment, care and support to mothers living with HIV and their children and families	
Mothers	
4.1 [ART for pregnant women eligible for treatment]	Y (≤ 200)
4.2 [Co-trimoxazole prophylaxis]	Y
4.3 [Continued infant feeding counselling and support]	Y
4.4 [Nutritional counselling and support]	Y
4.5 [Sexual and reproductive health services including family planning]	Y
4.6 [Psychosocial support]	Y
4.7 [Tuberculosis screening]	Y
Children	
4.8 [ARV prophylaxis]	Y
4.9 [Routine immunization and growth monitoring and support]	Y
4.10 [Co-trimoxazole prophylaxis starting at 6 weeks]	Y
4.11a [Early diagnosis testing for HIV infection at 6 weeks where virological tests are available]	Y
4.11b [Antibody testing for young children at 18 months where virological testing is not available]	Y

4.12 [Antiretroviral therapy for eligible HIV infected children]	Y
4.13 [Continued infant feeding counselling and support]	Y
4.14 [Screening and management of tuberculosis and other opportunistic infections]	
4.15 [Prevention and treatment of malaria]	
4.16 [Nutrition care and support]	Y (6 ms)
4.17 [Psychosocial care and support]	Y
4.18 [Symptom management and palliative care if needed]	?
4.19 [Diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illness (IMCI)]	Y
PMTCT national policy	
Existence of national guidelines for the prevention of HIV infection in infants and young children in accordance with international or commonly agreed standards (WHO, 2004a)	2008

APPENDIX 3: PMTCT INDICATORS IN SOUTH AFRICA

Category	Estimate
HIV prevalence estimates	
Estimated adult HIV prevalence rate, 2007, 15-49 (UNICEF, 2008)	18.1%
Estimated adult HIV prevalence rate, 15-49 (Specify if SADC or country report and year)	18.1%
Estimates based on population based survey data, 2007, 15-24 year-olds (SADC, 2008)	10.3%
PMTCT indicators	
Antenatal care coverage (UNICEF, 2008)	92%
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months. (WHO, 2004a)	
The percentage of public, missionary and workplace venues (FP and PHC clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services for the prevention of HIV infection in infants and young children in the preceding 12 months. (WHO, 2004a)	
The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling. (WHO, 2004a)	67.9%
The percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards) in the preceding 12 months.	57% 53% (NVP)
The percentage of HIV-positive infants born to HIV-infected women. (WHO, 2004a)	
The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (UNICEF, 2008)	--
The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within 2 months of birth (UNICEF, 2008)	--
Percentage of people receiving antiretroviral therapy who are children (WHO/UNAIDS, 2006)	8%

APPENDIX 4: SUMMARY OF PMTCT IMPLEMENTATION CHALLENGES

Implementation challenges	Yes, No, N/A: & Extent of Challenge
Inadequate financial resources, which are often narrowly earmarked by donors	
Inadequate human resources; problems with lay counsellors	X
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	X
Low coverage of PMTCT	
Stigma and discrimination;	X
Inadequate support for infant feeding which remains a complex issue, requiring further research	X formula supply problems
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	X
Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;	X
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services;	
Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;	X
Programme monitoring, recording and reporting	X inaccurate recording
Quality assurance and impact assessment;	X Poor quality of counselling
Inadequate efforts to ensure male engagement;	
Impact of gender inequality and of gender-based violence	
Lack of capacity to cost plans	
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	X
Slow scale-up of early infant diagnosis of HIV	
Other: Please include other challenges not covered above	

APPENDIX 5: PMTCT IMPLEMENTATION NEEDS IN SOUTH AFRICA

PMTCT implementation needs	Yes, No, N/A: & Additional comments
Need to speed up development of policies and guidelines	Update IYCF policy;
Need to improve M & E (PMTCT indicators, registers)	X PNC register piloted and ready to be printed
Need to improve C & T (quality)	X
Appropriate use of lay counsellors in the health care setting	
Improve integration of PMTCT into paediatric AIDS treatment and care activities	X
Effective communication on PMTCT	X
Scale up of co-trimoxazole prophylaxis	X
Improve community support/male involvement	X
Strengthen quality assurance for PMTCT services	X
To roll out more efficacious regimen in all facilities providing PMTCT services	X
To roll out early infant diagnosis	X
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

Date (day, month, year): 5 Feb 2009

Name of country: South Africa

Policy discussion: PMTCT

Participants /Stakeholders:

Representatives of the following organizations: Department of Health, AIDS Consortium, Reproductive Health and HIV Research Unit, Right to Care, Perinatal HIV Research Unit, Democratic Nursing Organisation of South Africa (DENOSA), Treatment Action Campaign.

Please tell me about the Country's PMTCT programme, what has been its great achievements or strengths, and where you think it could be improved?"

There number of accredited sites for PMTCT/ARV services has increased to over 2500, to be precise approximately 2525 sites.

DISCUSSION QUESTIONS

1. Are you aware of the existence of approved PMTCT policies and guidelines? And when they were published?

The first PMTCT policy was drafted in 2001. Revisions to this policy have been made in light of new research and new developments.

The Department of Health published new guidelines for PMTCT in February 2008.

The 2008 PMTCT guidelines say:

Women with CD4 counts below 200 or at WHO stage IV: start three-drug antiretroviral therapy for the mother's health in line with national guidelines, start cotrimoxazole prophylaxis.

Women already taking antiretrovirals when pregnancy is confirmed: if taking Efavirenz, switch to Nevirapine in the first trimester. If pregnancy is confirmed after this point, an Efavirenz switch is no longer necessary but a foetal anomaly scan is recommended due to the possible adverse effects of Efavirenz exposure on the foetus during the first trimester.

Mothers not requiring antiretroviral therapy for their own health: start AZT at week 28 or as soon as possible thereafter unless anaemic and take single dose Nevirapine at the onset of labour.

Infants: single dose Nevirapine after delivery and AZT for seven days. AZT should be given for 28 days if the mother received less than four weeks of AZT or HAART during pregnancy, or if the mother received only single dose Nevirapine.

Infant feeding options should be discussed with mothers, and for each woman the acceptability, feasibility, affordability, sustainability and safety (AFASS) of exclusive formula feeding should be discussed, with a recommendation for exclusive breastfeeding if the AFASS criteria are not met.

2. Was there a consultation process for developing PMTCT policy?

Yes. PMTCT policy guidelines were debated by the DOH Policy Committee which is the last process before approval. Government's role was to ensure that the Policy Committee fast tracked the adoption of the policy guidelines

The department has consulted widely in the development of the PMTCT accelerated roll-out plan. Those involved in the drafting of the SANAC PMTCT social mobilisation plan were invited by the Minister to present to the DoH team preparing the accelerated PMTCT roll-out. At this stakeholder meeting (26 November 2008) a Stakeholder Task Team was established; the plan was accepted by all key stakeholders.

3. Do the standards of PMTCT policies/comply with global minimum standards? Should they comply given the situation in your country? What is your view?

Civil society has consistently called for the adoption of a new PMTCT protocol that meets international best practice norms and includes the submissions of the Department of Health Task Team.

4. Gender issues addressed (e.g. are both men and women sufficiently informed and their voices heard)

Men are not sufficient involved and informed on PMTCT issues.

5. How men are involved in PMTCT, and identify best practices. (Note: This is a very important question which should be addressed by asking a sample of men how they think men are being involved in PMTCT. They are important stakeholders)

The social mobilization plan for the accelerated PMTCT plan is targeting men as important stakeholders in the programme. Men as partners programmes will be provided with information on the PMTCT so they can encourage men to support partners who need to take up PMTCT during pregnancy.

6. What are views of people living with HIV and AIDS, those with disabilities and adolescent mothers?

The Communications Technical Task Team which developed the social mobilization plan of the accelerated PMTCT plan had representatives from important stakeholder groups such as PLWHA and the disability sector. Their views were included in scaling up the PMTCT programme. However, adolescent mothers were not specifically invited

7. Are policies/guidelines easily available to all stakeholders?

Yes. The PMTCT policy and guidelines have been printed out and have been distributed to all stakeholders.

The guidelines are available for download from the South African Department of Health website at <http://www.doh.gov.za/docs/policy/pmtct-f.html>.

8. Are there gaps in PMTCT policies? Please give examples

- Monitoring & Evaluation of the PMTCT programme is not conducted by reputable national academic or research organization
- Management systems are not based on best practices and resources are not adequate to ensure PCR HIV testing is performed at 6 weeks and shortly after weaning.
- Inter-facility transfer of information has not been simplified and medication prescribed is not clearly noted on the relevant identification card.

9. What quality assurance challenges affect PMTCT?

The quality of counselling and the time taken in a counselling session determines the acceptability of the programme to pregnant women.

The mother's choice of feeding is also dependant on counselling, indicated by the large number of women who are unsure of the feeding method for their infant after being counselled.

10. PMTCT implementation coverage

We estimate that only 51.7% of mothers identified as HIV positive are receiving treatment. The Western Cape was the first to roll out dual therapy regimens.

The strategic objectives of the accelerated PMTCT plan are to:

- 1) Increase proportion of pregnant women tested for HIV or having had a CD4 count test
- 2) Increase proportion of HIV + pregnant women receiving ARV dual prophylaxis to ideally > 4 weeks
- 3) Increase proportion of eligible HIV + pregnant women initiated on HAART
- 4) Increase proportion of HIV-exposed infants receiving dual prophylaxis
- 5) Increase proportion of HIV-exposed infants receiving a PCR test at 6 weeks.
- 6) Reduce proportion of infants with a positive PCR

11. In your view what are the key Implementation challenges to scaling up PMTCT

Some of the bottlenecks in the implementation and scaling up of PMTCT include:

- (a) Data challenges in facilities
- (b) Incorporation of family planning into VCT (training)
- (c) Inclusion of unintended consequences
- (d) Prevention of vertical transition (early booking of mothers)
- (e) Maternity records silent on HIV status of mothers - thus no ARV's are dispensed during labour
- (f) HAART system for pregnant women; and
- (g) that CD4 counts are not being properly documented (filed).

Other challenges include:

- Too few people are accepting to be tested for HIV hence the testing rates remain low despite availability of testing sites
- Poor Nevaripine administration rates
- Poor transfer of information
- Poor data quality that makes programme assessment difficult
- No widespread campaigns, *what messages are we sending out?*
- Community involvement is lacking
- PMTCT is not seen as a priority by healthcare facilities, competing demands
- Poorly resourced programme, compared to others such as ARV rollout.

12. Is there a PMTCT implementation plan?

- An accelerated PMTCT implementation plan has been developed in selected districts
- The PMTCT accelerated roll-out plan and mobilization campaign will be launched by the Department of Health at the 4th South African AIDS Conference in March/April to obtain buy-in from key stakeholders.
- There must be a standing committee of researchers, academics and policymakers on PMTCT guidelines that meets once a quarter to consider new evidence and recommends new updates to the PMTCT protocol.

- Establishment of a clear and accountable hierarchy of management for PMTCT that takes responsibility for oversight of logistical problems down to the clinic level.
- Shift to Provider Initiated Testing (PIT) as the norm in the antenatal and maternity settings in the South African Public Health System.

13. PMTCT service delivery models. What would you recommend?

The accelerated PMTCT roll-out plan was introduced as a means to revitalise the national response to HIV and improve outcomes. It is also a means to invigorate and improve the public health system and a primary care approach. The plan will be phased into the 18 Priority Districts (poor performing districts) before expansion nationally. The identification of the 18 priority districts was done in systematic way.

14. Strategies to promote PMTCT uptake

Strategies to promote PMTCT uptake include:

- Political commitment, prioritizing the program
- Community mobilization, through door to door campaigns or other serious district campaigns have been proposed. PMTCT is seen as a catalyst for wider service coverage and for the implementation of the NSP
- Increase effective coverage, holding institutions accountable to this and watching the impacts of greater emphasis of provincial care
- Move to Provider Initiated Counselling and Testing
- Increase staffing for the programme
- Integration of services
- Keeping up with the latest science. We need to update our protocols and look at new therapy and regimens such as Dual therapy and when to begin HAART. Importantly, the resources need to also be able to keep up with the science- if 40% of women need to start HAART then we need to be able to make that happen.

POSSIBLE RECOMMENDATIONS FOR MINIMUM STANDARDS

In your view what issues should the minimum Standards for PMTCT in SADC critically consider in SADC:

- Provision of dual therapy
- Counselling on infant feeding
- Good basic antenatal services across SADC
- Good strong referral system that involves the referring health professional, patient and receiving health professional.
- Age of consent:
 - The age of consent in the new Child Care Act is 12 years

Performance Monitoring and Evaluation of the PMTCT programme

- All districts (not only priority districts for accelerated PMTCT plan) should conduct appraisal of current status of PMTCT
- Institute a PMTCT barometer to evaluate the level of performance on PMTCT in the districts
- Standardize data collection tools, strengthen M&E systems and improve the quality of District Health Information System (DHIS) data;
- Introduce Excellence award for the best performing district for PMTCT;
- Develop training packages and check lists, posters etc for community-based delivery packages