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

LESOTHO

Contact: Dr. Vincent U. Agu
Director, SAHARA and Team Leader
69-83 Plein Street
Cape Town 8001
South Africa
Phone: +27-21-466-7944
E-mail: vagu@hsrc.ac.za

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
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
IMAI	Integrated Management of Adolescent and Adult Illness
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
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)
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

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1. INTRODUCTION

1.1 HIV & AIDS and PMTCT in LESOTHO

In Lesotho, HIV and AIDS prevention, care, treatment and support at the health centres are being scaled-up through the WHO Integrated Management of Adolescent and Adult Illness (IMAI). Table 1 shows the HIV and AIDS Profile for 2005 and 2007.

Table 1 HIV & AIDS Profile[1]

Indicator	2005	2007
Adult HIV prevalence rate	23.2%	23.2%
HIV infected people	266,000	270,000
Adult HIV incidence rate	2.9%	2.35%
Number of new infections	26,000	21,558
AIDS mortality	24,000	18,200
AIDS related OVC	97,000	108,700
Projection of ART needs	56,000	84,791

As part of the increasing availability of testing, pregnant mothers and children will be provided with routine HIV testing and counseling. This will cover:

- All pregnant mothers attending Antenatal Clinics
- All children under 5 and as part of routine vaccinations at 6 weeks
- Children of adults enrolled in ART
- All children below 12 years admitted to hospitals and health centres
- All children who are failing to thrive
- All children testing HIV positive will be referred for post test services

PMTCT coverage increased from 5% in 2005, to 16% in 2006, 31% in 2007 and 36% in 2008. PMTCT indicators for 2008 are summarized in Table 2.

Table 2: PMTCT Indicators, 2008[2]

Indicators	2008
# of facilities providing PMTCT	179
# of new ANC clients	31346
# of clients pre-test counselled	32190
# of clients tested counselled	30661
# of clients post-test counselled	30785
# of clients HIV positive	8028
# of clients who received ARV prophylaxis	3134
# of clients who received ART	1184
# of clients who received ARV Prophylaxis & HAART	4318
# of deliveries	20843
# of HIV positive mothers delivering live births	4887
# of babies who received ARV prophylaxis	4111

Lesotho, HTC and PMTCT Programme. Progress to-date, Presented to SADC meeting December 2008 by Ms Nthati Lebona – NAC & Mrs Matsepeli Nchephe - MOHSW

Indicators	2008
HIV test uptake	95%
PMTCT Coverage	36%

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.
- review and analyse proposed minimum standards for the PMTCT policies;

2. METHODOLOGY

The PMTCT national focal person in Lesotho 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 Lesotho.

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 Lesotho. The field guide was piloted in one of the Member states in collaboration with SADC.

Policy discussions, Facilitated by the PFP, were held with various key stakeholders in the Lesotho, 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; Civil society.

3. FINDINGS

3.1 SWOT analysis of PMTCT in Lesotho

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

STRENGTHS	WEAKNESSES
• The PMTCT policy and guidelines are in a final draft (2008) • Consultative policy process • Policies and guidelines readily available • PMTCT up to 97%	• Operationalisation of the draft policy within the sites • Majority of programmes emphasise women's issues only • No clear policy for HIV negative pregnant women • QA – double counting occurs
OPPORTUNITIES	**THREATS**
• Partners in Health strong on men's issues	• Weak supply chain (drugs and test kits) • Insufficient HR

3.2 Analysis of PMTCT policies and protocols.

Integration of PMTCT into pediatric AIDS treatment and care activities

According to the current (draft) guidelines (July 2007)[3], "PMTCT services at all levels are integrated into ANC and MCH settings" but discussants indicated that a family centred and comprehensive model where PMTCT and counselling and testing are fully integrated is still needed. A final draft of PMTCT policy and guidelines was published in 2008, and is being operationalised within the sites

CD4

- Co-trimoxazole prophylaxis is recommended for pregnant women in clinical stage 1 and 2 if the CD4 count is ≤350
- For CD4 counts above 350; various prophylactic ARV regimens for mothers and infants are recommended (based on WHO guidelines).

Infant and Infant feeding

According to the current (draft) guidelines (July 2007), infant feeding options available for HIV positive mothers during the first six months of life include:

- Exclusive breast feeding from zero to six months

[3] Government of Lesotho. *Guidelines for the prevention of mother to child transmission of HIV (PMTCT).* July 2007. Maseru: Ministry of Health & Social Welfare.

- Replacement feeding with commercial infant formula, only if it is Acceptable, Feasible, Affordable, Sustainable, and Safe (AFASS) to do so

Age of consent

- National HTC policy indicates that minors may only consent to HIV testing from the age of 12 years, but pregnant minors may consent to testing at any age.

3.3 PMTCT policy gaps in Lesotho

- Retesting for HIV negative pregnant women.
- Procedures not clear as to what the health care provider should do at maternity room.

3.4 PMTCT situation analysis in Lesotho

See Appendix 3

3.5 PMTCT approaches/ Models in Lesotho

1. Primary prevention of HIV infections among women of child-bearing age
2. Prevention of unintended pregnancies among HIV infected women
3. Prevention of HIV transmission from infected mothers to their children
4. Provision of continuous care, treatment and support for infected mothers, their partners and children.

Strategies to promote PMTCT include:

- Advocacy
- PMTCT available at community health centers
- PMTCT integrated within MCH
- Male involvement
- Task shifting from doctors to nurse driven approach.

3.6 Key PMTCT policy discussion issues

See details in Appendix 6

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

1. Combined and more efficacious regimen, i.e. AZT – prophylaxis based
2. Minimum package for mother and infant
3. Family centered approach
4. Task shifting to other cadres of staff
5. Integration of PMTCT into maternal and child health services
6. Human resource strengthening in all health facilities
7. Quality assurance for PMTCT
8. Clear monitoring and evaluation indicators for PMTCT.

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]	Y
2: Preventing unintended pregnancies among women living with HIV	
2.1 [Family planning]	Y
2.2 [HIV testing and counselling]	Y
2.3 [Safer sex practices including dual protection (condom promotion]	Y
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 (Opt out)
3.2 [Retesting in late pregnancy]	
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]	
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 (≤350)
3.11 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y (Dual and triple)
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(≤350)
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 staring 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]	Y
4.15 [Prevention and treatment of malaria]	N/A
4.16 [Nutrition care and support]	Y
4.17 [Psychosocial care and support]	Y
4.18 [Symptom management and palliative care if needed]	Y
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 LESOTHO

Category	
HIV prevalence estimates	Estimate
Estimated adult HIV prevalence rate, 2007, 15-49 (UNICEF, 2008)	23.2%
Estimates based on population based survey data, 2007, 15-49 (SADC, 2008)	
Estimates based on sentinel surveillance data, 2007, 15-24 year-olds	18.7%
Estimates based on population based survey data, 2007, 15-24 year-olds	
PMTCT indicators	
Antenatal care coverage (UNICEF, 2008)	90%
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months. (WHO, 2004a)	255 (10.2%)
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)	90%
The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling. (WHO, 2004a)	62%
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.	32%
The percentage of HIV-positive infants born to HIV-infected women. (WHO, 2004a)	15%
The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (UNICEF, 2008)	77.2%
The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within 2 months of birth (UNICEF, 2008)	28%
Percentage of people receiving antiretroviral therapy who are children (WHO/UNAIDS, 2006)	7.3% (2007) MOHSW - HMIS

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	Y
Inadequate human resources; problems with lay counsellors	Staff shortages; Commitment to fund the community health workers to carry out HTC
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Y
Low coverage of PMTCT	Y more in urban, need more in health centers
Stigma and discrimination;	Y though very low due to the fact that more people live openly with their HIV status
Inadequate support for infant feeding which remains a complex issue, requiring further research	Y
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	Y
Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;	Y needs strengthening
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;	Y
Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;	Y
Programme monitoring, recording and reporting	Y needs strengthening of data management system
Quality assurance and impact assessment;	Quality assurance/ control not yet fully operational
Inadequate efforts to ensure male engagement;	Y
Impact of gender inequality and of gender-based violence	Y still a challenge as some women are abused due to their HIV positive status
Lack of capacity to cost plans	Y
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	Y challenge of human resource. Health care providers consider it as extra burden.
Slow scale-up of early infant diagnosis of HIV	Y DNA/PCR still done in the Republic of South Africa.
Other: Please include other challenges not covered above	

APPENDIX 5: PMTCT IMPLEMENTATION NEEDS IN LESOTHO

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)	Y PNC register piloted and ready to be printed
Need to improve C & T (quality)	Y
Appropriate use of lay counsellors in the health care setting	
Improve integration of PMTCT into pediatric AIDS treatment and care activities	Y
Effective communication on PMTCT	Y
Scale up of co-trimoxazole prophylaxis	Y
Improve community support/male involvement	Y
Strengthen quality assurance for PMTCT services	Y
To roll out more efficacious regimen in all facilities providing PMTCT services	Y
To roll out early infant diagnosis	Y
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

DISCUSSION QUESTIONS

1. Are you aware of the existence of approved PMTCT policies and guidelines? And when they were published?
    - The PMTCT policy and guidelines are in a final draft but already being operationalised within the sites. The final draft was published in 2008

2. Was there a consultation process for developing PMTCT policy?
    - Yes, consultations were made with all stakeholders in the development of the policy

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?
    - General view was that they must comply based on WHO guidelines especially as they address the resource limited settings.

4. Gender issues addressed (e.g. are both men and women are sufficiently informed and their voices heard)
    - Majority of issues addressed are pertaining to women as more women are targeted at maternal and child health sites. There is need for corners that address men's 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)*
    - Men are involved through male support groups (Partners in Health have a strong programme) and family support groups.

6. What are views of people living with HIV and AIDS, those with disabilities and adolescent mothers
    - PMTCT is a welcome intervention by the majority of Basotho the results are seen in the acceptance rate of more than 90%, with 96.7% in EGPAF sites.

7. Are policies/guidelines easily available to all stakeholders?
    - All stakeholders involved in the implementation of PMTCT have access to policies and guidelines.

8. Are there gaps in PMTCT policies? Please give examples
    - Retesting for HIV negative pregnant women. Procedure not clear as what the health care provider should do at maternity room.

9. What quality assurance challenges affect PMTCT?
    - Double counting is still a challenge and also the central laboratory for testing kits for quality assurance.

10. PMTCT implementation coverage
    - PMTCT coverage stands at 90% and in some sites at 97%.

11. In your view what are the key Implementation challenges to scaling up PMTCT
    - PMTCT implementation challenge is on drug supply chain, test kits supply chain and human resource.

12. Is there a PMTCT implementation plan?

    - There is an implementation plan available for service providers.

13. PMTCT service delivery models. What would you recommend?
    - Family centred and comprehensive model where PMTCT and counselling and testing are fully integrated.

14. Strategies to promote PMTCT uptake
    - Advocacy
    - PMTCT available at community health centers
    - PMTCT integrated within MCH
    - Male involvement
    - Task shifting from doctors to nurse driven approach.

POSSIBLE RECOMMENDATIONS FOR MINIMUM STANDARDS

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

1. Combined and more efficacious regimen, i.e. AZT – prophylaxis based

2. Minimum package for mother and infant
3. Family centered approach
4. Task shifting to and other cadres of staff
5. Integration of PMTCT into maternal and child health services
6. Human resource strengthening in all health facilities
7. Quality assurance for PMTCT
8. Clear monitoring and evaluation indicators for PMTCT.