



HSRC RESEARCH OUTPUTS

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**REGIONAL MINIMUM STANDARDS FOR
HARMONISED APPROACHES TO PREVENTION OF
MOTHER TO CHILD TRANSMISSION (PMTCT) IN THE
SADC REGION**

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Prepared by:
Directorate for Social and Human Development and Special Programs
SADC Secretariat
Private Bag 0095
Gaborone
Botswana

Karl Peltzer

Njeki Wabiri

John Seager

Geoffrey Setswe

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¹ SADC Communicable Diseases project team members: Mr Innocent Modisaotile – Project Coordinator, Dr Ityai Muvandi – Monitoring and Evaluation Expert, Mr Laneck Mithi Finance Manager, Mrs Christobel Chakwana – Gender Expert, Mr Winter Chinamale – Procurement Expert, Mr Trymore Sinyika – Finance Assistant and Mrs Vivian Morutwa - Secretary

² HIV and AIDS Unit members – Dr Ityai Muvandi, Mrs Doreen Sanje – Partnership Coordinator, Dr Alphonse Mulumba – Research Manager, Mr Paul Nesara – Database Manager, Dr Vitalis Chipfakacha – HIV and AIDS Mainstreaming advisor, Mrs Carol Buzwane - Secretary

ABBREVIATIONS

AFASS	Affordable, Feasible, Accessible, Safe and Sustainable
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azido-Thymidine
CDC	Centres for Disease Control and Prevention (in the USA)
CICT	Client Initiated Counselling and Testing
CT	Counselling and Testing
CTX	Cotrimoxazole
EID	Early Infant Diagnosis
EPI	Expanded Programme on Immunization
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
IHP	Integrated Health Plan
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health
MS	Member State (of the SADC Region)
NAC	National AIDS Council
NERSA	National Emergency Response System for AIDS in Swaziland
NGO	Non Governmental Organisation
NVP	Nevirapine
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PICT	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RCH	Reproductive and Child Health
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TAC	Technical AIDS Committee
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1. BACKGROUND

One of the main aims of the Southern African Development Community (SADC) is regional economic and political integration. However, as the region progresses towards the achievement of this objective, it is challenged by the adverse effects of HIV and AIDS on social, political and economic development. The region leads the world in terms of HIV infections, the majority of Member States have adult HIV prevalence levels of over 15%, and several have adult prevalence of more than 20%.

Eleven Member States are among the 27 countries that are estimated to account for 80% of all children living with HIV worldwide, and HIV infection in children is predominantly a result of mother-to-child transmission (MTCT). MTCT has a major impact on the HIV epidemic, and is an underlying factor in many infant and childhood illnesses and deaths in the region. There are indications, however, that prevention of mother-to-child transmission of HIV (PMTCT) programmes are beginning to have a noticeable impact on the prevalence of HIV and AIDS in children. According to the SADC (2008) epidemic report, the uptake of PMTCT is on the increase in the region, although it is generally below universal access targets. Nine Member States recorded an increase in the uptake of PMTCT in 2007 compared to 2005. Although Universal Access targets for some of them seem ambitious, a number of the Member States may be able to attain them if they maintain the tempo of implementation. Data on the uptake of PMTCT show that the range is 1.6% to 91%, implying that the Member States are at different levels in terms of programme implementation. In 2007, four SADC Member States had at least 50% of the HIV-positive pregnant women receiving PMTCT services.

In recognition of the devastating effects of the HIV and AIDS epidemic, the SADC Heads of State and Government made a commitment through the Maseru Declaration to combat HIV and AIDS and other deadly and communicable diseases. Through the declaration, they emphasized the need for rapid scale-up of PMTCT programmes, and to ensure that levels of uptake are sufficient to achieve the desired public health impact. The Maseru Declaration also reaffirmed earlier commitments, such as the United Nations General Assembly's 26th Special Session (UNGASS), which, among other things, committed to stopping the tragic transmission of HIV from mother to child. The UNGASS also committed to reducing by 20% by 2005 and 50% by 2010 the proportion of infants and children infected with HIV.

In line with the overall regional integration agenda and the control of communicable and other health problems, the SADC region has put together the Protocol on Health, which guides implementation of the regional health agenda. The Protocol calls for the harmonization of regional approaches as well as regional cooperation.

These regional minimum standards serve as a harmonization framework for regional approaches to PMTCT, and are, therefore, part of the operationalisation

of the different declarations to which the region is signatory to. They are also in line with the regional agenda of integration.

1.1. Purpose and scope of the regional minimum standards

The regional minimum standards serve as a framework which guides regional harmonization of approaches to the scale-up of prevention of mother-to-child transmission of HIV.

1.2. Rationale

The regional minimum standards are informed by the *SADC Protocol on Health*, and various articles of the Protocol address important issues which facilitate regional cooperation and integration. For example, Article 9 on communicable diseases calls for the harmonization of policies and the sharing of information by the region, while article 10, which deals specifically with HIV and AIDS, mandates Member States to:

- a) harmonize policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of sexually transmitted diseases (STDs) and HIV infection;
- b) develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonized, and standardized manner; and
- c) develop regional policies and plans that recognize the intersectoral impact of HIV/AIDS/STDs and the need for an intersectoral approach to these diseases.

The specific focus on PMTCT is adopted from the Maseru Declaration which calls for *"rapid scale up of programmes for prevention of mother-to-child transmission of HIV and ensuring that levels of uptake are sufficient to reach the desired public health impact"*

1.3. Guiding principles for regional minimum standards guidelines for PMTCT

The regional minimum standards are informed by the WHO framework for a comprehensive approach to prevention of HIV infections in infants and young children. They will, therefore, be organized following the following four main components of the comprehensive approach framework:-

- a) Prevention of HIV infection in women;
- b) Preventing unintended pregnancies in HIV infected women;
- c) Preventing transmission from an HIV infected woman to her infant; and
- d) Providing care and support for HIV-infected women, their infants and their families.

2. SADC REGIONAL MINIMUM STANDARDS FOR PMTCT

2.1. Minimum standards for prevention of HIV infection in women and couples

- 2.1.1. Women and/ or couples must be provided with health education and information on prevention and care including for sexually transmitted infections (STIs)
- 2.1.2. Member States HIV policies must promote HIV testing and counselling for couple, index and partner including support for disclosure using both voluntary counselling and testing and provider initiated testing and counselling.
- 2.1.3 Member States policies must make provisions for regular retesting for those with exposure to HIV.
- 2.1.4. MS must promote HIV counselling as part of routine health care.

2.2 Minimum standards for preventing unintended pregnancies in HIV infected women

- 2.2.1. Family planning counselling and contraceptives must be provided at all opportunities such as HIV care and treatment, voluntary counselling and testing, preconception, antenatal, and postpartum services.
- 2.2.2. Provider-initiated HIV testing and counselling (PITC) must be offered during family planning services and be linked with counselling on reproductive choices and awareness of PMTCT
- 2.2.3. Member States PMTCT policies and guidelines must include family planning and contraceptive options for pregnant HIV-positive women.
- 2.2.4. Services for the prevention of unintended pregnancies must be promoted, including access to reproductive health commodities and contraceptives which are more youth-friendly.

2.3. Minimum standards for preventing transmission of HIV from an infected woman to her infant

- 2.3.1. Member States must provide routine quality antenatal and postpartum care for all women
- 2.3.2. Safe obstetric practices for HIV infected women must emphasise
 - I. Delivery by a skilled birth attendant
 - II. Minimal invasive procedures during delivery
 - III. Care for newborns must include minimum suctioning of nostrils,

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- IV. Newborns should be immediately be given a bath, and a dose of AZT as soon after birth as possible.
- 2.3.3. Pregnant women must be given information about prevention of mother to child transmission of during antenatal information sessions.
- 2.3.4. Provider Initiated Testing and Counselling must be promoted according to the status of the epidemic as follows:
 - I. In generalized epidemics PITC for all persons attending health care facilities as a standard component of medical care and in all antenatal, childbirth, postpartum, and paediatric care settings
 - II. In low and concentrated epidemics, PITC may be considered for pregnant women identified as being at higher risk of HIV exposure according to national or local criteria.
- 2.3.5. Member States with generalized epidemics must provide routine retesting late in pregnancy
- 2.3.6. Pregnant women with HIV infection, who do not yet require ART, must be given ARV prophylactic regimens for prevention of mother to child transmission according to WHO recommendations.
- 2.3.7. Member States must support infant feeding and counseling and follow WHO recommendations for infant feeding for children of HIV infected mothers.

2.4. Minimum standards for providing care and support for HIV-infected women, their infants and families

2.4.1. Minimum standards for providing care and support for HIV-infected women

- I. Member States must endeavour to provide antiretroviral therapy (ART) for all pregnant women who are eligible for treatment based on clinical staging or CD4 testing.
- II. Member States must work towards adhering to WHO recommended cut-off point of 350 CD4 cell counts for starting antiretroviral therapy within the limits of the individual Member State
- III. Co-trimoxazole prophylaxis must be provided where indicated (i.e. clinical stage 4 or CD4 <200 cells/mm³).
- IV. Member States must promote and facilitate the active participation of people living with HIV, especially women and mothers living with HIV, in planning and delivering services, advocacy and community engagement.
- V. Tuberculosis screening and treatment must be provided for women living with HIV when indicated.

2.4.2. Minimum standards for providing care and support for HIV-infected children

- I. Member States must provide early HIV diagnostic testing and diagnosis of HIV-related conditions at 6 weeks where virological tests are available
- II. Where virological testing is not available, antibody testing must be done at 18 months
- III. All HIV-exposed children born to mothers living with HIV must start cotrimoxazole preventive treatment at 4–6 weeks after birth and continue until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
- IV. Provider-initiated age-appropriate HIV testing must be offered for all infants and children where HIV is possible, suspected, or HIV exposure is recognized.
- V. All children suspected or known to have TB must be offered an HIV test
- VI. All HIV exposed children must have a confirmatory HIV antibody test at or around 18 months.
- VII. All infants below 12 months of age with confirmed HIV infection must be started on ART, irrespective of clinical or immunological stage.
- VIII. Where virological testing is not available, infants below 12 months of age with clinically-diagnosed presumptively-severe HIV must start ART. For children age 12 months or older, clinical and immunological thresholds (<20% CD4 for 12-59 months, and <15 % CD4 for 5 years or over) should be used to identify those who need to start ART.
- IX. The following treatment regimens are recommended for the region:
 - a. For HIV infected infants with no exposure to maternal or infant non-nucleoside reverse transcriptase inhibitors, or whose exposure to maternal or infant antiretrovirals is unknown, standard nevirapine-containing triple therapy should be started
 - b. For HIV infected infants with a history of exposure to single dose nevirapine or non-nucleoside reverse transcriptase inhibitor containing maternal antiretroviral therapy or preventive antiretroviral regimens, a protease inhibitor-based triple antiretroviral therapy regimen should be started. Where protease inhibitors are not available, affordable or feasible, nevirapine-based therapy should be used.
- X. All children receiving ART must be monitored.
- XI. Ensure symptom management and palliative care if needed. This includes diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illnesses (IMCI).

2.5. Minimum standards for access to PMTCT in SADC

The recommendations on PMTCT made in the Model law on HIV/AIDS in southern Africa (2009) are endorsed:

- 2.5.1. Member States must ensure that HIV testing is available to pregnant women as part of antenatal care (ANC) services.
- 2.5.2. Women living with HIV must have access to counselling, information, and services enabling them to make informed and voluntary decisions in matters affecting their health and reproduction.
- 2.5.3. Member States must ensure that programmes on the PMTCT of HIV are available to all pregnant women living with HIV. Such programmes shall include psychosocial support, follow-up services, and nutritional support for disadvantaged mothers. The State must also provide pregnant women living with HIV with relevant and scientifically proven information regarding breastfeeding and alternatives to breastfeeding with the view to reducing the risk of HIV transmission.
- 2.5.4. When possible, and with the consent of the pregnant woman living with HIV, her partner or spouse must receive information and counselling on the implications of the PMTCT programme.

2.6. Minimum standards for integration of PMTCT into MCH and SRH services

PMTCT must be integrated into other sexual and reproductive health as well as maternal and child health programmes

3. IMPLEMENTATION MECHANISMS

Implementation of the regional minimum standards will take place following approval by all SADC structures. Implementation will be through the ministries of Health and other ministries, departments and governmental, non governmental and civil society organisations. National coordination will be through the National AIDS Authorities