

Coordinating Civil Society Action on Children, HIV and AIDS

Preventing Mother-To-Child Transmission of HIV (PMTCT)

This briefing document contains up-to-date information on preventing HIV infection in babies. This information can help pregnant women and their families as well as people providing services to pregnant women, and organisations advocating for improved services. Please share this information with others – it can save lives.

HIV is the leading cause of death among pregnant women, babies and young children in South Africa. It is also a major cause of disability and illness in children.

Most young children living with HIV are infected before, during or shortly after birth. Without treatment, care and support, most HIV-positive babies will die before their second birthday.

This does not need to happen. Effective implementation of Prevention of Mother-To-Child Transmission of HIV (PMTCT) programmes reduces transmission to well below 5%.

The Children's Sector believes that PMTCT can be used as a gateway to significantly improve maternal and child health, thereby supporting the greater realisation of women and children's rights. But to achieve this, we need to mobilise for PMTCT to become a "gateway" to a full range of services and support for mothers and children.

What is mother-to-child transmission of HIV?

HIV can be passed on to a baby during pregnancy, labour or breastfeeding. This is called mother-to-child transmission. It is also called "vertical transmission" by some people because the mother does not consciously or intentionally transmit the virus to the baby.

If a mother is HIV-positive and she receives no medical intervention, there is a 25-30% chance that she will pass HIV on to her baby. The risk is spread out roughly: 5-10% during pregnancy, 10-20% during labour and 10-20% through mixed feeding for more than 6 months. If HIV-positive breastfeeding mothers are on antiretroviral (ARV) treatment or their infants are on antiretroviral prophylaxis (e.g. daily Nevirapine), this significantly reduces the chances of transmitting HIV through breastfeeding.

When infected babies are not identified early and do not start ARVs in time, many die.

PMTCT is powerful prevention. Almost 99% of HIV can be prevented in young children

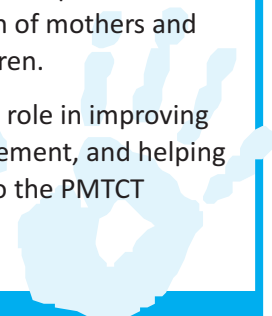
- In South Africa, we know how to protect babies from HIV transmission.
- We know how to support and care for HIV-positive mothers and children.

South Africa has a PMTCT plan to improve the health of women, their partners and children

- There is a good and effective government plan to achieve this.
- It is relatively inexpensive and will save lives – and money in the long term.

You can help get South Africa's good PMTCT plan on track

- The challenge to us all is to ensure the plan works.
- Successful implementation of South Africa's PMTCT programme will mean the prevention of unnecessary illness and death of mothers and infants, and disability in children.
- Network members can play a role in improving family and community involvement, and helping to get women and babies into the PMTCT programme.



South Africa has a PMTCT plan to improve the health of women, their partners and children.



What is South Africa's PMTCT Plan?

South Africa's PMTCT plan includes the four components of the internationally accepted comprehensive PMTCT strategy:

1. **Primary HIV prevention among women and girls of childbearing age**—this means preventing women and girls from getting HIV in the first place.
2. **Prevention of unintended pregnancies in women who are HIV-infected**—this means that part of the PMTCT approach should include programmes that support women to choose when and if to fall pregnant.
3. **Prevention of transmission of HIV to children.**
4. **Treatment, care and support for women living with HIV, their children and families.**

South Africa's targets for the Prevention of Mother-To-Child Transmission of HIV (PMTCT) are included in the National HIV & AIDS and STI Strategic Plan (NSP) 2007-2011. This plan aims to achieve the following by 2011:

- Reduce mother-to-child transmission to 5% through improved access to information and services for pregnant women.
- Increase the proportion of HIV-positive pregnant women who receive PMTCT to 95%.
- Increase the proportion of HIV-exposed babies tested with PCR by six months to 90%.
- Ensure that 100% of antenatal services provide PMTCT.

Feeding options

It is important for an HIV-positive mother to choose ONE infant feeding practice (exclusive breastfeeding OR exclusive formula feeding) and use only that method.

Mixed feeding (a combination of breast milk and formula feeding or other foods and liquids) increases the risk of the baby contracting HIV.

New World Health Organization guidelines introduced in 2009, recommend that mothers who know they are HIV-infected and are from resource poor areas should exclusively breastfeed and receive ARV treatment throughout breastfeeding.

However, since breastfeeding may not always be possible, or the mother's preferred choice, both options should be discussed during counselling.

- Expand coverage of PMTCT services by: developing guidelines to include postnatal services; providing nutritional support to 80% of women who breastfeed; providing formula feed to 40% of mothers who are eligible; and implementing responsible fatherhood programmes in 80% of health districts.

On World AIDS Day 2009 President Jacob Zuma announced that pregnant women would receive ARVs earlier in their pregnancy and that babies who test positive would receive ARVs immediately.

South Africa's PMTCT programme now guarantees every pregnant woman and mother the right to:

- HIV Counselling and Testing (HCT) on her first antenatal clinic visit, which should be before 14 weeks.
- ***If she is HIV-negative***, she should be offered a second test at around 34 weeks.
- ***If she is HIV-positive***, she should be enrolled in a PMTCT programme.
 - If her *CD4 count is over 350* she will receive AZT from 14 weeks of pregnancy (known as PMTCT regime or dual therapy) to be continued every 3 hours during labour, and a single tablet of Nevirapine and a single tablet of Truvada (Tenofovir plus Emtricitabine) given during labour.
 - If her *CD4 count is below 350*, she will start ARVs immediately (known as ART regime or triple therapy), and remain on this for life – there is no additional ARVs for PMTCT during labour or after for her if she is started on ARVs for her own health.
- Good guidance on infant feeding, including information about weaning and the benefits of exclusive breastfeeding while on ARV treatment.
- Access a child support grant if she does not have enough income.

And every newborn baby has the right to:

- daily Nevirapine for six weeks from birth if the mother is HIV-positive;
- daily Nevirapine beyond six weeks while breastfeeding, until one week after breastfeeding stops if the mother is not on ARVs;
- be tested for HIV at six weeks using PCR testing, six weeks after stopping breastfeeding, and at 18 months;
- be initiated on ARV treatment immediately if they test HIV-positive under one year of age;
- prompt referral for management of HIV if HIV-positive;
- have his/her birth registered.

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What is the situation in South Africa?

In South Africa, many HIV-positive women are in need of treatment, and infants are at high risk of HIV infection.

- HIV prevalence among pregnant women in 2008 was 29%.
- Without medical intervention, this leads to about 300,000 babies being exposed to HIV every year; of whom 30% (90 000) would become infected.
- AIDS accounts for 43% of maternal deaths and 40% of deaths in children under the age of five.
- 92% of women receive antenatal care.
- In 2009, 83% of HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child-transmission.
- 80% of pregnant women attending clinics underwent HIV testing (in 2007/08).
- At least 80% of babies whose mothers were known to be HIV-positive received ARVs within 72 hours of birth (in 2007/08).
- Although the number of women and babies with access to PMTCT has vastly improved over the past 2 years, there is high variability across the provinces and districts. Unless the NSP target is met consistently across South Africa and 95% of all HIV-positive mothers and babies receive prophylaxis treatment, we will not be doing all that is possible to prevent children from getting HIV through mother-to-child transmission.

Why is PMTCT not reaching all pregnant women and babies in SA?

- Two thirds of women and girls have their first antenatal visit too late. They come to the clinic after 20 weeks, although they should be taking ARVs before that if they are HIV positive.
- An estimated 25% of pregnant women have never had an HIV test.
- There is a lack of collaboration between healthcare workers and social and educational services.
- Low male involvement in PMTCT limits women and children's access to PMTCT.
- Within health systems, PMTCT is often not seen as a priority.
- Stigma and discrimination often stop women from testing and/or accessing PMTCT programmes.
- Mixed feeding, which increases the chance of infecting a baby, remains high.
- There is a lack of post-natal care – this is one of the major obstacles to effective PMTCT.
- PMTCT programmes often fail to link mothers, babies and families to treatment, care and support.
- Several thousand babies are not identified as HIV-exposed and hence are not tested for HIV, nor are they placed on Cotrimoxazole, which prevents death from a severe form of pneumonia.

The Children's Sector believes that PMTCT can be used as a gateway to significantly improve maternal and child health, thereby supporting the greater realisation of women and children's rights.

To achieve this, PMTCT must become a "gateway" to a full range of services and support, starting with:

1. Referrals and integration across health services (health of newborns, health of mothers, family planning, and general child health); and
2. Effective links between community, social, and health services, such as:
 - infant feeding and household nutritional support;
 - securing birth certificates and Identity Documents;
 - more rapid provision of grants, especially the Child Support Grant;
 - parenting support;
 - early identification of needs and referral for specialised support such as for disabilities.

You can help get South Africa's good PMTCT plan on track.



What can you do?

If you know anyone who is pregnant, support her to:

- Visit the clinic before 14 weeks of pregnancy.
- Have an HIV test early in her pregnancy, and *if HIV negative* test again at 34 weeks.
- *If HIV-positive*, have a CD4 test and request treatment, irrespective of CD4 count.
- Test in early labour, or soon after delivery if she did not test during pregnancy, so that if she is HIV-positive the baby can receive daily Nevirapine for a minimum of 6 weeks.
- Have her baby tested for HIV with PCR at 6 weeks (or earlier if her baby is regularly sick), and again 6 weeks after stopping breastfeeding.
- Get her baby on to antiretroviral treatment as well as Cotrimoxazole prophylaxis as soon as possible if she/he tests HIV-positive.
- Ask to be tested for TB as part of the antenatal screening and tell someone at the clinic if she knows someone in her household has TB or if she suspects someone has TB based on the following symptoms: a cough for longer than 2 weeks, chest pains, tiredness and weakness of the body, loss of appetite and weight, night sweats even when it is cold, coughing up blood.
- Find out about home visits to get support with maternal and newborn care.
- Ensure all children have their development monitored and learn about developmental milestones.
- Help with support groups and other activities around PMTCT.
- Promote the "Roots and Wings" programme – all children (not just those with parents with HIV) should have "memory boxes" containing vital information as well as photos and family stories.
- Involve the partner, father and family members including siblings to ensure a comprehensive approach.

In your workplace, organisation and community, you can:

- Integrate learning on PMTCT into staff development.
- Ensure employment practices and policies support comprehensive PMTCT.
- Support the implementation of PMTCT programmes into childcare, education, welfare and related services where you work.
- Link mothers and children to other essential services, such as birth registration, grants, social services and psycho-social support.
- Refer pregnant women, mothers and their families to legal services to access their rights.

Encourage Yezingane Network members to:

- Promote and support the suggestions listed above.
- Regularly document and share information and resources between members and with SANAC.
- Ensure structures and forums you are involved in know about and support PMTCT implementation.
- Build links between health and other services to make PMTCT programmes a "gateway" to other services.

Where to access PMTCT

The first place to begin accessing PMTCT is through your antenatal clinic. However, the full range of PMTCT care is offered at a number of different services including antenatal clinics, labour wards, postnatal wards and infant follow-up services such as social services.

In 2008, PMTCT programmes existed in about 3,000 or 90% of primary health care facilities countrywide and in all public hospitals. The NSP target is for 100% coverage in all antenatal services by 2011.



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