EXECUTIVE SUMMARY

BACKGROUND TO THE REPORT

This report primarily describes the process, progress and extent of service implementation in the 18 pilot PMTCT sites, so as to help improve the effectiveness and efficiency of PMTCT services and inform any planned expansion of the programme. Data and information are based on discussions and interviews with managers, co-ordinators and clinicians; site visits; routine statistics; document reviews; and attendance of national PMTCT steering committee meetings.

The report does not provide data on the impact of the programme on HIV transmission or health outcomes, mainly because the programme is still too young for this. However, Section 6 presents and discusses what is currently known about mother-to-child transmission, including the proven efficacy of NVP. It also discusses the effects of different forms of infant feeding on HIV transmission and child health, and raises a number of important policy issues.

OVERVIEW OF THE PILOT PROGRAMME

193 health facilities (hospitals, midwife obstetric units, community health centres and clinics) are currently part of the national PMTCT pilot programme. They cover approximately 6 090 antenatal bookings per month, which translates to about 9% of the total number of country-wide bookings.

The full figure for access to PMTCT in South Africa is considerably more. Some provinces have already begun to expand their services, and together with a number of clinical research sites, the full proportion of pregnant women in this country with access to HIV counselling, testing and NVP may be as high as 15%.

The rate at which pregnant women agree to be tested for HIV is currently 51% in the national PMTCT sites. This translates to about 3 133 pregnant women being tested per month, which is a very positive achievement. The testing uptake rate varies tremendously between provinces and sites (ranging from 17% to 90%), and the reasons for these differences are described in this report. Overall, the HIV testing uptake rate is likely to improve over time.

Of the women agreeing to HIV testing, about 30% are HIV positive. On the basis of these VCT uptake and sero-positivity rates, it is estimated that 6 343 HIV positive pregnant women have been identified in the national PMTCT sites. However, the recorded number of HIV positive women who have delivered with the administration of NVP to both mother and baby is 1 932. Some of the reasons for this large difference in numbers are:

- Because HIV testing usually occurs several months before delivery, at any given point in time, the cumulative number of identified HIV positive pregnant women will be more than the cumulative number of deliveries (especially at the beginning of a programme).
- Women accessing the PMTCT service antenatally may deliver elsewhere.
- An under-recording of statistics in the labour wards.

PROGRESS WITH IMPLEMENTATION AND LESSONS LEARNT

The experience with implementation has varied considerably, with some provinces and sites doing well, whilst others have struggled. Many of the difficulties and constraints to full and effective implementation were identified as being systemic in nature, and relate to the poor functioning of the health care system in general (as opposed to the functioning of the PMTCT programme specifically).

At the core of the differences between provinces and sites are the large inequities in health care infrastructure within the country.

Systems and infrastructure

In order to improve the quality and sustainability of PMTCT services, and to ensure a smooth and effective expansion of the programme, these broader health systems issues must be addressed concurrently. The report lists these challenges under the three headings of human, management and physical infrastructure in Section 7.1 of the report.

Human infrastructure

Human resources are the bed-rock of a well functioning health system and PMTCT programme. Staffing needs to be adequate in terms of both quality and quantity.

- Minimum staffing levels for midwives, nurses, doctors and lay counsellors need to be established, and the national and provincial Departments of Health, particularly their Human Resource Directorates, must develop and implement a plan to reach these staffing levels.
- Lay counsellors are central to the programme. Some provinces, however, are still not employing them, and many of the 18 sites lack sufficient numbers. The involvement, support and clinical leadership of doctors in some sites also needs to be improved.
- The inconsistent management, training and remuneration of different kinds of lay workers within and between provinces needs to be addressed.
- Developing and sustaining staff competencies and attitudes remains an

unfinished challenge in most of the current sites. A carefully developed training plan will be essential for the successful expansion of the PMTCT programme.

- ➢ Improving the regular support and supervision of frontline staff and the attitudes of health workers (at the same time as developing their knowledge and skills) will be important elements of a comprehensive training strategy.
- ➢ The deficiencies in undergraduate nurse and medical training institutions must be addressed as soon as possible so as to reduce the intensity of in-service training required.

Management infrastructure

A functional health system with effective sub-district health management teams capable of integrating community-based, clinic-based and hospital-based services is critical. The ideal sub-district health system would also help integrate PMTCT services into other related health programmes in a way that will maximize efficiency and effectiveness.

- ➢ The active interest and support of senior managers in the PMTCT programme has led to faster and more effective implementation in some sites. However, the level and standard of leadership and management varies between the provinces.
- ➢ The slow progress with the establishment of a functional sub-district health system capable of integrating PHC delivery needs to be speeded up.
- ➢ The areas of management identified in the report as requiring priority attention are human resource management and programme evaluation. There have been no significant problems with the management of supplies and equipment.
- ➢ NGOs and local PWA support groups are potentially invaluable role-players within a PMTCT programme. Managers at all levels of the health system need to continue to develop an environment that is more enabling for effective partnerships between government, NGOs and civil society.

Physical infrastructure

Inadequate physical space and privacy has hampered the ability to provide adequate counselling and HIV testing services, as well as intra-partum (childbirth) care in many facilities. In rural sites, the difficulties and expense of simply getting to health facilities remain major barriers to adequate coverage of the programme as well as to adequate continuity of care.

- ➢ Plans to upgrade the physical infrastructure of PHC facilities and district hospitals across the country need to be expedited.

PMTCT service delivery issues

Section 7.2 of the report lists the lessons and recommendations that are specific to the PMTCT service. Important issues to highlight include:

- ➢ 'Counselling' has been too strongly associated with consent for an HIV test, and needs to incorporate a broader set of activities that include: empowering pregnant women with knowledge and information (e.g. about their childbirth, HIV, MTCT and infant feeding); providing ongoing psychological and

emotional support to HIV positive women as well as advice on disclosure; and facilitating access to community support groups, welfare grants etc.

- ➢ Efforts to provide 'couple HIV testing' as well as community-targeted interventions to address stigma, ignorance and prejudice, are important but relatively neglected components of the PMTCT programme that need to be strengthened.
- ➢ The option of using rapid saliva tests as an alternative to rapid blood tests should be explored as this could relieve some of the workload on professional staff.
- ➢ In view of the recognized clinical efficacy of NVP, operational research is required to determine whether the NVP that is dispensed is taken correctly; whether midwives and doctors pro-actively ask women in labour about their HIV status and self-administration of NVP; and whether labour wards are able to provide adequate patient confidentiality regarding HIV status.
- ➢ Some lack of clarity about the clinical and obstetric management of HIV positive women in labour needs to be addressed.
- ➢ Guidelines on post-partum care need to be modified as they are currently unrealistic. Sites should develop their own targets and guidelines that are context-based and feasible.
- ➢ Patient-held records are essential for adequate continuity of care. The need to protect patient confidentiality about HIV status needs to be balanced against the need to promote continuity of care and the desire to encourage a greater openness about HIV status.

EXPANDING THE PMTCT PROGRAMME

There are no good reasons for delaying a phased expansion of PMTCT services in all provinces. The pilot sites have already generated a lot of useful and important lessons that can now be put to use.

The systemic weaknesses and infrastructural constraints identified by this evaluation are not reasons for delaying action, but are important for informing the planning and expansion of PMTCT services.

Plans for expansion must therefore simultaneously address the systemic and infrastructural constraints in order to avoid a multiplication of poor and/or non-sustained service delivery, as well as to reduce levels of health care inequity. As with other services, the full potential of the PMTCT programme to reduce the number of HIV infected babies and improve overall health status will only be realized if the health system is capable of delivering the service optimally.

While it would be wrong for the systemic and infrastructural constraints to be used as reasons for non-expansion, reducing the challenge of implementing a country-wide PMTCT programme to the administration of NVP is misleading. The impression created that implementing the PMTCT programme is as easy as dispensing aspirin, fails to

convey the many genuine complexities that are outlined in this report.

It would be more useful to highlight the potential of the PMTCT programme to act as an engine or catalyst for the improvement of the health system and of primary health care services in general. This is described in Section 6.3 of this report. Failing to conceptualize the PMTCT programme in this broader and catalytic role could represent a missed opportunity for the country, or even worse, result in the PMTCT programme undermining other essential areas of PHC.

The temptation to adopt a rapid and vertical approach to expanding coverage across the country, particularly given the intense media and public pressure, should be resisted. A more measured and phased approach would ensure better sustainability and coverage; help strengthen the health care system as a whole; invigorate the broader HIV/AIDS programme; and raise the general standard of maternal and child health care. However, it is contingent upon government to develop a coherent, transparent and credible plan.

While a phased and systematic expansion of comprehensive PMTCT services is being planned, NVP can and should be provided immediately to all pregnant women who are already known to be HIV positive, with appropriate counselling and information.

Given the differences in capacity and infrastructure, it would be reasonable for provinces to expand the provision of PMTCT services at different speeds. For provinces that are currently struggling with implementation in their two learning sites, a plan for expansion should include and begin with a strengthening of provincial management and support structures and the continued improvement of services in the learning sites.

With political and senior management commitment at both the national and provincial level, it should be possible for all provinces to begin implementing PMTCT services in some new sites by the middle of 2002.

A more appropriate budgeting formula will be required to ensure that historically under-resourced areas receive a more equitable share of funding and support, should there be an expansion of the programme. The 'gap' between existing resources and a minimum standard of health care infrastructure (especially in terms of human resources) should be measured in every sub-district across the country to help ensure that this gap is narrowed in the fullness of time.

Within provinces, the variation in health care infrastructure and other factors necessitates a more context-based approach to planning and implementation. Local conditions and problems require local solutions, and the formation of an effective 'sub-district health system' offers the best organizational framework for the delivery of the PMTCT programme and of PHC in general.

INFANT FEEDING AND CHILD HEALTH

With all the publicity surrounding government's position on NVP, the more important and serious issue of its policy on infant feeding and providing free formula has been neglected.

The current policy needs to be reconsidered, as there is a danger that it may do more harm than good in many communities. When one looks at overall child health as an outcome, instead of just HIV transmission, the benefits and advantages of promoting free formula become questionable. The downside of promoting formula feeding, and government subsidizing it are explained and discussed in section 6.2 of this report.

Although the long-term aim should be to enable all HIV positive women to provide safe and affordable *exclusive* formula feeding, under the current circumstances, the policy may lead to higher rates of mortality and morbidity due to other diseases, as well as higher rates of mixed feeding.

A national commission of experts should be urgently set up to review the current policy and guidelines on infant feeding and mother-to-child transmission.

One option that must receive serious and urgent attention is the post-natal administration of short-course antiretroviral treatment to mothers and/or babies as a strategy for making breastfeeding safe.

Finally, the imperative to save babies from HIV should provoke a broader and urgent response from government and civil society to address child poverty, the unacceptable levels of child care and child mortality from easy-to-prevent causes.