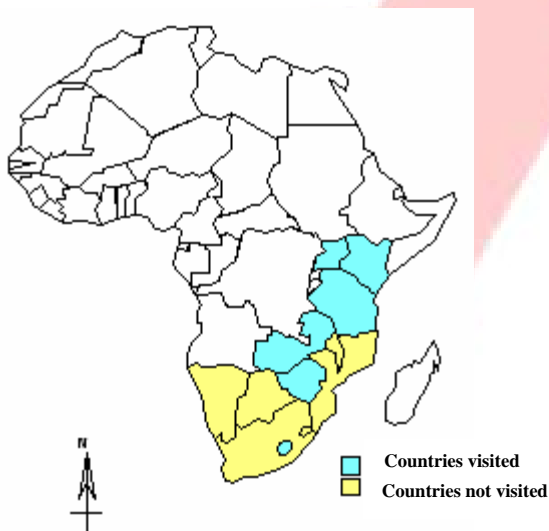


Programs, Policies and Guidelines for **PMTCT** in **ECSA-HC** Member Countries

Background

What progress has been made so far within the East, Central and Southern Africa Health Community (ECSA-HC) member states in implementing interventions for Prevention of Mother to Child Transmission of HIV (PMTCT)? In order to answer this question, the ECSA Health Community Secretariat with funding from USAID/REDSO commissioned a review to assess the progress made towards putting in place programs, policies and guidelines for PMTCT within the member countries. The activity which was implemented from 26th July to 27th August 2004 covered six (6) member countries namely: Lesotho, Zimbabwe, Zambia, Tanzania, Kenya and Uganda.



Mother to child transmission of HIV (MTCT) is a particularly urgent and growing problem in sub-Saharan Africa.

UNAIDS reported that more than $\frac{3}{4}$ (76%) of all the women living with HIV and AIDS were found in this region and that 76% of young people aged 15 to 24 years who were living with HIV and AIDS in this region were female. In the year 2004 alone, about 640,000 children were infected with HIV worldwide, virtually all of them through mother to child transmission and 90% of them in sub-Saharan Africa due to a combination of the high HIV prevalence among women of reproductive age, high fertility rates and ineffective nationwide interventions to prevent mother to child transmission. The brunt of this epidemic has been borne by the East, Central and Southern Africa sub-region, where it is estimated that by the year 2010, AIDS may have increased the mortality of children under the age of 5 years by more than 100%.

The review involved an intensive literature search for relevant information on policies, guidelines and programmes on the prevention of mother to child transmission of HIV in the ECSA-HC member states. The team visited the selected countries and conducted interviews with representatives from the relevant Government Departments that included National AIDS Commissions, Reproductive and Child Health Departments of the Ministries of Health; National AIDS Control Programmes and Nutrition Departments. Information was



also obtained from Development Partners supporting HIV/AIDS interventions and PMTCT, including the United Nations Agencies, bilateral and multilateral donors. The civil society organisations involved in implementation of PMTCT activities, organisations for people living with HIV/AIDS, faith-based organisations and medical professional organisations or associations were also consulted.

PMTCT Program Status

Prevention of Mother to Child Transmission of HIV was observed to be one of the priority interventions in the HIV/AIDS response of all the member states that were visited. The PMTCT programs were integrated within the various Ministries responsible for Health, were being scaled up and located either in the Reproductive Health divisions (Lesotho, Zambia and Tanzania) or in the HIV/AIDS Control Programs (Kenya, Uganda and Zimbabwe). Regardless of the location, a critical observation from the review was the need for a very viable link to the related programs so as to strengthen the continuum of care for the woman and her family.

The capacity for coordination and management of the national PMTCT programs was also found to vary among the different member states. Zambia, Lesotho and Tanzania had relatively small teams who were handling PMTCT related activities alongside other responsibilities. In Kenya, Uganda and Zimbabwe, there were comparatively larger teams with some of the officers being responsible for handling only PMTCT activities. The amount of work required to coordinate and manage a

national program that is being scaled up was found to be significantly high. It was observed that the country PMTCT programs that had adequate human resource capacity at the central Ministry of Health level to deal with the workload performed comparatively better than those with smaller teams.

Kenya, Uganda and Zambia had developed and operationalized specific PMTCT strategic plans while the other countries were utilizing the national HIV/AIDS strategic plans to roll out PMTCT activities. The PMTCT package being offered was clearly defined in all the member countries visited. It is a known fact that the primary prevention of HIV infection strategy aims at supporting women to begin a pregnancy when they are not infected with HIV. While the majority women who are tested under the PMTCT programs are actually not infected with HIV, none of the PMTCT programs visited had clear interventions for supporting these women to ensure that they remained uninfected.

Virtually all the PMTCT Programs provided family planning services for clients attending antenatal clinics. However, the services were found to be not specifically responsive to the needs of persons living with HIV/AIDS in that they did not focus on counseling and supporting them to avoid unintended pregnancies. The programs were also observed to be quite adequate in addressing the strategy for reduction of HIV transmission from an infected mother to her child. However, virtually all the countries visited were not aligned to the new developments in this area such as the routine offer of HIV counseling and

testing within the antenatal clinics as well as the move towards more efficacious ARV regimens for PMTCT. In addition, community mobilization that targets male responsibility as well as involvement in PMTCT services were not effectively addressed in all the PMTCT country programs reviewed.

Care and support for the HIV infected woman and her family was found to be fairly weak in all the PMTCT programs reviewed. Interventions such co-trimoxazole prophylaxis and TB prophylaxis were not being implemented at clinics that offer PMTCT services. Furthermore, while the main recommendation was to refer the mother to existing programs for antiretroviral therapy, there were no clear guidelines in most cases on how the mothers and their families could be effectively supported to access comprehensive HIV/AIDS care that includes HAART.

The procurement and logistics systems for PMTCT inputs varied among the member states visited, with definite attempts to integrate from a parallel system into the existing national system being evident. Tanzania had more or less integrated while Uganda was still grappling with the challenges. Despite the differences in the system among the countries, a common finding was that of a relatively high rate of commodity stock out, which negatively impacted on the PMTCT program performance.

All the member countries visited had adopted the minimum set of indicators for monitoring of the PMTCT program namely: mothers counseled; mothers tested; HIV positive mothers; ARVs to

mothers; and ARVs to babies. However, the total number of indicators significantly varied among the member countries, being quite detailed in some of them. This could have partly contributed to another common finding, which was poor reporting from the PMTCT implementing health facilities within the countries. In almost all the countries, the PMTCT monitoring system was not integrated into the national Health Management Information System (HMIS).

The PMTCT Policy Environment

Only one of the countries visited (Uganda), had a specific PMTCT policy document. In all the other countries, the PMTCT policy issues had been included in related HIV/AIDS and Reproductive Health policy documents. The PMTCT guidelines had been finalized and disseminated in Uganda and Kenya but the other countries had working draft copies that were being utilized to operationalize the programs.

There was a significant variation in the content and scope of the PMTCT guidelines among the member countries. Significant gaps in the guidelines included failure to effectively address the first and fourth strategic prongs of comprehensive PMTCT as well as a relatively weak second strategic prong. In addition, the guidelines did not take into account the recommendations by WHO for a move towards more efficacious regimens that include HAART for the eligible mothers under the third strategic prong.

The member countries visited had put in place training curricula and manuals related to building the capacity for

PMTCT implementation. There was variation among the member countries in terms of content as well as the recommended types and duration of training for PMTCT. A clear gap was in the area of pre-service training, which was evident in virtually all the countries visited.

Partnership and Collaboration

There was a strong partnership and support for PMTCT in all the member countries visited. However, the amount of support from donors to the national program and scale up process varied from country to country. This was found to be fairly low in Zimbabwe compared to others such as Kenya and Tanzania. The relationship between the HIV/AIDS program and the Reproductive Health Divisions in the countries visited was found to be good, with evidence of collaboration between the two. There was also evidence of collaboration with the other programs such as IMCI, EPI and ART. However, the linkage particularly with the ART programs was found to be not strong enough to facilitate effective and efficient referral.

Conclusion

Prevention of Mother to Child Transmission of HIV was found to be

clearly a priority and key intervention within the national HIV/AIDS response of the member countries visited. The PMTCT policies and guidelines were in place and the programs were in the process of being scaled up.

However, the policies and guidelines need to be reviewed and updated such that the four strategic prongs that constitute the comprehensive PMTCT intervention are adequately addressed. This should be followed by wide dissemination and utilization of these policies and guidelines to improve implementation of the PMTCT programs within the region. The human and physical infrastructural capacity for delivery of PMTCT services should be addressed as well as the mobilization and involvement of communities in the PMTCT programs.

The ECSA-HC has a critical role of advocacy for implementation of PMTCT interventions, effective resource mobilization and provision of technical support to facilitate the scaling up and quality assurance of PMTCT services. In addition, ECSA-HC should facilitate the harmonization of policies and guidelines as well as the PMTCT training curricula for both pre-service and in-service use among member states in the region.