Integration Reproductive Health & HIV Services for Women: PMTCT

the secret of the care of the patient is in caring for the patient”

F. Peabody

Vivian Black
What should we consider when counseling women in a high HIV prevalence setting?

- **Women at risk of HIV**
  - **Wants a pregnancy?**
    - **Yes**
      - **Fertility counselling**
    - **No**
      - **Contraception, EC**

- **Women infected with HIV**
  - **Not on ARVs**
  - **On ARVs**
South African data

- 5/40 million HIV infected
- Majority in reproductive age group.
- >50% women.
- 75% unaware they are HIV positive!
- Only test when sick
Treatment gap adults

- Currently 640 000 need HAART.
- 300 000 on HAART
- Shortfall—these people die.
- Every year more people are added into the system

P. Barker F. Venter, SAMJ 2007
Adult treatment gap

Die!

Annual need for HAART
Annual HAART initiations

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Treatment gap pediatrics

Die!

- current annual new infections
- annual HAART initiations
- annual new infection @5%

P. Barker F. Venter, SAMJ 2007
PMTCT in South Africa

- Pregnant women prevalence 29%
- Transmission rates >20%.
- > 63 000 infants were infected with HIV in 2006.

Actuarial Society of SA, UNAIDS, National DoH
Using PMTCT fight against HIV

- PMTCT program - finds healthy HIV infected women
- With strengthening of PMTCT programs:
  - stage HIV infected pregnant women;
  - initiate them on HAART;
  - Find partners, other children
- Reduce pediatric HIV.
- Reduce infant and child mortality
How have we done

- Reduced transmission to 4.3%.

- Developed a post natal clinic– seen over 1200 patients
What we have done

- Integrated an ARV clinic into an antenatal clinic
- > 850 pregnant women with HAART
- No HAART deaths
- Few HAART side effects
- In those tested ¾ had a viral load < 400 by time of delivery
Integration is important

- Even free clinic visits cost the patient money
- Patient inconvenience impacts on compliance
- Duplicate services increase costs for both the patient and the health service
The patient’s journey

- Make an appointment for ANC
- First ANC visit
- Test for HIV
  Prevention for women who test HIV negative
The HIV infected patient’s journey

- Issued NVP
- Staging of HIV with CD4 count
- Referral to ART if qualify
The HIV infected patient’s journey

**Labor**
- Taking of intra-partum labor ART
- Infant post exposure prophylaxis
Post natal follow up of woman and infant

- Adherence support
- Feeding choice
- Partner involvement
- Contraception
- Infant testing
- Missed opportunities
- Pre-conception support
In summary barriers to PMTCT are:

- Access to health systems
- Poor HIV testing uptake
- No follow up of women of unknown HIV status
- Poor ongoing support for HIV infected women
- Referral for staging
- Referral for HAART
- Taking NVP in labor and post labor
- Follow up of HIV exposed infants
- Post natal follow up
The way forward

- Improve PMTCT services to care for HIV infected women (shift focus from preventing HIV in children to caring for the HIV infected women):
  - Maternal and pediatric health will improve
  - Pediatric HIV will decrease
  - Increased HIV awareness within communities
  - Reduce the HIV treatment gap

- Integrate reproductive health into PMTCT including pre-conception management, family planning and post natal care
Evolving relationship with Pepfar

- Changing emphasis from numbers to quality
- Embrace innovative ideas, and where successful rapidly implement them
- Stringent reporting requirements of Pepfar has resulted in strengthening of organizational structures to comply. Could build on this for PMTCT and Reproductive Health
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