



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

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Offering ARV Prophylaxis at Time of HIV Diagnosis

Implementer's Guide Prevention of Mother-to-Child Transmission

Background Expanding access to interventions that successfully prevent mother-to-child transmission is an urgent priority. As countries continue to roll out prevention of mother-to-child transmission (PMTCT) services, many achieve high uptake of HIV counseling and testing but do not secure optimal uptake of antiretroviral (ARV) prophylaxis among HIV-positive pregnant women.¹ In many countries, single-dose nevirapine (SD-NVP) continues to be the most feasible ARV prophylactic regimen for PMTCT. It consists of one 200 mg tablet ingested by the mother at the onset of labor and a single dose of NVP syrup provided to the infant within 72 hours of birth.

Description National policies on dispensing maternal SD-NVP are still evolving. Initially, most national PMTCT policies only permitted maternal SD-NVP to be prescribed and dispensed in maternity wards when women arrived for delivery, to be ingested immediately with direct observation. However, many of the programs of the Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) recognized that women might not deliver in healthcare facilities or might arrive at the facility too late to receive the NVP tablet.² To reach additional women, some countries have begun providing SD-NVP to mothers in antenatal care (ANC) at a fixed point of gestational age; for example, at 28 weeks gestation or later, advising women to swallow the table at the onset of active labor.³ However, healthcare providers have discovered that many women who have initial ANC visits early in gestational age do not return to the facilities later in their pregnancies or after the fixed point, limiting the distribution of the nevirapine. Accordingly, some countries now encourage healthcare providers to distribute the nevirapine tablet when pregnant women are diagnosed with HIV regardless of the gestational age.³ Instructions are provided to the pregnant woman to ingest the medication at the onset of labor. This practice does not require additional resources and enhances pregnant women's opportunity to receive the intervention. Provision of SD-NVP at the time of diagnosis ensures the pregnant woman has access to the medication at the onset of labor, but does not ensure that the medication is actually ingested.

This program brief is part of an Implementer's Guide which has been developed by the Elizabeth Glaser Pediatric AIDS Foundation to highlight successful approaches in implementing PMTCT and care and treatment programs. The audience for the guide includes program implementers, managers, clinicians and anyone involved in creating, managing, or providing PMTCT and care and treatment services.

Percentage of Identified HIV-Positive Pregnant Women Provided with ARV Prophylaxis

Foundation Country PMTCT Program	Policy Allowing Dose at 28 Weeks	Revised Policy: Dose at Diagnosis
Uganda Program	63.4%	N/A
Tanzania Program*	54.6%	99.9%
Kericho Kenya Program	72.5%	94.4%
Cameroon Program	40.8%	87.4%

* Implemented in the Nzega, Igunga, and Sikonge districts over a six-month time period.

Implementation

As stated above, PMTCT policies in some countries have restricted delivery of maternal ARV prophylaxis to a fixed gestational age. For example, Uganda and Tanzania have only permitted the distribution of the maternal NVP dose to women who have reached at least 28 weeks gestation. However, the Uganda PMTCT program recently removed restrictions on provision of maternal SD-NVP. In addition, the Foundation's program in Tanzania and the Ministry of Health have jointly implemented a pilot program offering NVP upon HIV diagnosis in selected districts. Kenya, Malawi, and Cameroon have also changed their PMTCT policies to provide the maternal NVP dose at diagnosis. The Foundation has found that giving HIV-positive pregnant women NVP tablets at the time of diagnosis, rather than waiting for a fixed gestational age, increases their access to the intervention.

PMTCT interventions should take into account the patients' circumstances. Healthcare providers should counsel HIV-positive pregnant women to return for recommended ANC visits and to deliver at a healthcare facility. However, many mothers confront economic and cultural barriers that make this extremely difficult. Consequently, programs must find ways to provide all HIV-positive pregnant women with

access to critical PMTCT services and interventions, including SD-NVP.

Program Highlight: Malawi

The Foundation's PMTCT program in Malawi serves more than 20,000 antenatal mothers per year. Implemented by the University of North Carolina at Chapel Hill (UNC), PMTCT services in that country started in April 2002 and are currently provided at five sites: Bwaila Hospital; Kawale, A/18, and A/25 Health Centers; and Mitundu Community Hospital. UNC implements services at the first four sites and provides technical support to Mitundu Hospital.

The program boasts a 98 percent uptake rate for HIV testing of all newly-enrolled mothers at four antenatal clinics. It has also achieved a sustained 100 percent uptake rate for HIV counseling since the beginning of 2005 compared to 75 percent before then, and a 100 percent uptake rate for maternal ARV prophylaxis compared to 50 percent before 2005. The maternal NVP uptake increased as policy shifted from providing mothers with the NVP tablet at 32 weeks gestation to giving them the tablet upon HIV diagnosis.⁴

Results of the Malawi Program

Year	New ANC	PMTCT/HIV Counseled	Tested	HIV Positive	NVP Dispensed
April 2004–March 2005	20,510	15,447 (75%)	15,434 (99%)	2301 (15%)	1148 (50%)
April 2005–March 2006	20,129	20,129 (100%)	19,763 (98%)	2901 (15%)	2901 (100%)

The Malawi program includes health education sessions at which information on HIV and PMTCT is provided to all mothers arriving at ANC. Women are pre-test counseled in groups of 8–12 per session, and post-test counseled individually. HIV-positive mothers who receive post-test counseling are advised on the importance of ARV prophylaxis for PMTCT, receive infant feeding counseling, and are given a single NVP tablet with instructions to ingest the tablet at the onset of labor. The women receive a small plastic purse custom-made by UNC, comparable to what they would purchase in the local market, with the addition of an extra “secret” zippered compartment for the single NVP tablet. The mothers are encouraged to deliver at the healthcare facility so the infants can receive their NVP dose within 72 hours after birth. The mothers are scheduled to come to the facility at 32 weeks gestation to examine the condition of the NVP tablet and receive renewed instructions for taking it. The women receive a new tablet if they have lost it, or if the tablet is not in good condition or has expired.

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See Also

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Key Points

- SD-NVP can be provided to HIV-positive pregnant women upon HIV diagnosis with instructions to take it at the onset of labor.
- When given SD-NVP upon diagnosis, HIV-positive women who may deliver outside the healthcare facility are able to take the drug before delivery and bring the infant to the facility later for his or her dose of NVP.
- Additional human resources to provide SD-NVP during the initial ANC visit are not required.
- NVP uptake increases if pregnant women receive the tablet during the initial ANC visit.
- The current uptake data report the number of women who received ARV prophylaxis rather than the number who ingested it. However, women must have access to the drug if they are to take it.
- PMTCT policies should be amended to allow maternal SD-NVP to be provided during the same visit that the women's HIV status is determined, regardless of gestational age.