Challenges and opportunities around positive motherhood- Closing the gap in a globalised world

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In the wealthy countries of the ‘North’ interventions are routinely available that reduce the risk of vertical HIV transmission to less than 2%. However, the prevailing inequities that continue to scar our globalised world result in half a million of children being infected with HIV every year- the great majority through vertical transmission. Less than 10% of pregnant women in resource poor countries today have access to effective Prevention of Mother to Child Transmission or antiretroviral treatment services. Main challenges remain: should opt-out or opt-in testing replace voluntary testing and counselling; how can weak health systems be strengthened so that the new WHO proposed regimen for prophylaxis and treatment becomes feasible; which infant feeding policy to propose; how to offer comprehensive prevention, treatment and care using a multisectoral approach.

Feelings of motherhood are probably the oldest, deepest and globally most shared form of human love. For women around the globe, pregnancy and motherhood are a time of joy and bring fulfilment to a woman’s life. Sadly, however, this is not always the case. HIV/AIDS has cast dark clouds over motherhood for many women and their partners- particularly in the most affected countries. Today, with the increasing feminisation of the epidemic, being female and of reproductive age assigns one to a group at high risk of HIV infection. Should a pregnant woman be HIV positive then the further tragedy of the virus being transmitted to her baby is in these countries all too real.

In a country like Switzerland, HIV testing is strongly recommended to all pregnant women as a routine during antenatal checks. Here, to be infected with HIV and to wish to have a child are not irreconcilable. It is medically possible and no longer viewed as irresponsible on the part of the parents: their child has a very high chance of being born HIV negative and antiretroviral therapy means that parents can still expect to live long lives and care for the child as it grows up, despite their infection. In 2006 the Swiss Federal Office of Public Health reported just one case of mother to child transmission- the mother had not been aware of her HIV infection. Not a single case of vertical HIV transmission amongst pregnant women who had known about their HIV status has been reported since 2004. Near universal screening for HIV, antiretroviral prevention or combination therapy given to the mother during pregnancy and to the newborn following delivery, primary elective caesarean section around week 38 and the recommendation to refrain from breast feeding form the package of measures offered to HIV positive

pregnant women in Switzerland. In a country like ours these interventions have brought the transmission rates from HIV positive mothers to their babies down to below 2%.

Why is it then, that every year, around half a million children under the age of 15 become infected with HIV- most of them in resource poor countries and through vertical HIV transmission? The reasons are manifold- but if we try to summarise, they boil down to the prevailing inequities that continue to divide our world: inequities between the rich and the poor, between men and women, between rural and urban populations, between the educated and those who have no access to information, between those who do have access to good quality health care and those who do not.

Globally, 18 million women are HIV positive. Since 2002, the number of women living with HIV has increased in every region of the world. The problem is not limited to Sub Saharan Africa: East Asia experienced the sharpest increase in the number of women being infected with HIV with 56% in two years, followed by Eastern Europe and Central Asia with 48%. In Sub Saharan Africa women account for 59% of all those infected- and the proportion is even higher amongst younger age groups. Most of these women are not even aware of their status due to limited access to HIV testing and fear of using such services.

The world is far from reaching the global commitments as agreed in the 2001 UN Declaration of Commitment on HIV/AIDS (UNGASS), a commitment to which Switzerland also subscribed. The aim then was to achieve an 80% coverage of antiretroviral prophylaxis for HIV positive pregnant women by 2005- this compares poorly to what has been achieved to date. Only around 9% of pregnant women in resource poor countries have access to services that help prevent transmission of HIV to their infant. In 2005, more than a quarter (25%) of infants born to HIV infected mothers in the most affected countries resulted in being infected. If we remember that in the absence of any intervention, some 15-30% of babies born to HIV positive women will become infected during pregnancy and delivery and a further 5-20% of them during breastfeeding, we become painfully aware, that very little- far too little- has been achieved in this field. The 25% just about reflect the transmission rates we had in Switzerland before effective prevention became available in 1994.

Today, vertical transmission of HIV- that is the infection of the newborn in the womb, or during delivery or breastfeeding- is a problem that can be nearly eliminated with effective prevention measures that are also cost effective. A comprehensive strategy of prevention to eliminate vertical HIV transmission combined with the provision of care for the parents' health should be a top priority of the AIDS response, particularly in low income countries. Currently, however, those prepared to engage in promoting safe

motherhood and preventing vertical transmission in the context of high prevalence of HIV are faced with several fronts of heated debate.

Debate Nb 1: HIV testing

HIV testing can be undertaken through three main strategies: voluntary, mandatory or routine testing. Even though we know that worldwide over 90% of people currently living with HIV are unaware of their status, mandatory testing is not an acceptable public health approach for pregnant women- neither in the North nor in the South. Voluntary testing and counselling (VCT) has long been seen as the gold- standard, offering the greatest protection of human rights. Individuals voluntarily elect to undergo HIV testing, which is accompanied by pre- and post-test counselling under conditions of full confidentiality. However, the limits to this approach are magnified in societies where acceptance of VCT is low and the stigma associated with HIV infection is high. To what degree can VCT contribute to reducing HIV prevalence in such a setting? Is the personal autonomy of the individual hereby valued at the expense of the human rights of many others? Is there a case for introducing a more proactive solution when societal and cultural factors prevent women from exercising their voluntary choice?

Routine testing could be such a strategy. There are two ways in which routine testing can be offered: opt-in and opt-out. Opt-out is where a test is performed in all cases except for when the woman explicitly chooses for this not to be done. This is the strategy that was introduced in Botswana in 2004. It has resulted in an impressive increase in testing rates (19% in the one year interval between 2004 and 2005). Opt-in is basically the model offered to pregnant women in Switzerland.

As a public health decision maker in one of the most affected countries, you face a difficult choice when having to decide on a testing strategy for your health system. Some of the questions you need to answer are: How can individual rights be protected while safeguarding public health? How can your system offer quality counselling, which is free of coercion? How can you ensure that those tested positive are not subjected to stigma and discrimination? How can we avoid creating a situation where only HIV positive mothers are cared for and HIV negative mothers – who need support to remain that way – are neglected? Is there sufficient antiretroviral treatment and care to provide for everyone who is tested and found to be positive - what will each strategy cost your health budget?

Johanna Kehler of the AIDS legal network makes the point that in the societal contexts in which HIV testing takes place in most resource poor countries, the question has less to do with which HIV testing strategy to propose, than with creating an enabling environment for HIV testing in general.

A first step in this direction is the call for a change in wording when talking about the issue at the heart of today's conference. "Prevention of Mother to Child Transmission" puts the blame on the mother. It is suggested to replace this wording with "prevention of vertical transmission" or "prevention of paediatric HIV".

Debate number 2: Which antiretroviral prophylaxis?

Firstly, it is important not to confuse ARV prophylaxis in pregnancy with the long term use of antiretrovirals to *treat* the mothers HIV infection. After years of having nothing to offer to HIV positive pregnant mothers in developing countries for either scenario, studies conducted in the nineties in Thailand, Uganda and Ivory Coast gave rise to hope in the prevention of vertical transmission. A single dose of the drug Nevirapine (Viramune) given to the mother in the initial delivery stages and to her newborn in the first 72 hours after birth was shown to be a low-cost intervention, easy to administer and medically not very complex.

However, even this comparatively "easy" solution hasn't succeeded in going to scale in the context of resource-limited health systems. In addition, its effectiveness has been increasingly questioned and concerns about drug resistance surrounding the use of this mono therapy option have grown. The current consensus is that single dose Nevirapine should only be used when no alternative drug regimen is available.

According to the 2006 guidelines of the World Health Organisation the regimen recommended for preventing vertical HIV transmission in resource limited settings uses a combination of drugs over a much longer period of time. The woman needs to start taking Azidothymidine (AZT) from 28 weeks of pregnancy onwards. In addition to a single does of Nevirapine, she needs to receive AZT and Lamivudine, (3 TC) during labour and for a week after delivery. Her baby should receive a single dose of Nevirapine right after birth, followed by a seven-day course of AZT. It is already apparent that this is much more complicated than the initial single-dose Nevirapine intervention. Regimes become even much more complex when we look at PMTCT+ programmes. Here we are looking beyond preventing vertical transmission to safeguarding the mother's health, by offering her antiretroviral *treatment* if she qualifies for it, and – ideally - also addressing her partner's HIV status and treatment needs.

Countries like Tanzania or Uganda have already shifted their official policy to be in line with the new WHO recommendations. Uganda is one of the poorest countries to have reached the 3by 5 goal when country-level statistics are taken. However, the reality on the ground shows itself to be very more complex, marked by an important urban rural gap. In one of the rural districts of the country, Iganga, some of the health workers have been trained in using the new combination regimen. However, the drugs are still not being delivered through the logistical pipeline to such remote rural areas. Only Nevirapine is available – and even this doesn't reach all the women in need. If the new drugs were to arrive, the problem would still be far from solved. In Iganga district the majority of women deliver at home. This poses the challenge of how to facilitate their access to the needed medication. Health workers have thought about providing the drugs to be taken at home, but concerns prevail due to the drugs potentially serious side-effects. In addition, stigma forces many women to hide such drugs from their relatives and husbands. The arrival of PMTCT programmes in decentralised health services, in addition, poses huge challenges on the resources of the system. Midwifes are turned into counsellors, lab facilities are short of what is needed, the competition over the allocation of meagre health budgets is growing and human resources are strained even further than

they were before. The result is that most women in a context like rural Uganda, have little chance to access such services.

Not just Uganda is faced with a dilemma. The choice between providing a simplified, cheap and easy to administer solution or attempting to upgrade to the more complicated combination option recommended by WHO is a truly challenging one.
In the North we would never accept the first solution on the grounds of its limited effectiveness, the threatened drug resistance and the associated public health hazard that this presents. Yet, when weak health systems have struggled to make even the easier option widely available how can they be seriously expected to handle even more complex and resource intensive strategies? One more and very strong argument for speeding up and intensifying investments in an effective strengthening of health systems in resource limited countries.

Debate number 3: caesarean section for all HIV positive mothers?
Elective caesarean section performed before the onset of labour and before the membranes rupture reduces the risk of transmission of HIV to the newborn. A caesarean section is therefore the recommended delivery option for HIV positive mothers in a country like Switzerland. In the developing world this benefit has to be balanced against the risk to the woman of the surgical procedure. Maternal mortality and morbidity are greater after a cesarean section than after vaginal delivery. And, of course, access to a caesarean section is not given in many health systems in poor countries. In many rural regions of Africa there is a lack of health staff and equipment needed to perform this operation. Families cannot afford transport to referral hospitals and most women in need of emergency obstetric care die somewhere on the way to the next hospital. Performing elective surgery at 38 weeks - the norm for preventing vertical transmission in Switzerland – sounds utopian in such a setting and will clearly not be a feasible policy option in the near future.

Debate number 4: which infant feeding policy?
It is widely recognised that formula feeding is not a feasible option for most women in resource poor countries. Research from South Africa just published in the Lancet suggests that exclusive breast feeding for six months followed by rapid weaning has a lower risk of HIV transmission as compared to so-called mixed feeding. The results support those who call for a revision of the WHO/UNICEF guidelines on infant feeding. Dr Coovadia of the University of KwaZulu Natal stresses, however, that this does not mean we have found a solution. There are many societies, like the South African one, where mixed feeding is a cultural practice that goes back hundreds, if not thousands of years. Recommendations for exclusive breastfeeding in such societies put women at risk of becoming stigmatised, not to speak of the confusion that will be created when changing the recommendation after telling HIV positive mothers for years that they should abstain from breastfeeding.

These, however, are not the only challenges faced when developing an effective response to preventing vertical transmission and promoting safe mother/parenthood. The response has to go far beyond the medical sector. What is needed is a comprehensive strategic approach embracing primary prevention, so that women and men do not become

infected with HIV in the first place, as well as ways to reduce the numbers of unintended and unwanted pregnancy and create access to safe motherhood. Socio-economic, cultural and factors linked to education are as crucial to these issues as they are to questions of preventing vertical transmission and providing appropriate and accessible treatment, care and support to mothers, their partners, and most crucially to their children. Besides the strengthening of health systems we need conducive legal frameworks and policies, adequate and safe nutrition, socio-economic development and- most of all- we need to combat stigma and work towards supportive societies where the discrimination of people living with HIV becomes a thing of the past.

There are no magic bullets or quick wins in this field. This reflects the complex reality we are living and working in. However, solutions are available which are cost effective and have been shown to have an impact both at the public health level AND at reducing unnecessary human suffering at the individual level. The international community- and the partners of aidsfocus - must step up efforts to overcome the inequities that surround positive motherhood in order to move towards Universal Access.

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