Improving Prevention of Mother-to-Child Transmission (PMTCT) Programs in Sub-Saharan Africa:

Policy Recommendations

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Executive Summary

Canada has demonstrated remarkable commitment to the global struggle against HIV/AIDS. Importantly, much of Canada’s efforts are directed towards improving maternal and child health, a critical component of any program aimed to reduce HIV infections. One of the most effective ways to reduce new infections is through the improvement of prevention of mother-to-child transmission (PMTCT) programs, an area in which Canada is well positioned to be a global leader. This briefing argues that Canada has the opportunity to strengthen their position as a global leader in maternal and child health through the promotion of approaches that result in improved outcomes in PMTCT programs, and ultimately lower rates of new HIV infections.

This briefing maintains that the best way to reduce new HIV infections is to promote programs that broadly expand a country’s ability to better implement PMTCT programs and contribute to improved maternal and child health more generally, regardless of particular country contexts. Three specific recommendations are made. The first is to support the strengthening of data collection capabilities. Amelioration of monitoring and evaluation capabilities is a global priority, and will provide countries with crucial data that can be used to improve equitable access to programs and ensure that women who begin PMTCT programs are not lost along the way. The second recommendation is to promote innovative approaches based on emerging data. Improvements in data collection capabilities must be put to use in context-specific ways in order for program quality to benefit. Promoting the innovative use of this information will contribute to improved programs, and will create local demand for more and higher quality data, ensuring that data collection remains a priority. The final recommendation is to promote women’s and maternal health unconditionally. Numerous barriers to entry and opportunities for exit from the health system exist for women, so it is critical to ensure that any interventions or support for programs act to promote the increased and ongoing accessibility of health services to women, and the best way to do this is to remove any conditionality from foreign funding and support.

This policy briefing proceeds as follows. It first outlines the importance of PMTCT programs, followed by a discussion of particular challenges that effective implementation of these programs face. Canada’s current position regarding this issue area is presented, and the brief concludes with policy recommendations designed to improve the effectiveness of PMTCT programs while strengthening Canada’s position as a diplomatic leader in the area of maternal and child health.
**Summary Policy Brief**

**Policy Goal**
To improve Canada’s position as a global leader in maternal and child health through a focus on improving the effectiveness of PMTCT programs in sub-Saharan Africa.

**Significance**
PMTCT programs are cost-effective, established interventions that dramatically reduce the risk of pre- and post-natal HIV infection. There is widespread support for PMTCT programs in sub-Saharan Africa, but commitment is not necessarily matched with the ability to effectively implement such programs. Like many interventions addressing the spread of HIV/AIDS, the issue with PMTCT programs is not one of commitment, but rather of finding ways to improve implementation, particularly in terms of increasing the equitable access to programs and retaining participants once they have begun the programs.

**Canada’s Interest in the Issue**
Canada has proven to be a committed supporter of HIV/AIDS programs in the developing world, committing almost $1.4 billion to their active programs focused on STD control, including HIV/AIDS. Nearly 40% of these programs address PMTCT in some way, and Canada has demonstrated global commitment to improving women’s and children’s health through participation in several global initiatives. Continued focus on the expansion and the effectiveness of PMTCT programs will only serve to strengthen Canada’s position as a niche diplomatic power in the area of maternal and child health.

**Policy Recommendations**
The first recommendation is to support the strengthening of data collection capabilities. Improving monitoring and evaluation capabilities will provide countries with crucial data that can be used to improve equitable access to programs and ensure that women who begin PMTCT programs are not lost along the way. The second recommendation is to promote innovative approaches based on emerging data. To be useful, this data must be put to use in context-specific ways. Promoting the innovative use of this data will contribute to improved programs, and will also create further demand for more and higher quality data. The final recommendation is to promote women’s and maternal health unconditionally. Numerous barriers to entry and opportunities for exit from the health system exist for women, so it is critical to ensure that interventions or support for programs act to promote the increased access of women to health services, and the best way to do this is to remove any conditionality from foreign funding and support.

**Significance of the Issue**
The global HIV/AIDS pandemic is one of the most pressing health challenges of our time. UNAIDS estimates that in 2012, between 32.2 and 38.8 million people were living with HIV globally, and between 1.9 and 2.7 million people became newly infected with the virus (UNAIDS
2013). These numbers reflect a steady improvement in the efforts to control the disease, and importantly, demonstrate a large decrease in the number of new infections over previous years. Regardless, the pandemic is still heavily concentrated in sub-Saharan Africa, which, as a region, accounts for roughly 70% of all existing as well as new infections (UNAIDS 2013). Epidemics are unique events, and each country experiences different (and often multiple) epidemics, shaped by the context in which they occur. Infection rates, manners of transmission, and responses are heavily affected by local political, social, and economic factors. As such, the epidemic that is localized to Vancouver’s Downtown Eastside cannot be approached in anywhere near the same way as the one in Johannesburg, even though both epidemics report similar infection rates. Each unique epidemic requires a unique response.

Unlike HIV epidemics in the developed world, epidemics in sub-Saharan Africa tend to be generalized in the entire population, not concentrated within small, at-risk groups. Critically, the most affected and most at-risk individuals are women. Women are biologically more susceptible to infection, but they are also more likely to be at risk due to social and economic conditions (Dodoo and Frost 2008; Heise and Elias 1995; Clark 2004; Luke 2005; Buvé, Bishikwabo-Nsarhaza, and Mutangadura 2002). Poverty, gender-based violence, and societal norms all create contexts in which women have higher chances of contracting HIV. Women living with HIV may not know their status, and thus may pass the virus to their sexual partners or to their unborn and newborn children. Indeed, mother-to-child transmission represents a large - and largely preventable - source of new HIV infections in sub-Saharan Africa. In 2012, approximately 230,000 children became newly infected with the virus in utero, during child birth, or through the consumption of HIV-infected breast-milk (UNAIDS 2013). If the goal of an “AIDS-free generation” is to be accomplished, it is crucial to ensure that newborn children are born free from infection and remain that way for the rest of their lives.

The risk of infection for children can be reduced dramatically through the proper implementation of prevention of mother-to-child transmission (PMTCT) programs. These interventions are not new (UNAIDS 2013; De Cock et al. 2000), and have been refined and improved in recent years to establish best practices and integrate lessons learned (UNAIDS 2013; World Health Organization 2012). When implemented successfully, PMTCT interventions reduce mother-to-child transmission to approximately 2%; without interventions, transmission rates are between 20-45%, depending on the amount of time the child is breastfed (UNAIDS 2013; World Health Organization 2007). In Europe and North America, infant HIV infection has been virtually eliminated, largely due to the effectiveness of treatment and prevention programs (UNAIDS 2013). PMTCT is not a particularly difficult or expensive intervention. In its ideal form, it involves starting pregnant women on antiretroviral therapy (ART) in order to reduce the likelihood of transmission in utero, during pregnancy, and during breastfeeding, as well as daily ART for infants during the breastfeeding period (World Health Organization 2010b).

These interventions are cost effective, have long lasting positive impact, and are available to any country that wishes to provide them. Recent studies have discounted the belief that these interventions are less effective in resource-constrained environments. Global funding bodies, including the Canadian government, have demonstrated increased commitment to maternal and child health, however the question is not simply one of commitment: like many
interventions addressing the spread of HIV/AIDS, the issue is not of what to do, but rather of how to do it well in a particular context.

This is the case with PMTCT. Governments know that it is a priority focus area, but they do not necessarily have the resources to pursue PMTCT in the most effective way. As such, this policy brief argues that Canada should focus its support on the areas that improve governments’ capabilities to better implement context-specific interventions. In general this means improving the monitoring and evaluation of programs. Canadian support should be directed towards the better collection and use of data on mothers and children, and crucially, Canada should support efforts that encourage and enable women - especially pregnant women and new mothers - to engage with health services. Any commitment to reducing infections in children and keeping them HIV free for their entire lives must start with a strong focus on the health and health-related knowledge of women.

Policy Goals and Challenges

The issue with PMTCT programs in sub-Saharan Africa is not one of convincing governments to pursue them, but rather of improving the effectiveness of the programs. An examination of the most recent National Strategic Plans on HIV/AIDS from 42 countries in sub-Saharan Africa confirms that regional commitment to preventing new infections in children already exists. Countries in general have good national-level policies on PMTCT, closely reflecting the guidelines provided by UNAIDS and the WHO, but the elimination of mother-to-child transmission is still lagging. Rapid movement towards universal access to PMTCT programs can be achieved, even in extremely resource-constrained contexts (Ngubane 2010; UNICEF 2010; World Health Organization 2008a). Written policies are not the problem; the challenge lies rather with their implementation. To be successful, countries need to overcome issues of weak political leadership, gendered power relations, low levels of access to services, geographic barriers, and poor data (Ngubane 2010; UNICEF 2010; Msellati 2009; World Health Organization 2008b; World Health Organization 2007). Each country’s challenges are different, and as such, any support offered by external agencies should be flexible and adaptable across contexts. A commitment to improving political leadership or to reducing societal stigma may be what is needed, but beyond blanket recommendations such as encouraging political leaders to support PMTCT programs, general policy recommendations along these lines must necessarily remain vague, and will be more effective in some cases than in others. Instead, this policy brief recommends targeting those areas of intervention that will strengthen any country’s efforts to improve outcomes, regardless of the context.

Increasing Access to Maternal Health and PMTCT Programs

Potential access to PMTCT is relatively high (South et al. 2011), but it is by no means universal. In low- and middle-income countries, only about half of HIV positive pregnant women received any form of antiretroviral therapy in order to prevent infection of their child (UNAIDS 2010). While that is a large improvement over the 10% who received treatment for PMTCT in 2004, given the
simplicity of the intervention this rate of improvement leaves much to be desired (Msellati 2009; UNAIDS 2010). Looking only at sub-Saharan Africa, the number of women with access to PMTCT programs varies dramatically. While some countries have done remarkably well\(^1\), reaching over 75% of coverage of PMTCT services to pregnant women, even more countries show rates of access less than 25%\(^2\) (UNAIDS 2012).

A significant challenge to reducing mother-to-child transmission is to get more mothers who do not know their HIV status to test (South et al. 2011). Increasing the availability of access to PMTCT services is a crucial step in encouraging all women to engage with health services during pregnancy, opening up the possibility of testing, treatment, and ultimately the reduction of the number of new infections in children. The importance of this cannot be overlooked. Women who test for HIV before pregnancy, in addition to the individual health benefits they will gain through knowledge of their status, are significantly more likely to participate in PMTCT programs (Nassali et al. 2009). Regular access to pre- and post-natal care also greatly increases a woman’s likelihood of participating in PMTCT programs (Nassali et al. 2009). The connection between increased use of maternal health services and increased participation in PMTCT is an important one.

**Equitable Access to Services**

Increasing access to services is a problem, but a broader issue is to ensure that this access is increased equitably and reaches the women who need it most. If improved access only occurs in urban areas, for example, rapid and sustained reduction in new infections amongst infants will not be achieved. Structural barriers to access are a serious issue in rural areas where health services are limited. Access to some communities is difficult, and geographic distance and high transport costs pose real challenges to equitable access to PMTCT services. Inaccessible rural communities are already generally disadvantaged when it comes to the availability of skilled practitioners, antiretroviral drugs, doctors, and hospitals.

These areas are also often overlooked in data collection and reporting, and yet form the evidence base for decisions on what programs governments pursue and where they pursue them. Underrepresentation in reporting sustains this disadvantage, as policy makers do not have the full picture of the epidemic and make policy decisions based on information that has an urban bias. This occurred most famously with Uganda’s early experience of the epidemic. Initial HIV prevalence data was based on results from only a handful of ante-natal clinics in Kampala, resulting in an extremely high estimate of HIV prevalence, and a limited understanding of how to approach the epidemic (Parkhurst 2002). The numbers and the characterization of the epidemic changed dramatically over the years as more representative national surveys were conducted.

Improving access for everyone can be a difficult undertaking, especially in low-resource and geographically challenging environments. The key challenge to ensuring equitable access is

\(^1\) Botswana, Ghana Namibia, South Africa, Swaziland and Zambia have PMTCT coverage of above 75%.

\(^2\) Angola, Chad, Congo, Eritrea, Nigeria, and South Sudan are below 25% PMTCT coverage.
having a clear idea of who needs treatment and where - information that requires reliable and accurate data collection tools.

**Increased Retention of Participants**

Even when programs are equitably available, PMTCT interventions face the problem of retention, as it is unfortunately common for women who get involved in PMTCT programs to be lost along the way. The pipeline for PMTCT programs can be complex, with multiple points of entry and multiple institutions, and thus multiple points of difficulty and potential exit. As South et al. (2011) note, women can be lost at all stages of treatment: “being referred to the HIV service, registering at the HIV service, being assessed for their need for lifelong ART [antiretroviral therapy], and then actually starting ART” (South et al. 2011). Looking at cases in Tanzania and Kenya, the authors found that roughly 4% of women who tested HIV-positive through PMTCT services eventually ended up beginning HAART (Highly Active Antiretroviral Treatment) (South et al. 2011). The need to retain more women who test positive in PMTCT programs is evident.

One of the reasons why women may be abandoning the process is due to gender and community dynamics, specifically surrounding the stigma of being discovered as being HIV positive. Mothers have been known to actively cover up their positive status, which often means dropping out of PMTCT programs or not following guidelines due to the fear of having their status discovered (Cataldo, Limbani, and Van Lettow 2012). Domestic violence and divorce or separation are also concerns if women are found by their partners to be HIV-positive (World Health Organization 2008b; Nassali et al. 2009; Cataldo, Limbani, and Van Lettow 2012). The lack of involvement of male partners in the PMTCT and HIV testing process is of particular concern (World Health Organization 2008b; Msellati 2009; Nassali et al. 2009; Cataldo, Limbani, and Van Lettow 2012; World Health Organization 2008a). The inclusion of male partners in such programs has the potential to “benefit adherence, improve uptake and continuation of family planning methods and provide family-centred care and treatment” (World Health Organization 2008a).

Importantly, the initial barrier of getting women into the health system when they are pregnant has been largely overcome. In 1999, approximately 70% of women in sub-Saharan Africa have attended an ANC (ante-natal clinic) at least once during their pregnancy (South et al. 2011). Women may enter the system at one point or another, but they do not necessarily stay. It is much less difficult to convince a woman to have an HIV test than it is to convince her to return to get her results and remain in the treatment process (Msellati 2009). A further issue can be found on the health systems side. With multiple points of entry into the treatment process, and varied record keeping systems that have not been designed for sharing between institutions, many women may be lost due to a simple inability to follow up with their care. In general, ANC services (as they are only concerned with pregnant women) are not designed with the long-term treatment of individuals in mind; a shift away from a perspective of single interventions towards one of a “longer continuum of care” is necessary to ensure retention and proper implementation of PMTCT services (South et al. 2011; UNAIDS 2011). Of particular
concern is the fact that unique patient identifiers\(^3\) are not present. This means that the same woman returning for a second time is recorded as a new case, leading to over-counting and difficulties determining who has accessed services and who has pursued a referral. It also severely complicates the sharing of data within and between organizations (South et al. 2011; UNAIDS 2011).

**Canada’s Interest in the Issue**

Canada has proven to be a committed supporter of HIV/AIDS programs in the developing world. From 2001, 130 programs were funded that dealt with STD control, including HIV/AIDS (Government of Canada 2013). According to Foreign Affairs, Trade and Development Canada, there are currently 61 active projects that address STD control. Canada has committed a maximum of almost $1.4 billion to these active programs.

Most of these programs (74%) have HIV/AIDS prevention and/or treatment as a major component. Furthermore, 38% of the active programs, representing roughly $845 million dollars in funding, specifically address prevention of mother-to-child transmission in their brief project summaries (Government of Canada 2013). Canada has set a precedent for investing in programs that address maternal and child health.

Indeed, Canada’s commitment to this issue is seen not only in the funding provided to various governments, NGOs and global organizations, but is also matched by Canada’s high-level leadership in the Muskoka Initiative, a global effort to “reduce maternal and infant mortality and improve the health of mothers and children in the world’s poorest countries” (Government of Canada 2012). Canada has committed 15% ($1.1 billion) of the overall total of $7.3 billion to this initiative. This is in addition to the $1.85 billion already being spent by the Canadian government on maternal and child health initiatives (Government of Canada 2012).

Furthermore, the Rt. Hon. Stephen Harper served as the co-chair for the Commission on Information and Accountability for Women’s and Children’s Health, a commission that was tasked with determining “the most effective international institutional arrangements for global reporting, oversight and accountability on women’s and children’s health” (World Health Organization 2011). Canada is carving out a diplomatic niche for itself regarding maternal and child health, and its continued and refined focus and attention to the expansion and the effectiveness of PMTCT programs will only serve to strengthen Canada’s position as a diplomatic leader in this area.

**Policy Recommendations**

The challenges to reducing mother-to-child transmission of HIV in sub-Saharan Africa are numerous, interrelated, and often eschew simple interventions. As such, many policy documents and strategies put forth by the WHO, UNAIDS and other organizations tend to be presented in general language, such as ‘reduce the number of HIV-related maternal deaths by

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\(^3\) A unique patient identifier would be the health system equivalent of a SIN number, a unique number that ensures that data collected is being filed under only one, and the correct, patient.
These recommendations and the language surrounding them are easily assimilated into domestic policy documents, making comparisons between countries difficult. As such, this policy brief is not concerned with whether or not a country’s official policies are in line with those of international organizations, especially in light of Oberth’s (2012) findings that countries that deviate from international policy norms can outperform those who do not. Instead, this brief is more interested in focusing on interventions that strengthen a country’s capability to improve the implementation of programs. This is especially important for simple and effective programs such as PMTCT.

**Support the strengthening of data collection capabilities**

As Peter Drucker once famously declared, “what gets measured, gets managed.” The key policy recommendation that is offered in this briefing is that Canada’s investment and support should be focused heavily on improving monitoring and evaluation of the activities and the efficacy of PMTCT programs in sub-Saharan Africa. Without accurate data, informed policy decisions cannot be made, and any investments that are made in PMTCT are going to be less effective, less equitable and less sustainable than they could be. This is articulated well by UNAIDS, and should become a specific area of focus for Canadian investment:

> Clear contracts and reliable data and information represent the basis for mutual accountability: for governments and partners to each other, and to the people who need, use and benefit from the services. Systems need to be in place to collect essential data to support accountability and the capacity of communities needs to be built to use the data for programme planning, implementation and course correction. At same time, the currently high burdens of data collection and reporting must be reduced. (UNAIDS 2011).

Indeed, there is a concerted effort on the part of global agenda setters towards better monitoring and evaluation of health programs concerning PMTCT. The WHO’s position is similar to UNAIDS’, declaring that “better programme methods are needed to monitor and evaluate indicators for the number of pregnant women initiating ART, as well as their adherence and response to treatment, in terms of their own health, MTCT transmission rates, and the health of their children” (World Health Organization 2010a). Overall, there is consensus in the academic literature and among international organizations about the critical need for improved data collection, monitoring, and evaluation in order to strengthen health systems and improve PMTCT programs (UNAIDS 2011; Ngubane 2010; World Health Organization 2010c; World Health Organization 2010a).

A commitment to improved monitoring and evaluation programs is not outside Canada’s current diplomatic mandate, especially given the Rt. Hon. Stephen Harper’s role as co-chair for the Commission on Information and Accountability for Women’s and Children’s Health. This is an area where Canada should practice niche diplomacy (Behringer 2005; Fourie 2012), strengthening its position as a leader in the area of maternal and child health through establishing a strong commitment to the importance of accurate data collection, reporting, and
evaluation. Canadian policy should be focused explicitly on promoting this aspect of health systems-strengthening. Doing so will provide countries with the opportunity to better allocate resources to PMTCT, increasing the availability and equity of access to this critical intervention.

**Promote innovative approaches based on emerging data**

To further this mandate and to increase the efficacy of PMTCT programs, in addition to promoting particular initiatives to strengthen and expand data collection capabilities, Canada should support programs and initiatives that seek to use the collected data, either as ways of augmenting existing services, or for programs that seek to apply insights gained from the data collected to innovative, context-specific projects. Without proper incentives to actively use and engage with the information that has been collected, there is a risk that it will only be collected to meet the demands of external agencies. Creating an environment where engaging with the data is rewarded will promote its use, and will likely contribute to the demand for more and higher quality data by those working with it.

Efforts that combine more effective data collection methods with specific plans for the use of this improved data should be encouraged. However, these programs should be engaged with critically in order to promote only those initiatives that are sustainable in a given context. For example, introducing electronic hospital records may help to link patients to HIV clinics (Fergusson et al. 2010) and would be a boon to data collection, but it would also be difficult (and expensive) to implement in more inaccessible areas. In addition, efforts to increase the volume of collected data should be encouraged. For example, opt-out testing as opposed to opt-in testing\(^4\) would increase the amount of women being tested (and thus the amount of data collected). Likewise, providing same-day testing and results may help to improve retention in PMTCT programs thus allowing for greater collection over time as well as improving patient health outcomes (Msellati 2009)\(^5\). Facilitating and encouraging the use of data in context-specific ways will assure that interventions are designed and adapted based on strong evidence, leading to more effective programs.

**Promote women’s and maternal health unconditionally**

There is a worrying norm in international funding to attach conditions to how money is spent. This policy briefing urges the Canadian government to refrain from doing so in the area of maternal and child health. For example, Minister Paradis recently confirmed that Canada’s commitment to funding maternal and child health would not involve funding towards any abortion services. The issue here is not one of the content of the condition, rather on the presence of conditions themselves. Conditions on funding create unexpected incentive structures and may, in the long run, generate more harm than good. For example, limiting

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\(^4\) Opt-in HIV testing requires a patient to give consent to be tested, while opt-out testing tests everyone by default and requires a patient to explicitly opt-out of the process.

\(^5\) These procedures can bring further issues, however, such as increased cost and the need to expand peer-counseling programs, and are included not as a recommendation per se, but rather as an example of what kinds of programs would fall under this umbrella.
access to legal abortion services does not necessarily reduce the number of abortions that will be performed. Instead, it may put women at a much greater health risk. Rape and sexual violence are established and significant vectors of HIV transmission (Jewkes et al. 2010), and refusing to fund organizations that perform abortions creates incentives for organizations to stop offering them. As a consequence, victims of sexual violence will turn instead to alternative abortion options, either outside of the formal system, or in neighbouring countries, further jeopardizing their health (Singh 2006). The result is that a group of individuals who have a higher likelihood of infection do not enter the formal system, do not get tested, and do not get treated. They may spread the disease to their partners, and importantly, by having a negative experience with a health service in the past, they may have little reason to engage with the formal system if they get pregnant in the future. For every woman turned away from accessing maternal healthcare innumerable others, including unborn children, are put at risk of contracting HIV.

Promoting improved access to maternal health services in order to get women into the health system and keep them there is critical, and needs to be done unconditionally. The more opportunities or incentives there are for women to abandon health care services, the less effective prevention and treatment efforts will be.

**Conclusion**

This policy brief argues for the importance of establishing, nurturing, and expanding the proper monitoring and evaluation of efforts to increase the uptake of PMTCT programs across sub-Saharan Africa. PMTCT is a straightforward medical intervention that has been shown to be effective even in resource-constrained settings, and an examination of national policy documents shows high levels of commitment to the approach. The issue at hand is less about convincing governments of the importance of PMTCT, and more about ensuring that its implementation is more effective. The best way to do this is to improve the ability of governments to measure their epidemics, track their patients, and promote the use of this data in revising program implementation.

This brief argues for the importance of supporting the strengthening of data collection capabilities. Improving monitoring and evaluation capabilities will provide countries with crucial data that can be used to improve equitable access to programs and ensure that women who begin PMTCT programs are not lost along the way. Furthermore, it recommends promoting innovative approaches based on emerging data. To be useful, this data must be put to use in context-specific ways. Encouraging the innovative use of this data will contribute to improved programs, and will also create further demand for more and higher quality data. Finally, this policy brief urges the Canadian government to support women’s and maternal health unconditionally. Numerous barriers to entry and opportunities for exit from the health system already exist for women, so it is critical to ensure that any interventions or support for programs act to promote the increased access of women to health services, and the best way to do this is to remove any conditionality from foreign funding and support.

With proper commitment, the virtual elimination of mother-to-child transmission is well
within the grasp of any country that pursues it. Without proper data and systems to enroll and retain mothers in PMTCT programs, however, the hope of an AIDS-free generation will remain out of reach.

Annotated Bibliography


This policy brief, prepared for the ‘Africa Initiative’, argues that the key way to reduce mother-to-child transmission is to improve the rate of HIV testing amongst women who do not know their status. It articulates many barriers to testing, including social constraints and system-level barriers to health care access.


This review article of clinical research on mother-to-child transmission in developing countries argues that successful implementation of PMTCT programs could improve global child survival rates dramatically. It makes the case for viewing PMTCT not as an issue of HIV/AIDS prevention, but within the broader contexts of child and reproductive health.


Developed in cooperation with the WHO and UNICEF, this high-level document outlines guiding principles, goals and targets, and recommends specific actions and strategies that countries can take to decrease mother-to-child transmission. The report stresses the importance of targets and data for tracking progress, as well as the need for better approaches to monitoring and evaluation of responses.


This article investigates why access to PMTCT programs is not growing as fast as expected. The author performs a literature review of PMTCT programs in West Africa, finding a need to improve uptake of testing, and importantly, to increase the number of women who return to obtain their test results. The author recommends simple interventions that may increase both rates, such as shifting to opt-out testing and
offering tests and results on the same day. The importance of monitoring and evaluation of PMTCT programs is also stressed in order to identify areas of improvement.


The authors examine the challenges to adherence to postnatal PMTCT programs in sub-Saharan Africa. They find that previous participation with PMTCT programs and mobile phone access were important determinants to adherence. Importantly, mothers who had previous experience with postnatal care of any kind were more likely to fully participate in PMTCT programs. Important determinants for full adherence included spousal support, ease of physical access to the program, and mothers’ perceived benefits of the program. The article suggests the importance of general participation in health care, better tracking of and follow up with participants, and expanding the umbrella of maternal health to include spouses.


This policy brief prepared for DFID reports on findings generated from a pilot of the Accelerated PMTCT Plan in South Africa. The author reports that clear monitoring and evaluation and a reliable health information system were crucial for improving the overall health system. Other barriers to improved outcomes included geography and misinformation amongst health clinic staff.


This briefing paper prepared for ‘Evidence for Action’ demonstrates that access to PMTCT programs can often be overly complex, and that there are many opportunities to improve initial access and retention of women in PMTCT programs. Women are lost at various points along the way, and simplifying the process and improving data collection abilities would yield dramatic improvements in access to care. Importantly, improvements need to be made in monitoring patients and tracking their access to various health facilities. The authors also argue for the importance of approaching PMTCT more broadly in terms of maternal, rather than simply child, health.

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