African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

PMTCT COUNTRY REPORT

MAURITIUS

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
CSW	Commercial Sex Workers
DHS	Demographic and Health Survey
HIV	Human Immunodeficiency Virus
HSRC	South African Human Sciences Research Council
IDU	Injecting Drug Users
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MOHQL	Ministry of Health and Quality of Life
MS	Member State
NAC	National AIDS Council
NACP	National AIDS Control Programme
NGO	Non Governmental Organisation
PEP	Post-exposure Prophylaxis
PFP	Project Focal Person
PICT, PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSS	Psychosocial Support
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
TAC	Technical AIDS Committee
TOT	Training of Trainers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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1. INTRODUCTION

1.1 HIV/AIDS and PMTCT in Mauritius[1]

The HIV/AIDS epidemic in Mauritius is concentrated, characterized by prevalence below 1% among the general population and a higher prevalence of generally above 5% in specific vulnerable groups such as commercial sex workers (CSWs) and injecting drug users (IDUs).

The country is experiencing a rapid increase in incidence due to the high vulnerability of IDU. During recent years, the epidemic has risen exponentially with a concurrent marked shift in the predominant mode of transmission from unprotected heterosexual sex (64% in 2001 to 8% in 2004) to injecting drug use (7% in 2001 to above 88% in 2004). In 2005, 921 new HIV infection cases were documented (among which over 90% were in IDU group), which corresponds to the highest annual incidence for the past 16 years.

There is growing concern regarding the generalization of the epidemic away from the IDU group, indicated by the increasing monthly HIV incidence rate in pregnant women: an increase to 5 HIV positive cases per month was notified for January and February 2005 as opposed to the average 1.4 per month in past years. This trend demonstrates the initial stages of the generalization of the epidemic.

A National AIDS Control Programme (NACP) was established in 1987, with support from the Global Programme of Action, WHO & UNDP, and focused on primary prevention strategies, which included blood transfusion safety and access to information.

Access to antiretroviral treatment for the prevention of mother to child transmission (PMTCT) was integrated into the NACP in 2000. Universal free anti-retroviral therapy treatment has been provided since 2002. However, marginalized groups like CSW and IDU have low medical consultation rates.

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for policies, protocols and guidelines for PMTCT in the SADC region.

To achieve this, the project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) - see appendix 1 - is reviewing and analysing policies, protocols and guidelines for PMTCT in each SADC member state (MS), in collaboration with the PMTCT national focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on PMTCT, and come up with best practices in implementation of PMTCT policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in PMTCT; and
- review and analyse proposed minimum standards for the PMTCT policies.

2. METHODOLOGY

The PMTCT national focal person in Mauritius was tasked with three key responsibilities:

[1] The information in this section is drawn from material contained in the *Government of Mauritius Council of Religions/UNDP 2006-2007 Action Plan on HIV&AIDS in Mauritius* (http://un.intnet.mu/undp/html/mauritius/Council%20of%20Religions%20Pro%20Doc.pdf) accessed 15/03/09

2.1: Identify policies, procedures and frameworks on PMTCT
2.2: Participate in the assessment of the policies, procedures and frameworks on PMTCT
2.3: Facilitate dialogues and stakeholders consultations on policies relating to PMTCT, including policy discussions on the development and implementation of policies, procedures and frameworks on PMTCT in the country.

A field guide, consisting of relevant tools and instructions for each of the task, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key stakeholders in the country. The field guide was piloted in one of the Members states in collaboration with SADC.

Policy discussions, Facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for PMTCT policies, protocols and guidelines;
- civil society official(s) responsible for PMTCT policies, protocols and guidelines;
- representative(s) of international organizations responsible for PMTCT;
- representative(s) of private or informal sector responsible for PMTCT policies, protocols and guidelines; and
- Others as appropriate.

The policy discussions were scheduled at the convenience of the respondents and conducted in the community or at an office where there was an undisturbed atmosphere. The PFP received direction and guidance from SAHARA project team on how to conduct policy discussions. Selected respondents were invited by letter or email to participate in the discussions, and included officials from the national AIDS council and national AIDS coordination programmes; PMTCT programmes and administrative staff; primary stakeholders, such as technical partners, donors and implementing agencies; Civil society.

3. FINDINGS

3.1 SWOT analysis of PMTCT in Mauritius

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats in regard to the PMTCT programme in Mauritius (details are in appendix 2, 3, 4, 5)

STRENGTHS	WEAKNESSES
• PMTCT protocol (2004) • PMTCT guidelines (2008) • >95% of pregnant women attending govt. facilities are tested • Free HIV and PMTCT services, including ART	• No PMTCT policy • Inadequate PMTCT M&E • Poor male involvement • Guidelines not easily accessible
OPPORTUNITIES	**THREATS**
• Scale-up decentralization of PMTCT delivery points to regional hospitals • Development PMTCT policy	• Private clinics do not do HIV testing • Concentrated epidemic progressing to generalised epidemic

3.2 Analysis of PMTCT policies and protocols.

There is no PMTCT policy but revised guidelines were developed in 2008. The guidelines were developed with stakeholders through a consultancy. The guidelines comply with global minimum standards, which are seen as appropriate for the country.

Integration of PMTCT into paediatric AIDS treatment and care activities

- There is a need to integrate PMTCT into paediatric AIDS treatment and care activities.

CD4

- ART for pregnant women with CD4 ≤300

Infant and Infant feeding

- Nutrition care and support offered up to 24m; first year is infant formula and second year full cream milk.

Age of consent

- Based on available data, the age of consent appears to be 15.

3.3 PMTCT policy gaps in Mauritius

- Lack of a policy means that testing in private facilities cannot be mandated.
- An information campaign is needed to maintain uptake of PMTCT.

3.4 PMTCT situation analysis in Mauritius

See Appendix 3.

3.5 PMTCT approaches/ Models in Mauritius

The National Day Care Centre for the Immuno-suppressed (NDCCI) became functional in 1999 offering the following services:-

- Treatment of opportunistic infections
- Voluntary Counselling Testing
- Implementation of a Prevention of Mother to Child Transmission programme as from December 1999.
- Provision of Post Exposure Prophylaxis treatment to all accidental injuries and victims of sexual abuse.
- Provision of antiretroviral drugs, free of any user cost, since April 2002, to all HIV/AIDS patients in need.

There is a commitment to provide PMTCT services in all ANC health centres. Testing in ANC then referral to regional hospital for PMTCT protocol.

3.6 Key PMTCT policy discussion issues

See details in Appendix 6

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

- All ANC attendeesoffered testing for HIV.
- All pregnant women who are HIV infected should be offered PMTCT (28th week of pregnancy).
- Delivery by Caesarean Section (C/S); C/S scheduled 2 weeks before expected delivery date.
- ARV therapy for babies born to HIV infected mothers.
- Provisions of infant formula milk for all children born to HIV infected mothers who should receive infant feeding/nutrition counselling.
- Fertility management education post-delivery for HIV infected mothers – Male/Female condoms distributed free.
- Testing to determine HIV status of babies.

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF PMTCT POLICIES, PROTOCOLS AND GUIDELINES

Prongs	Indicator
1: Primary prevention of HIV infection among women of childbearing age	
1.1 [Health education]	Y
1.2 [HIV testing and counselling]	Y
1.3 [Couple HIV counselling & testing]	Y
1.4 [Safer sex practices including dual protection (condom promotion]	Y
2: Preventing unintended pregnancies among women living with HIV	
2.1 [Family planning]	Y
2.2 [HIV testing and counselling]	Y
2.3 [Safer sex practices including dual protection (condom promotion]	Y
3: Preventing HIV transmission from a woman living with HIV to her infant	
[Quality antenatal and delivery care]	
3.1 [HIV testing and counselling]	Y
3.2 [Retesting in late pregnancy]	Y
3.3 [HIV pre-test counselling]	Y
3.4 [Post-HIV test counselling]	Y
3.6 [Male involvement]	N
3.7 [Gender-based violence; stigma]	N
3.8 [Involvement of PLHIV]	Y
3.9 [Clinical (staging) and immunological assessment of pregnant women]	Y
3.10 [ART for pregnant women eligible for treatment]	Y (≤300)
3.11 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y (triple)
3.12 [Safer obstetric practices]	Y
3.13 [Infant feeding counselling and support]	Y
4: Providing appropriate treatment, care and support to mothers living with HIV and their children and families	
Mothers	
4.1 [ART for pregnant women eligible for treatment]	Y (<300)
4.2 [Co-trimoxazole prophylaxis]	Y
4.3 [Continued infant feeding counselling and support]	Y
4.4 [Nutritional counselling and support]	Y
4.5 [Sexual and reproductive health services including family planning]	Y
4.6 [Psychosocial support]	Y
4.7 [Tuberculosis screening]	Y
Children	
4.8 [ARV prophylaxis]	Y
4.9 [Routine immunization and growth monitoring and support]	Y
4.10 [Co-trimoxazole prophylaxis staring at 6 weeks]	Y
4.11a [Early diagnosis testing for HIV infection at 6 weeks where virological tests are available]	Y

4.11b [Antibody testing for young children at 18 months where virological testing is not available]	N/A
4.12 [Antiretroviral therapy for eligible HIV infected children]	Y
4.13 [Continued infant feeding counselling and support]	Y
4.14 [Screening and management of tuberculosis and other opportunistic infections]	Y
4.15 [Prevention and treatment of malaria]	N/A
4.16 [Nutrition care and support]	Y (24m) 1st yr formula, 2nd yr full cream milk
4.17 [Psychosocial care and support]	Y
4.18 [Symptom management and palliative care if needed]	Y
4.19 [Diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illness (IMCI)]	Y
PMTCT national policy	
Existence of national guidelines for the prevention of HIV infection in infants and young children in accordance with international or commonly agreed standards (WHO, 2004a)	Y 2008 Dr. C Gaud

APPENDIX 3: PMTCT INDICATORS IN MAURITIUS

Category	
HIV prevalence estimates	Estimate
Estimated adult HIV prevalence rate, 2007, 15-49 (UNICEF, 2008)	1.8%
Estimates based on sentinel surveillance data, 2007, 15-24 year-olds (SADC, 2008)	0.35%
PMTCT indicators	
Antenatal care coverage (UNICEF, 2008)	99%
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months. (WHO, 2004a)	
The percentage of public, missionary and workplace venues (FP and PHC clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services for the prevention of HIV infection in infants and young children in the preceding 12 months. (WHO, 2004a)	100% (all 142 MCH, 5 regional Hospitals)
The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling. (WHO, 2004a)	96%
The percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards) in the preceding 12 months.	34% (2007)
The percentage of HIV-positive infants born to HIV-infected women. (WHO, 2004a)	0% (2006)
The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (UNICEF, 2008)	100%
The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within 2 months of birth (UNICEF, 2008)	100%
Percentage of people receiving antiretroviral therapy who are children (WHO/UNAIDS, 2006)	Around 2%

APPENDIX 4: SUMMARY OF PMTCT IMPLEMENTATION CHALLENGES

Implementation challenges	Yes, No, N/A: & Extent of Challenge
Inadequate financial resources, which are often narrowly earmarked by donors	Political commitment, + financial in budget
Inadequate human resources; problems with lay counsellors	Lack of staff, need capacity building
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	
Low coverage of PMTCT	Poor follow up

Stigma and discrimination;	HIV & AIDS Act 2006; Civil status act is amended. However stigma still high
Inadequate support for infant feeding which remains a complex issue, requiring further research	No problem in infant feeding supply & feeding counselling
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Follow up problem from the patient. HIV+ bus fare refunded when attending for treatment.
Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;	Good referral service, Govt. take care all HIV+ pregnant women free of charge
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services;	Yes. Govt. already embarked in this direction by opening 10 new HTC centres this week
Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;	No. SRH services are provided free in all health centres which are all within walking distance. More information campaigns should be done.
Programme monitoring, recording and reporting	Poor. Lack of staff & need for capacity building
Quality assurance and impact assessment;	Continuous training, more needs to be done to track poor compliance
Inadequate efforts to ensure male engagement;	Yes, more campaigns to sensitise male involvement
Impact of gender inequality and of gender-based violence	NA
Lack of capacity to cost plans	Need more training & capacity building
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	Lack of trained staff, but this year more is done; i.e. 10 new HTC centres & more to come - to a total of 25.
Slow scale-up of early infant diagnosis of HIV	NA
Other: Please include other challenges not covered above	

APPENDIX 5: PMTCT IMPLEMENTATION NEEDS IN MAURITIUS

PMTCT implementation needs	Yes, No, N/A: & Additional comments
Need to speed up development of policies and guidelines	Revise 2004 PMTCT protocol. Revised protocol 2008 - no policy.
Need to improve M & E (PMTCT indicators, registers)	Finalizing National HIV/AIDS M&E Framework Operational Manual. Much has to be done in PMTCT M&E, and is being done. Training of service providers ongoing
Need to improve C & T (quality)	Greater emphasis on continuous training
Appropriate use of lay counsellors in the health care setting	Yes
Improve integration of PMTCT into paediatric AIDS	Yes

treatment and care activities	
Effective communication on PMTCT	Aggressive campaign to break stigma
Scale up of co-trimoxazole prophylaxis	
Improve community support/male involvement	Yes, much is needed to increase male involvement
Strengthen quality assurance for PMTCT services	Yes to improve treatment compliance
To roll out more efficacious regimen in all facilities providing PMTCT services	Increase in HIV+ pregnant women. Need to decentralize PMTCT delivery points at least to the Regional Hospitals
To roll out early infant diagnosis	Is done
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

1. Are you aware of the existence of approved PMTCT policies and guidelines?
   - No Policy but Guidelines yes.
   - And when they were published? Guidelines in 2008.

2. Was there a consultation process for developing PMTCT policy?
   - PMTCT Guidelines through consultancy (Dr.C.Gaud) & stakeholders

3. Do the standards of PMTCT policies/comply with global minimum standards?
   - Guidelines, Yes
   - Should they comply given the situation in your country? Yes
   - What is your view? *We should always target 0% infant infected*

4. Gender issues addressed (e.g. are both men and women are sufficiently informed and their voices heard)
   - Yes. Recently passed Equal opportunities Act.

5. How men are involved in PMTCT, and identify best practices. (Note*: This is a very important question which should be addressed by asking a sample of men how they think men are being involved in PMTCT. They are important stakeholders*)
   - Poor male involvement. In Mauritius all women go to ANC alone as the service is at walking distance, their husband has no objection but encourage their wives to attend all appointments & follow the advice of the health personnel .

6. What are views of people living with HIV and AIDS, those with disabilities and adolescent mothers?
   - I met mothers at National Day Care Centre for the Immunosuppressed (NDCCI), they are satisfied with the quality of service provided to them at the centre; but they would like the service to be decentralised as some have to travel a long distance. They want it to be the same as other health service provided to all centres.

7. Are policies/guidelines easily available to all stakeholders?
   - No

8. Are there gaps in PMTCT policies? Please give examples
   - No Policy

9. What quality assurance challenges affect PMTCT?
   - Poor treatment compliance.

- Private clinics not offering HIV test.
- No PMTCT available in private clinics.

10. PMTCT implementation coverage:
    - >95% of pregnant women are tested, all coming to government are tested but those going to private doctor are not offered testing

11. In your view what are the key Implementation challenges to scaling up PMTCT?
    - Nearly 5% that goes to private sector are not tested.
    - The need for PMTCT POLICY is felt thus the private Drs & clinics will abide by such a policy.

12. Is there a PMTCT implementation plan? no
13. PMTCT service delivery models. What would you recommend?
    - To give PMTCT service in all ANC health centres
14. Strategies to promote PMTCT uptake
    - Information campaign to maintain uptake
    - Advocacy for policy

POSSIBLE RECOMMENDATIONS FOR MINIMUM STANDARDS

In you view what issues should the minimum Standards for PMTCT in SADC critically consider?

- All women/ANC attendees tested for HIV
- All pregnant women HIV+ offered PMTCT (28th week of pregnancy)
- Delivery by C/S, C/S scheduled 2 weeks before EDD
- ARV therapy for babies born to HIV mothers
- Provisions of infant formula milk for all children born to HIV+ mothers – Infant feeding/Nutrition counselling for them
- Fertility management education post-delivery for HIV+ mothers – Male/Female condoms distributed free
- Testing to determine status of babies