PRACTICE POINTS

Scaling the frontier – should traditional birth attendants also be used to provide nevirapine for PMTCT in Uganda?

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Despite considerable progress in stemming the tide of the epidemic in Uganda over recent years,[1] HIV prevalence still remains high in the general population. With a current estimated HIV sero-prevalence of under 10% in many sentinel surveillance antenatal clinics in Uganda, a vertical transmission rate of 27%,[2] and a crude birth rate of 52 per 1000 in a country of 23 million; almost 30 000 of the 1.2 million babies born each year will acquire HIV from their mothers if no preventive interventions are put in place.

In January 2000, the Ugandan Government with assistance from UNICEF, UNAIDS and other partners, embarked on a programme to provide Prevention of Mother-to-Child HIV Transmission (PMTCT) and Voluntary Counselling and HIV Testing (VCT) interventions with the aim of reducing the risk of transmission of HIV from mother to the newly born and to promote awareness and responsible living with AIDS. The programme involves the administration of anti-retroviral drugs to the mother in the peri-partum period and to the baby within the first week post-partum. Nevirapine (200mg) given orally as a single dose to the mother at the onset of labour and to the baby (syrup of 2mg/Kg) within 24 hours of delivery, is one of the drugs that is used in the PMTCT programme in Uganda. In July 2000, the German pharmaceutical company Boehringer Ingelheim, which manufactures Viramune® (nevirapine), offered to provide this drug free of charge for PMTCT programmes in developing countries for five years. Uganda is one of those countries currently participating in the Viramune® Donation Programme. Despite proposed plans to rollout PMTCT to health facilities in all the 56 districts of the country by the end of 2004; there is a danger that a large proportion of the mothers who should benefit from this intervention will not be reached. In most of the high HIV burden countries in sub-Saharan Africa, more than 60% of the population resides in rural areas where access to health services is often quite poor. In Uganda, the Ministry of Health estimates that while up to 90% of pregnant women make contact with a health provider at least once during pregnancy, only 38% of them actually deliver in a health facility.[3,4] With such a low proportion of pregnant women actually using health facilities for delivery, health facility based efforts to deliver PMTCT could end up having far less impact on mother-to-child transmission of HIV than should ideally be the case.

An effort ought to be made to reach those mothers who do not utilize health facilities for delivery. Many of those mothers who deliver elsewhere (30%)[4] make use of traditional birth attendants (TBAs) within the community. In this letter, we would like to discuss the issue of whether TBAs should be incorporated in current PMTCT efforts in Uganda.

Nevirapine is a simple, cheap and easy to administer regimen for PMTCT but the lack of adequate infrastructure and medical personnel, limited access to voluntary counselling and testing (VCT) in many antenatal clinics and the lack of community sensitization and mobilization for PMTCT, has made usage of this drug quite low in many high HIV burden countries in sub-Saharan Africa.

The utilization of traditional birth attendants, in those areas where they carry out the bulk of child delivery, could be used to further expand the availability of PMTCT. TBAs have been successfully assisting mothers to deliver in sub-Saharan Africa for millennia and more importantly

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over the last decade many of them have been given training in modern midwifery skills as part of the Safe Motherhood Initiative.[5] Giving additional training to this group on how to properly administer nevirapine to HIV infected mothers and their children if given could lead to more equitable accessibility of this life saving regimen.

We propose that policy makers and health authorities in Uganda should consider this approach. Our suggestion is not far fetched; the medical literature is replete with examples of how non-medically trained personnel have successfully collaborated with the formal health sector in order to deliver treatment for wide range of diseases. One of the most successful of such cases is the current WHO-recommended use of laypersons to deliver and supervise anti-TB treatment. A wide spectrum lay workers are involved in TB programmes around the world and these range from illiterate rural women in Bangladesh,[6] to Traditional Healers in South Africa.[7]

We believe that TBAs have the potential to provide single dose nevirapine to mothers for several reasons: Community-based TB treatment delivery, since it involves the usages of up to 4 different types of drugs and takes up to 6-8 months to complete, is a lot more complicated than administering a single oral dose of nevirapine to the mother and her baby. Additionally one often finds that TBAs due to the nature of the obstetric work they have got to undertake are given a lot more training than the laypersons assist in programmes such as TB treatment delivery. Again in some countries in sub-Saharan Africa, TBAs are already being utilized to provide other drugs, such as those for malaria prevention, to pregnant women.[8]

Another important advantage of using TBAs is that they are often closer to the communities they work in than health sector personnel. They often speak the local languages, allow the practice of traditionally preferred birthing methods and often have the trust and respect of the local community.[5,9] In fact a recent study in Malawi found that TBAs were more influential than formal health workers in rural women's lives.[10] This could mean that in many rural communities, TBAs could also effectively be used to persuade pregnant mothers to go for VCT as well as mobilize community support for PMTCT.

We recognize however that important constraints to involving TBAs in the PMTCT programme do exist. Proper provision of PMTCT presupposes the widespread availability and accessibility of voluntary counselling and testing to pregnant mothers, something that is not the case especially in the areas where most of the TBAs are based. Secondly, there are concerns about the issue of confidentiality, and fears may be raised that local women may be uncomfortable about the prospect of revealing their HIV sero-status to TBAs who live within the same community.

Nonetheless, we believe that these constraints are not insurmountable. With the advent of rapid HIV tests, whereby a client can be counselled and tested and then receive the test results during a single visit to a health center, VCT services can be made more accessible. As reported earlier, almost 90% of pregnant mothers visit a health facility at least once during the course of their pregnancy; this opportunity could be used to persuade mothers to take up VCT and learn about their HIV sero-status before going on to deliver under TBAs.

Furthermore, it is possible to train TBAs to respect patient confidentiality and after more than two decades of the HIV epidemic in Uganda, such is the awareness about the disease that stigma against infected persons is highly unlikely to be a major stumbling block to PMTCT programmes.

We conclude by proposal that the relevant operational and ethnographic research be carried out to determine whether it is feasible and acceptable to involve traditional birth attendants in the PMTCT programme in the country.

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