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African Journal of Reproductive Health, ISSN: 1118-4841
Women's Health and Action Research Centre

African Journal of Reproductive Health, Vol. 7, No. 2, Aug, 2003 pp. 109-111

Letter to the Editor

Routine Screening for HIV Infection in Pregnant Women: A Highly Justified Component of Antenatal Care in Developing Countries

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I wish to comment on an article titled "Routine Screening for HIV Infection in Booked Antenatal Women: How Justified in Developing Countries?" This article appeared on pages 7-9 of the *African Journal of Reproductive Health*, Volume 5, Number 2, August 2001.

The human immunodeficiency virus and the acquired immune deficiency syndrome (HIV/AIDS) pandemic is an undisputable reality of our time. With a worldwide prevalence of 36.1 million and an estimated 5.3 million new infections in the year 2000 alone¹, the magnitude of the HIV/AIDS pandemic can be better appreciated. The fact that an estimated 71.7% of the new infections in the year 2000 occurred in sub-Saharan Africa alone suggests that the HIV/AIDS pandemic could be described as a sub-Saharan African problem.

In keeping with the increasing trend of HIV infection worldwide, the prevalence of HIV seropositivity among the antenatal population in Nigeria has increased from 4.5% in 1996 to 5.4% in 1999² and to 8.3% in 2001.³

In view of the recognised benefits of prior knowledge of a positive HIV status to the pregnant woman, her unborn baby, the health staff and the society at large, routine testing for HIV has been recommended^{4,5} and adopted in most hospitals in the developed countries. For the same reasons, it has similarly been recommended⁶ and adopted in many

hospitals in developing countries.

The view expressed by the authors - that routine HIV screening for booked antenatal patients in developing countries is unjustified⁷ - seems to shift significantly from contemporary progressive thinking. In this era when efforts should be geared towards standardising medical practice across the globe, it is unacceptable to suggest a lower standard of care for HIV positive pregnant women in developing countries. The authors gave the following reasons to support their view: (1) that most women in developing countries cannot afford the prohibitive cost of routine HIV screening; and (2) that there are inadequate structures in place to take care of the HIV positive pregnant women and their babies. They tried to buttress their position with the 39% default rate in antenatal HIV screening in their centre. However, it would appear that such a high default rate was due to inadequate counselling rather than considerations of cost or the realisation that 'nothing more could be done for them even if it was discovered that they were HIV positive', as implicated by the authors.

The importance of proper counselling of patients was demonstrated in one survey⁸ where 80% of booked antenatal patients supported routine HIV screening but only 44.4% individually accepted it. The low acceptance rate was due to fear of positive results and lack of knowledge of the availability of measures to reduce mother-to-child transmission, rather than financial considerations. This underlies the need for proper education and adequate pre-test counselling of patients. In another survey of a better counselled obstetric population⁹, 96% accepted routine HIV screening, giving the following reasons for their acceptance: prevention of vertical transmission (70%), early treatment if tested positive (50%), and protection of other patients (40%). Effective information, education and communication machinery is therefore very important in promoting the acceptance of routine HIV screening in booked antenatal patients, apart from the need for the same machinery in promoting general awareness of HIV infection and its prevention.

To say that routine antenatal HIV screening in developing countries should be jettisoned because its cost is prohibitive and unaffordable is akin to saying that the cost of antenatal HIV screening outweighs other costs of antenatal care and childbirth. Women in developing countries can go to any length to protect the interest of their babies. If appropriately counselled, most of them will, at least in the interest of their babies, afford four hundred naira (₦400) (approximately US\$3), which is the average cost of HIV screening in most centres in Nigeria today.

If infertile women and even women of proven fertility who fail to achieve pregnancy within a self-stipulated time frame can invest a huge amount of money in investigations and treatment in search of pregnancy, they can spend four hundred naira and more in the interest of their babies. In most public hospitals, initial antenatal booking deposit exceeds one thousand naira (₦1000.00) and women who choose to go to such hospitals do not

complain and nobody has succeeded in convincing such hospitals to reduce the fee. Yet hospitals can readily dispense with such booking deposits without infringing on the rights of the woman or her unborn child, as would be the case if routine HIV screening were dispensed with. The pregnant woman and her unborn baby have a right to the highest standard of care. This human right angle should always be borne in mind when recommending lower standards of care for women in developing countries, compared with their counterparts in the developed countries.

Other components of routine antenatal investigations, some of them of questionable relevance, cost more than four hundred naira and women in developing countries have been subjected to these investigations over the years. Families happily spend money in preparation for the arrival of their babies. Baby napkins, soap, powder and cream are common components of such preparation and some of them cost much more than four hundred naira. Prohibitive cost of HIV screening is, therefore, not an issue, as mothers spend much more than the cost of HIV screening on other probably less valuable aspects of antenatal and child care. Appropriate counselling will orientate the booked patient correctly.

The notion that in the developing countries the structure for taking care of HIV positive pregnant women is not in place, and the dismissal of zidovudine and other antiretrovirals as 'not available' and even if available 'not affordable' are simply overstatements. The structure for taking care of HIV positive pregnant women is very much in place in the developing countries. This structure does not entail drugs alone but also other multidisciplinary measures to (a) minimise vertical transmission; (b) ensure that the woman receives optimum care; (c) ensure adequate counselling on the implications of pregnancy and HIV infection; (d) minimise the risk of nosocomial infection and other forms of horizontal transmission; and (e) ensure early involvement of the paediatrician in affected neonates.

Standard¹⁰ and abbreviated¹¹ zidovudine regimens as well as the two-dose nevirapine regimen¹² have proven efficacy in reducing vertical transmission. Granted that these drugs are not readily available and are ordinarily expensive, the Federal Government of Nigeria recently took delivery of a large consignment of antiretroviral agents to be dispensed at little or no cost to HIV positive patients. Besides, there are individuals who can afford these drugs at any cost and from any source. Such individuals, who may not be aware of their positive HIV status, could be missed if routine antenatal screening is not adopted.

Other strategies for minimising vertical transmission such as avoidance of invasive investigations, elective caesarean section, vaginal lavage with chlorhexidine, early washing of the baby and avoidance of breastfeeding are other 'structures in place' for taking care of HIV positive pregnant women and their babies. Although caesarean section is not a favorite mode of delivery among women in developing countries, most women

accept elective caesarean section if counselled correctly. The issue of breastfeeding has remained contentious. Some authors¹³ recommend breastfeeding to HIV positive women in developing countries because of the risk of diarrhoeal diseases from bottle feeding. They argue that after all breastfeeding increases the vertical transmission rate by only 14%.¹⁴ However, other authors¹⁵ recommend avoidance of breastfeeding universally. Despite the controversy, avoidance of breastfeeding is a proven strategy for minimising vertical transmission, which should be recommended to all HIV positive women. Educating the women on higher standard of hygiene should minimise the risk of gastroenteritis from bottle feeding.

We should aim at the highest standards of care for our patients. In fact, for us in the developing countries, aiming at a global standard while bearing in mind our gross infrastructural, socio-cultural and economic impediments avoids complacency and encourages improvement.

Routine HIV screening for booked antenatal patients should be adopted universally for the benefit of the mother, her unborn child, the health community and the society at large. Proper counselling will improve acceptance rate. The low likelihood of testing positive and the availability of measures, not necessarily pharmaceutical, to minimise vertical transmission should form part of pre-test counselling. Although it could be a devastating experience for a woman to learn of her positive HIV status in pregnancy, it would be much more devastating for her to learn that something could have been done to prevent HIV infection in her baby when the latter is already down with AIDS.

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