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Commentary

Routine provision of nevirapine to women of unknown serostatus: at best a temporary solution to prevent MTCT

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Mother-to-child transmission (MTCT) is the dominant mode of acquisition of HIV infection for children worldwide. The risk of peripartum MTCT can be reduced with antiretroviral prophylaxis given to HIV-infected women in late pregnancy and during labour and delivery; prevention of MTCT depends also on avoiding infections in women of childbearing age (*1*). Current MTCT prevention programmes do not reach many of the women who need them, partly because the provision of prophylaxis is conditional on the identification of HIV infection in pregnant women after voluntary HIV counselling and testing, which may not be acceptable, feasible or of perceived benefit (*2*).

Would routine provision of nevirapine to pregnant women ensure that more MTCT is prevented than is the case using the present targeted approaches (*3*)? Would routine provision mean less support for infected and uninfected women to remain healthy? Improving support services during and after delivery, in particular with antiretroviral treatment for infected women with more advanced disease (*1*), would directly benefit the mother and is likely to increase uptake of services. Maternal HIV has a major direct impact (through her vital status) and indirect impact (through MTCT) on infant and child mortality rates (*4*). Support for a mother in the years following delivery would probably reduce the risk of her dying and thus make it less likely that her children, infected or not, die in childhood.

Could improvements to voluntary counselling and testing and MTCT intervention uptake be achieved in other ways? Involvement of the partner and family and provision of couple or family counselling (including testing of couples together) provide a more stable and supportive environment for the mother and child; such measures increase the likelihood that women identified as infected accept interventions to reduce MTCT, including appropriate infant feeding (*5*). To increase the number of pregnant women being tested, and decrease stigma attached to HIV testing, an opt-out approach — in which everyone is tested unless someone specifically asks not to be — would normalize HIV testing and reach more women than the current widely used opt-in approach (*6*). Rapid testing with results available the same day also increases the number of women whose HIV infection status is known (*7*). Provision of voluntary counselling and testing services outside the antenatal setting would have the benefit of making the services more relevant and accessible for men and women of all ages. These services should aim to identify not only infected but also uninfected people, and to provide appropriate support for both groups.

To achieve the targets set by the United Nations, universal provision of nevirapine to all pregnant women to reduce

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peripartum MTCT in settings with high neonatal and infant mortality, high HIV prevalence and limited mother and child health services (*3*) may be a way forward, but only as a temporary measure. There is considerable benefit to be derived from individual voluntary counselling and testing for all women, with appropriate and optimal support depending on the test result. Recent evidence of the substantial effectiveness of postexposure prophylaxis for the neonate alone using one week zidovudine and single-dose nevirapine highlight the continued benefit of identifying infected women even during delivery (*1*). Furthermore, a combination of short-course regimens of antiretrovirals is substantially superior to single-dose nevirapine in reducing MTCT, while single-dose nevirapine may impact on future treatment options for infected women (*1*). Therefore, universal prophylaxis programmes should not replace efforts to increase voluntary counselling and testing services and to improve support for both infected and uninfected women. ■

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