KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

2030 NDP

KWAZULU-NATAL · 2010/11 TO 2026/27

Reducing vertical transmission to children

[AWACC 2026] · 28 October 2026

Sixteen years of antenatal and infant data: what guideline change achieved, and what still stands between us and elimination

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Introduction

1. Elimination of mother-to-child transmission (EMTCT) of HIV— **vertical transmission elimination**—is one of the most significant public health achievements in global health.
2. Without intervention, transmission rates range from **15% to 45%**. However, with modern interventions, the transmission rate can be reduced to **below 2% to 1%**.
3. KwaZulu-Natal (KZN) has consistently recorded the highest antenatal HIV prevalence in South Africa, though rates have shown a gradual decline due to expanded prevention and antiretroviral therapy (ART) programs.
4. **2010:** 39.5% , **2011:** 37.4%, **2013–2019:** Maintained above 40% for a significant portion of this period, with provincial rates staying high across public sentinel sites (hovering near or above 40% depending on the specific survey cycle). **2019:** High baseline tracking (part of the national plateau where overall rates remained around 30% nationally, and KZN remained the leading province). **2022: 37.1%** (or **37.2%**
5. **Highest District:** uMkhanyakude District recorded the highest antenatal HIV prevalence in the province at **44.0%** in the 2022 survey. **Lowest District:** uMzinyathi District has historically reported lower prevalence compared to coastal and urban KZN hotspots (e.g., around 24.6%).

Global Progress and Milestones

•First Validation (2015): Cuba became the first country in the world to be officially validated by WHO for eliminating mother-to-child transmission of HIV and syphilis.

•Broadening Global Success: Since 2015, numerous countries and across different regions (including Thailand, Belarus, Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Armenia, Oman, Botswana, and several European nations) have achieved validation or path-to-elimination status.

•Key Challenges Remaining

• Despite major progress globally, barriers remain in high-burden regions:

1. **Late Antenatal Care:** Women entering prenatal care late in pregnancy miss the critical window for viral suppression.
2. **Seroconversion During Pregnancy/Breastfeeding:** High-risk women acquiring HIV late in pregnancy or during lactation often have spike viral loads, increasing transmission risks.
3. **Treatment Adherence & Retention:** Drop-outs from care during the postpartum period due to stigma, lack of support, or healthcare access issues.
4. **Pediatric Diagnosis Gaps:** Ensuring early infant diagnosis (EID) via DNA PCR testing at 4–6 weeks to initiate early infant treatment if seroconversion occurs.

The Four Pillars of PMTCT

A comprehensive approach to eliminating vertical transmission of HIV — from primary prevention through lifelong care (WHO / SA National Guidelines)

1 PILLAR 1

Primary Prevention of Infection

Prevent new HIV and other transmissible infections among women of reproductive age — through safer sex practices, male partner involvement and Pre-Exposure Prophylaxis (PrEP).

2 PILLAR 2

Preventing Unintended Pregnancies

Provide comprehensive sexual & reproductive health services — family planning and contraception — so women living with HIV can safely plan and space pregnancies.

3 PILLAR 3

Preventing Vertical Transmission

Stop transmission from mother to infant during pregnancy, labour, delivery and breastfeeding — anchored in early testing, immediate lifelong ART and infant prophylaxis.

4 PILLAR 4

Treatment, Care & Support

Sustain continuous care for mother, infant and family — lifelong ART, nutritional support, infant follow-up testing, and addressing stigma and psychosocial needs.

PREVENT (Pillars 1–2) → **PROTECT** (Pillar 3) → **SUSTAIN** (Pillar 4) — all four are required to eliminate vertical transmission

Sources: WHO PMTCT framework; South African National Guidelines for Vertical Transmission Prevention (VTP); SA HIV Clinicians Society.

Key Clinical Protocols (Prong 3)

1. **Universal Antiretroviral Therapy (ART):** Every pregnant or breastfeeding woman diagnosed with HIV is started immediately on lifelong ART (Option B+ strategy), regardless of CD4 count, to suppress viral load.
2. **Safe Delivery Practices:** Suppressing viral load (< 50 copies/mL) allows for safe vaginal delivery.
3. **Infant Post-Exposure Prophylaxis (PEP):** Newborns receive infant antiretroviral prophylaxis (e.g., Nevirapine or Zidovudine) for 6 weeks or longer depending on transmission risk.
4. **Infant Feeding Guidance:** In low- and middle-income settings where unsafe water poses higher risks (diarrhea, malnutrition), exclusive breastfeeding accompanied by maternal ART and infant PEP is recommended

•WHO Criteria for EMTCT Validation

Impact Targets

Impact Target 1: Transmission rate reduced to < 2% in non-breastfeeding populations OR < 5% in breastfeeding populations.

Impact Target 2: New pediatric HIV infections due to vertical transmission rate reduced to < 50 cases per 100,000 live births.

Process / Coverage Targets (Maintained for at least 2 years)

•ANC Coverage: At least 95% of pregnant women attend at least one antenatal care visit.

•Testing Coverage: At least 95% of pregnant women know their HIV status.

•ART Coverage: At least 95% of HIV-positive pregnant women receive antiretroviral therapy.

THE POLICY STORY

Each guideline change moved a part of the cascade

2010

Dual therapy

AZT from 14 weeks; lifelong ART only if CD4 ≤350

2013

FDC for all pregnant women

Triple ART regardless of CD4 (Option B)

2015

Option B+ and birth PCR

Lifelong ART; PCR at birth for every HIV-exposed infant

2016

Universal test and treat

Same-day ART; routine ANC re-testing

2019–21

TLD, VL <50, PrEP

Dolutegravir; 6-month PCR; PrEP for pregnant women

2023

VTP guideline

HIV, syphilis and hepatitis B managed together

South African National Department of Health PMTCT / VTP guidelines, 2010–2023

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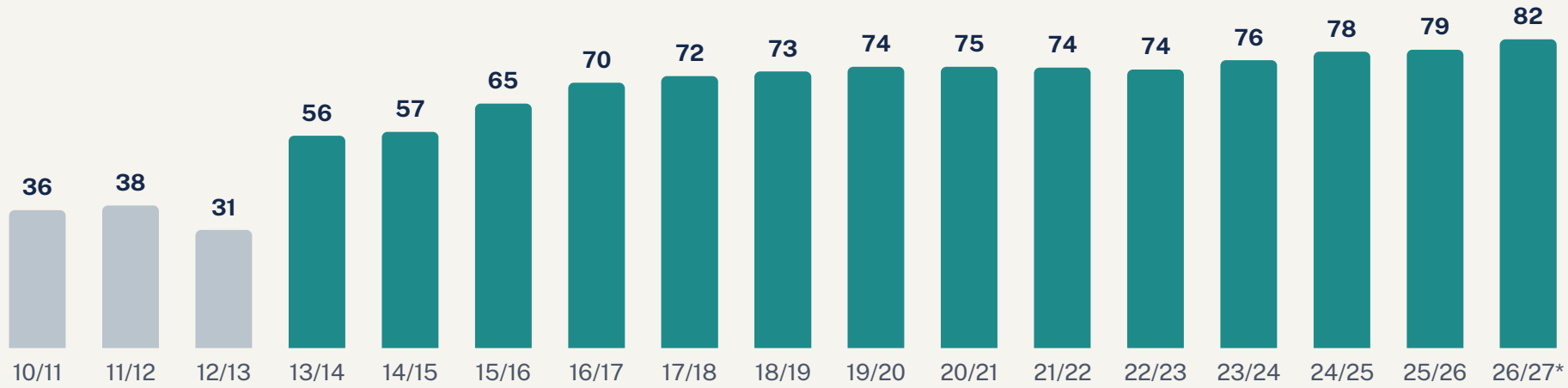
1 · EARLY BOOKING

ANC booking before 20 weeks has more than doubled

The step-change in 2013/14 coincides with ART for all pregnant women (grey: before; teal: after). Still, 1 in 5 women books late.

36% → 82%

booked before 20 weeks, 2010/11 vs 2026/27 to date



Antenatal 1st visit before 20 weeks rate (%). Source: DHIS2, KwaZulu-Natal, financial years Apr–Mar. *2026/27 partial year to date.

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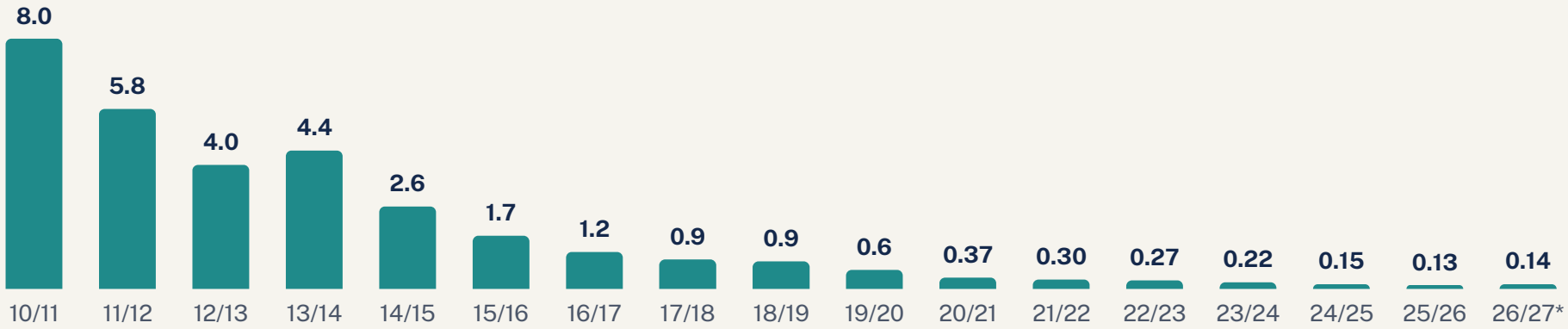
2 · SEROCONVERSION IN PREGNANCY

Far fewer women now acquire HIV during pregnancy

HIV re-test positive as a share of ANC re-tests. Re-tests grew ninefold, from 51,000 to 452,000 a year, while positives fell from 4,053 to 597.

8.0% → 0.13%

re-test positivity, 2010/11 vs 2025/26



Antenatal HIV re-test positive ÷ antenatal client HIV re-test (%). Source: DHIS2, KwaZulu-Natal. *2026/27 partial year to date.

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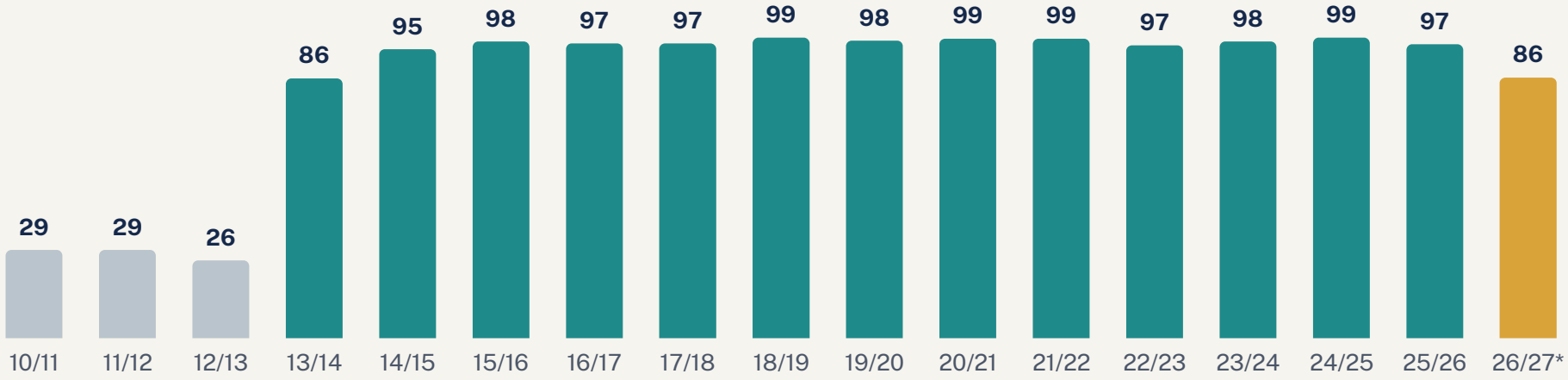
3 · ART INITIATION IN ANC

ART for all lifted initiation above 95%

26% → 86%

in one year, 2012/13 to 2013/14

Grey: CD4-based eligibility; teal: ART for all from 2013. Gold: 2026/27 to date has slipped to 86%, the first drop below 95% in a decade.



Antenatal client start on ART rate (%). Source: DHIS2, KwaZulu-Natal. *2026/27 partial year to date.

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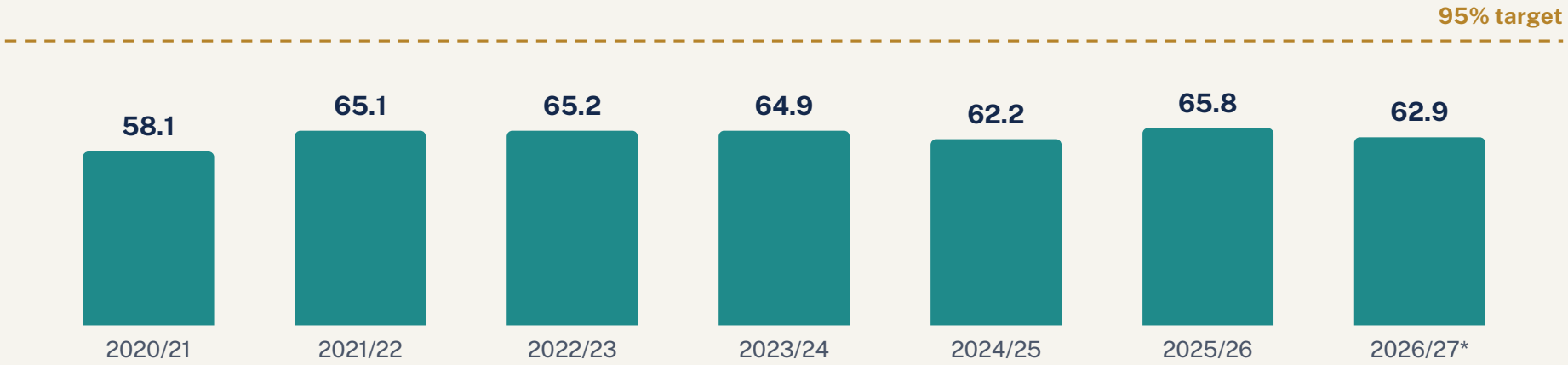
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4 · VIRAL SUPPRESSION · THE MAIN GAP

Only two in three women on ART are suppressed

~30 pts
short of a 95% suppression target

Suppression has been flat at 62–66% since the <50 c/ml measure was introduced. This is where most remaining transmission risk sits.



ANC on ART with VL suppressed (<50 c/ml) at specific interval rate (%). Source: DHIS2, KwaZulu-Natal.
*2026/27 partial year to date.

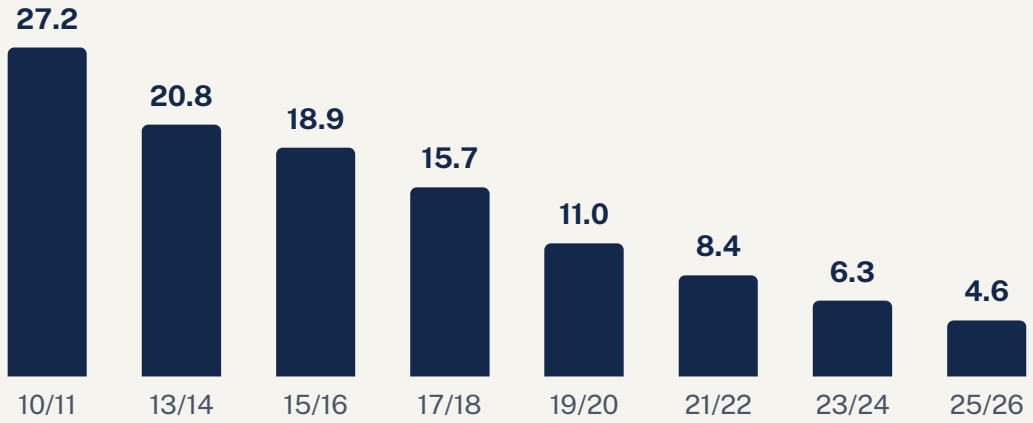
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5 · MOTHERS AND BABIES

As ANC positivity fell, infant infections fell with it

HIV positivity at first ANC test (%)



PCR positive at birth
0.68% → 0.36%
2015/16 to 2025/26

Infants PCR positive at 10 weeks
449 → 114 babies
2016/17 to 2025/26 · a 75% fall

PCR positive around 6 months
0.85% → 0.37%
2020/21 to 2025/26

ANC HIV 1st test positive ÷ ANC HIV 1st test; infant PCR rates as reported. Source: DHIS2, KwaZulu-Natal.

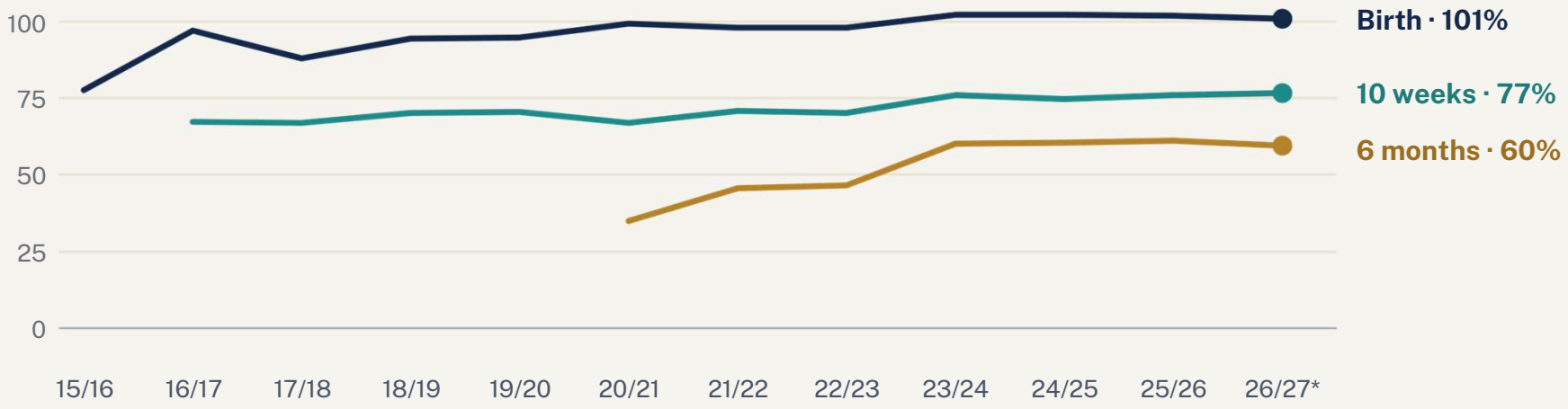
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5B · INFANT TESTING COVERAGE

Birth PCR is universal; follow-up testing drops off

Uptake (%) of infant PCR at birth, around 10 weeks and around 6 months, 2015/16 to 2026/27



Infant PCR uptake rates as reported in DHIS2, KwaZulu-Natal; birth uptake above 100% reflects denominator differences. *2026/27 partial year.

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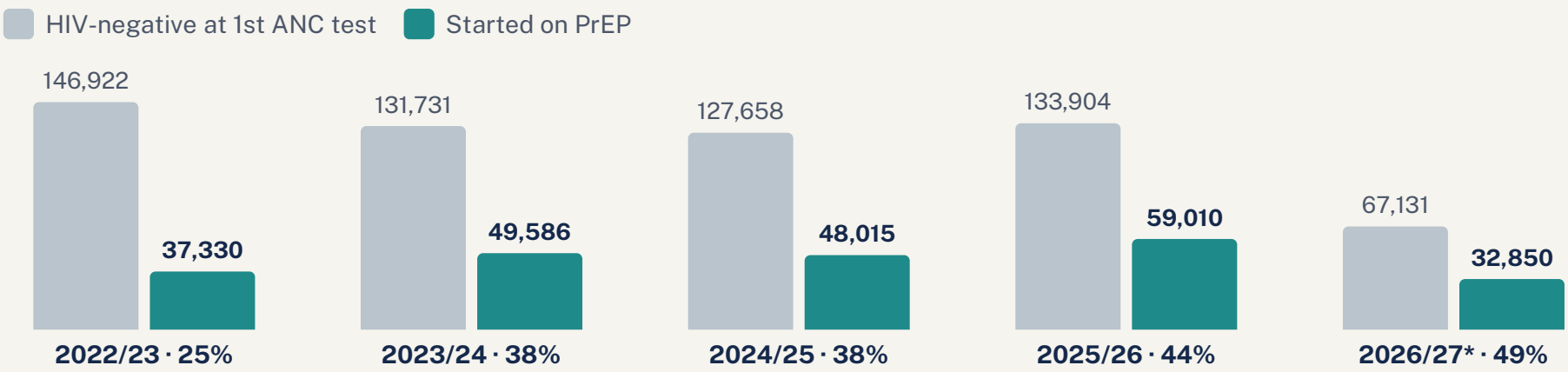
6 · PREVENTION FOR HIV-NEGATIVE WOMEN

PrEP reach in ANC has nearly doubled

PrEP starts as a share of women HIV-negative at first ANC test. More than half still leave ANC without PrEP.

25% → 49%

PrEP starts per HIV-negative woman, 2022/23 vs 2026/27 to date



Antenatal client started on PrEP ÷ antenatal client HIV 1st test negative. Source: DHIS2, KwaZulu-Natal.
*2026/27 partial year to date.

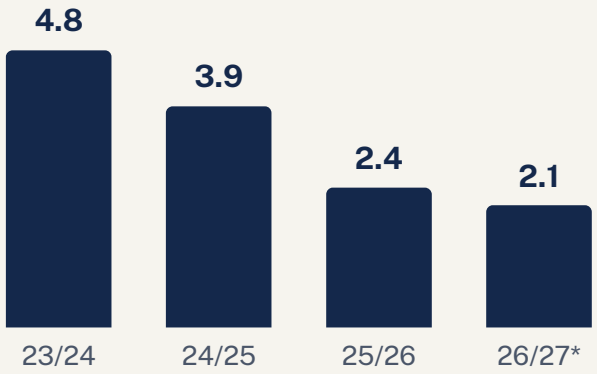
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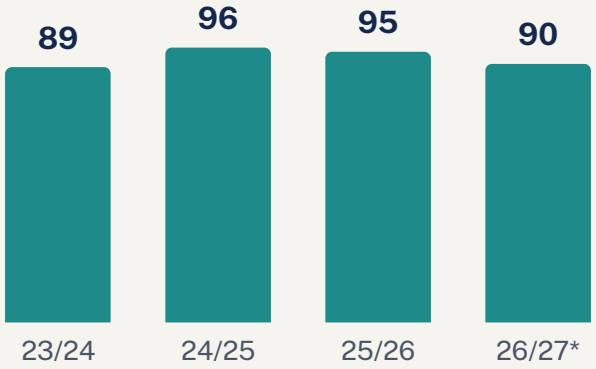
7 · SYPHILIS

Syphilis positivity is falling; full treatment lags

ANC syphilis positivity (%)



Positive women given BPG 1st dose (%)



Treatment completed

78%

of positive women, 2025/26 and 2026/27 to date. About 1 in 5 does not finish all three BPG doses.

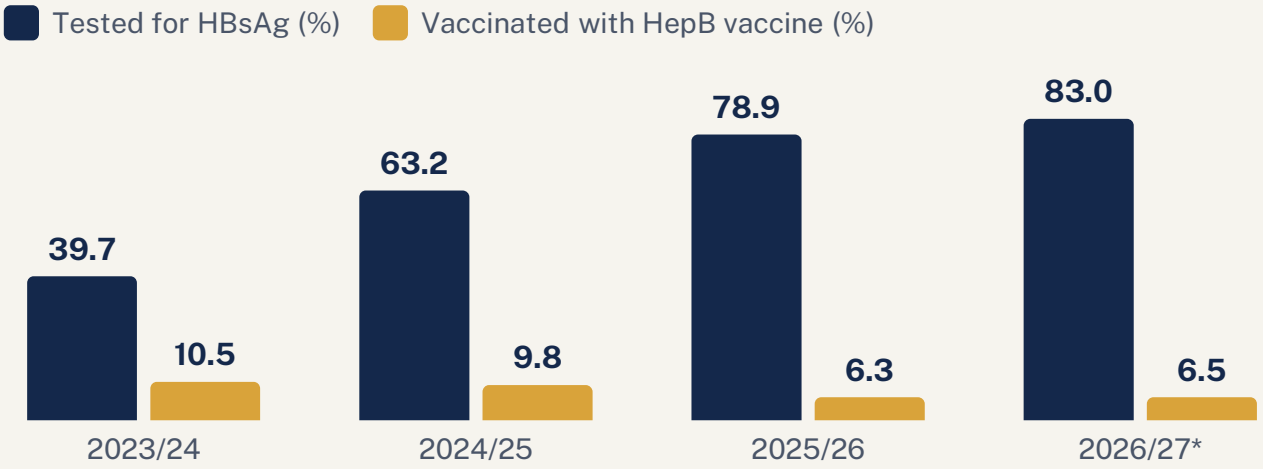
Positivity: DHIS2 reported rate. BPG 1st dose ÷ (1st test positive + re-test positive). Source: DHIS2, KwaZulu-Natal. *2026/27 partial year.

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8 · HEPATITIS B

HBsAg screening has doubled; vaccination has not followed



Tested for HBsAg

143,481

women in 2025/26, up from 74,827

HBsAg positivity

[Add from DHIS2: not in this data extract]

Antenatal client tested for HBsAg rate; antenatal clients vaccinated with HepB vaccine rate. Source: DHIS2, KwaZulu-Natal. *2026/27 partial year.

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Scorecard: gains made, gaps remaining

Indicator	Then	2025/26	Verdict
Booking before 20 weeks	36%	79%	Gain · 1 in 5 still books late
Seroconversion in pregnancy	8.0%	0.13%	Gain · 597 women still seroconverted
ANC start on ART	29%	97%	Gain · watch 86% in 2026/27
VL suppressed <50 c/ml	58%	66%	Gap · flat since 2021/22
HIV positivity, 1st ANC test	27.2%	4.6%	Gain
PCR positive at birth	0.68%	0.36%	Gain · now plateauing
6-month PCR uptake	35%	61%	Gap · 4 in 10 infants missed
PrEP reach, HIV-negative women	25%	44%	Improving · half still missed
Syphilis treatment completed	n/a	78%	Gap · 1 in 5 incomplete
HepB vaccination in ANC	10.5%	6.3%	Gap · falling

"Then" = first year each indicator is available. Source: DHIS2, KwaZulu-Natal.

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GLOBAL ALLIANCE TO END AIDS IN CHILDREN BY 2030

One global goal, four pillars

Launched in 2022 by UNAIDS, UNICEF, WHO and 12 high-burden countries, South Africa among them. National launch in KwaZulu-Natal in 2023; provincial chapters since, including Eastern Cape (December 2024).

1
Test and treat children and adolescents; reach viral suppression

2
Close the treatment gap for pregnant and breastfeeding women

3
Prevent new infections in pregnant and breastfeeding women

4
Address rights, gender equality and structural barriers

Pillars 2 and 3 are where today's provincial data shows the most work remains: viral suppression, and new infections in HIV-negative women.

Global Alliance to End AIDS in Children (UNAIDS, UNICEF, WHO); UNICEF South Africa, December 2024.

Celumusa Rose Ndimande, RN RM, MCur, IHI Improvement Advisor

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GLOBAL ALLIANCE QI ACHIEVEMENTS · NOV 2024 TO AUG 2026

50+ facilities across four KZN districts

Expanding to the Eastern Cape and Gauteng. An initiative to close gaps in HIV prevention, diagnosis and treatment for children and adolescents.

76% → ≈92%

Zululand viral suppression

18 facilities across 6 sub-districts
≈92% reconfirmed in July 2026

76% → ≈85%

iLembe viral suppression

15 facilities across 5 sub-districts
Sundumbili CHC reached 100%

3 children

Found and started on ART

Previously undiagnosed, Ezakheni No 2 Clinic
ART started on the day of diagnosis

How: weekly tracking of each child, named clinician accountability, adherence and caregiver support

Relevance to vertical transmission: connect maternal HIV prevention and care with timely child diagnosis and sustained treatment.

Source: GA Close-Out Report, August 2026, pp. 4–5. Programme outcomes shown here do not measure vertical transmission rates.

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THE LAST MILE

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Guidelines got women onto treatment. Quality and continuity will finish the job.

01

Suppress before delivery

VL <50 for every woman, with fast action on high results

02

Keep negative women negative

PrEP for every eligible woman, re-testing through breastfeeding

03

Finish the infant cascade

Trace mother–baby pairs to the 10-week and 6-month PCR

04

Complete the triple agenda

All three BPG doses; act on every HBsAg result

Ngiyabonga · Thank you