MESSAGE
From the Editor

This edition of the *Southern African Journal of HIV Medicine* is coming out slightly earlier than scheduled, timed to coincide with the first Southern African HIV Clinicians Society Conference in Cape Town. The conference features an exciting line-up of leading local researchers, as well as international experts. During 2013, the Journal will carry some of the reports and papers from the meeting; therefore, if you can't attend the conference, you will still be able to keep up to date on the latest trends and developments in HIV medicine and clinical care.

In this issue we feature a number of pieces related to the management of HIV-infected pregnant women. Some researchers, clinicians and policy makers see the prevention of mother-to-child transmission (PMTCT) of HIV as rather straightforward, and I've sat in on more than a few meetings where PMTCT is described by colleagues (both South African and international) as important yet 'boring'. Quite to the contrary, PMTCT interventions and policies are currently a hotbed of debate at the intersection of science, service delivery and policy-making. Along with other pieces in the Journal over the last few months, several of the contributions in this edition help to demonstrate why this is so. Firstly, Martin and Black[1] discuss the role of isoniazid preventive therapy (IPT) for tuberculosis in HIV-infected pregnant women. They suggest that given the relative health of HIV-infected pregnant women, even with low CD4 cell counts, routine use of IPT during pregnancy may not be the best use of resources to promote the health of HIV-infected mothers and their children. In addition, the choice of antiretrovirals (ARVs) during pregnancy can be controversial, with particular local concern surrounding ARV-related toxicities in pregnancy. Usually these concerns focus on fetal development and potential teratogenicity, but the choice of non-nucleoside reverse transcriptase inhibitors (NNRTIs) also has implications for maternal health. In this issue, Bera *et al*.[2] report two cases of apparent nevirapine (NVP) toxicities in pregnant women initiating ART. While case reports are rarely suitable evidence for making clinical or policy decisions, the authors point out that the evidence against the use of efavirenz in pregnancy comes mostly from case reports of teratogenicity – so perhaps these cases of NVP toxicity help to balance the scales somewhat.

Arguably the most contentious issue in PMTCT today regards the choice of prophylactic regimens for women with higher CD4 cell counts (e.g. >350 cells/mm^3). There is little debate that pregnant women with advanced HIV disease require rapid initiation of lifelong antiretroviral treatment (ART). However, the best ARV intervention for women with higher CD4 cell counts is unclear. Currently, South Africa and many other countries implement zidovudine prophylaxis during pregnancy for women with high CD4 cell counts (referred to as PMTCT 'Option A' in the World Health Organization (WHO) 2009 guidelines), while in Europe, Brazil and North America, triple-drug prophylaxis during pregnancy (WHO 'Option B') is commonplace. To date, these prophylactic strategies appear roughly equivalent in their effectiveness for PMTCT, and a randomised controlled trial comparing them is underway, with several sites in South Africa.

Recently there has been a call for universal initiation of lifelong ART for *all* HIV-infected pregnant women, regardless of CD4 cell count or WHO stage. This approach (sometimes referred to as WHO 'Optional B+') is the focus of a commentary in this issue by Besada and colleagues[3] from Médecins Sans Frontières (MSF). The WHO 'Optional B+' approach is being promoted heavily by WHO, the United States President's Emergency Plan for AIDS Relief (PEPFAR), and a range of international agencies, and – as presented here – there are strong hypothetical arguments for the idea of universal ART for pregnant women. On the other hand, there are also significant concerns raised by any strategy that calls for universal ART for all HIV-infected individuals. Yet, throughout these discussions about 'Optional B+', there is a striking absence of substantive evidence, and the knowledge base that could help inform a policy decision to implement universal initiation of lifelong ART for all HIV-infected pregnant women is astonishingly thin. In particular, there is as yet no meaningful evaluation of a programme that attempts to provide lifelong ART to all HIV-infected pregnant women. Without such evidence, national policy decisions regarding patient management can be leveraged by individual opinions, institutional agendas and donor priorities. In this context, we eagerly anticipate a decision by the National Department of Health on the future strategies for PMTCT in South Africa. Hopefully, along with the other PMTCT-related contributions in this issue, this debate helps to demonstrate that this is a topic that is anything but boring.

Happy reading.

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1. Martin CE, Black V. Tuberculosis prevention in HIV-infected pregnant women in South Africa. Southern African Journal of HIV Medicine 2012;13(4):182-184. [http://dx.doi.org/10.7196/SAJHIVMED.789]
2. Bera E, Naidoo D, Williams M. Maternal deaths following nevirapine-based antiretroviral therapy. Southern African Journal of HIV Medicine 2012;13(4):196-197. [http://dx.doi.org/10.7196/SAJHIVMED.869]
3. Besada D, Van Cutsem G, Goemaere E, Ford N, Bygrave H, Lynch S. The case for Option B and Optional B+: Ensuring that South Africa's commitment to eliminating mother-to-child transmission of HIV becomes a reality. Southern African Journal of HIV Medicine 2012;13(4):178-181. [http://dx.doi.org/10.7196/SAJHIVMED.864]