cation programs are long and deter individuals who are ready to deal with their addiction from doing so. Obstacles to individuals' access to detoxification and rehabilitation must be removed

Finally, we must seriously re-examine our social policy, especially in the context of the Aboriginal population. Current policies create the conditions for social degeneration and disorganization that lead to multiple psychological and social problems, including injection drug use. We must fully involve addicted individuals in efforts to identify new and potentially effective means to address the problem of addiction, as well as to increase the proportion of injections that are free from the risk of HIV and other serious blood-borne infections.

Unfortunately, it is difficult to be hopeful in this regard. Similar observations were made in a study from the same group almost exactly 5 years ago,[5] following the first wave of high HIV incidence among IDUs in Vancouver. One has to wonder what it will take for policy-makers to deal seriously with this problem.

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Aiming for zero: preventing mother-to-child transmission of HIV

Kathleen Steel O'Connor, Susan E. MacDonald

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This issue (page 904) contains a report by Ari Bitnun and colleagues about 6 HIV-infected infants born to women who were unaware of their seropositive status.[1] None of these women were tested for HIV during pregnancy and, in spite of recommendations in Ontario that all pregnant women be offered HIV testing during pregnancy, 3 of these women recalled no offer of testing.

In working toward the elimination of mother-to-child transmission of HIV, 5 activities are critical in the prenatal and perinatal period.[2] Pregnant women must present for prenatal care and must be offered and accept HIV testing. Women found to be HIV-positive must accept and be able to complete a regimen of chemoprophylaxis.

Presentation for prenatal care

Almost all pregnant women in Canada present for prenatal care.[3] There are few published studies of the frequency and timing of prenatal care in Canada, but one such study in British Columbia reported that most women present before the second trimester, which is the optimal time for the initiation of treatment of women found to be infected with HIV.[4] There are, however, subgroups of women who may not receive adequate care.[3,4] Some groups, particularly immigrant and refugee women who may not receive adequate care if they lack medical coverage, may also be at increased risk for HIV infection. For women who receive no antenatal care, an enzyme-linked immunosorbent assay test should be done as early as possible in labour, with informed consent. Although chemoprophylaxis given solely in labour has been found to reduce the risk of transmission,[5] these interventions are not as effective as regimens begun earlier in pregnancy.

Offer and acceptance of HIV testing

Because many HIV-infected women have no identified risk factors other than heterosexual intercourse,[6] and are unaware of their seropositive status, universal screening is the only means by which all infected women may be identified. The existence of a universal policy increases the likelihood that a physician will offer the test.[7] There is evidence that, if it is offered, most women accept screening for HIV during their pregnancy.[8] A universal offer therefore increases the

likelihood that a pregnant woman will be screened.[9] In 1996/97, only 54.5% of Canadian physicians reported that they offered HIV screening to all of their prenatal patients, whereas 31.5% offered it only to those they perceived to be at high risk.[10] This is clearly not good enough.

How can screen rates be raised? Evidence is accumulating that an "opt-out" policy toward prenatal HIV testing achieves the highest rates of screening. An "opt-out" policy treats HIV screening as a routine prenatal screening test; a pregnant woman is informed that testing will be done, but consent is implied unless she specifically refuses. An "opt-out" policy reduces the stigma of screening and has been shown to increase uptake. In Alberta, in the first year of the "opt-out" strategy (1998/99), only 4% of women declined testing, and in the second year this percentage was even lower at 2.4%.[9] Until January 2002, physicians in Ontario were required not only to provide pretest counselling and obtain consent but also to indicate on the test requisition that these had been done; in Ontario, HIV testing was performed for only 51% of pregnancies in 1999/2000.[9] One woman, in the series of cases reported by Bitnun and colleagues,[1] said that she had been offered and had accepted HIV testing, but the test had not been done. It is possible that the "tick boxes" that confirmed counselling and consent were missed on the requisition.

There is some resistance to performing HIV testing without expressed consent, even though it is an approach that we take with other prenatal tests, including syphilis and hepatitis B. This resistance is perhaps a reminder that we should be educating women about all the tests we do. Before taking the sample, there should be full disclosure that the HIV test will be part of the antenatal assessment; this gives women an opportunity to decline if they wish, but this also provides an opportunity to lay the groundwork for subsequent counselling if it is necessary. It is interesting that 3 women in the series report by Bitnun and colleagues assumed that testing had been done, suggesting that they would have accepted routine testing.

Acceptance and completion of chemoprophylaxis

The final steps in the prevention of mother-to-infant transmission are the acceptance of chemoprophylaxis and full compliance with treatment. The most significant barriers to acceptance are womens' concerns about side effects to themselves or their infants, and cost. Experience has shown that most pregnant women who know that they are HIV-positive accept therapy.[11] In Canada, the issue of the cost of the antiretroviral therapy would very rarely be a barrier, because means exist in every province to cover the cost of these medications.

Even if all of these steps are taken and an HIV-positive pregnant woman completes treatment, there will still be a risk of maternal–fetal transmission. This can be as low as 1%, depending on the maternal viral load.[12]

The proportion of pregnant women who do not present for prenatal care, who refuse testing when it is recommended, who refuse or cannot access treatment when indicated, or whose treatment fails is small. The weakest link, currently, is the offer of screening. The "opt-out" strategy ensures the highest level of testing, is used for other prenatal tests and appears to be acceptable to women.

Let us all work to ensure that the only infants in Canada found to be HIV-positive fall into the very small group for whom prophylaxis failed. "Opt-out" testing would ensure that it would never again be because their mothers were not offered the opportunity for screening and, therefore, did not receive treatment because they did not know about their seropositive status.

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