

Fiji Policy on Prevention of Parent to Child Transmission (PPTCT) of HIV



Ministry Of Health- Republic of Fiji



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DEFINITIONS

Counselling: Counselling is interaction between a counselor (helper) and another person or persons whom the counselor offers the time, attention, and respect to explore, discover, and clarify ways of dealing with a problem. In the context of HIV and AIDS, a confidential dialogue between a client (or patient) and a counselor (health care worker) aimed at enabling the client to cope with stress and make personal decisions related to HIV

CD4: The number of CD4 T-lymphocyte cells usually expressed as the number of cells per cubic millimeter. The CD4 count reflects the "health" of the immune system. A normal count in a healthy adult is variable and can range from 500-1400 cells/mm³ Discordant partners: Where one patient can be HIV positive and his/her partner is HIV negative.

Opt Out: Choosing not to participate in HIV testing

Provider Initiated Counseling and Testing: Client received information about HIV testing either in a group or on an individual basis, the client is also given an opportunity to ask questions and the healthcare provider ensures that the client understands HIV testing in the context of PPTCT. Unless the client declines, the client is asked to sign consent form and HIV test is performed.

Prophylaxis: A measure taken for the prevention of a disease or condition.

Pre-Test Counseling: Is counseling done to an individual on HIV before the client receives a blood test.

Post- Test Counseling: Is counseling the client receives after the blood test is done and the patient is receiving a counseling when receiving results for HIV. Post Test Counseling is done regardless of HIV Status.

Pre-test group information session: Is information session on HIV and other STIs provided as part of ANC information sessions (Health talks) to a group of ANC attendees before HIV testing

Rapid Testing Kits: Rapid Testing Kits are kits used for HIV testing where results can be obtained in less than 30 minutes.

TB/HIV co-infection: Is a state of the patient being both TB and HIV positive at the same time. Where in that instance the treatment care of the patient becomes a multidisciplinary with TB and HIV team, though the TB

treatment is started prior to HIV Anti-Retroviral Therapy.

People Living with HIV and AIDS: Are the patients who are living with HIV and AIDS regardless of their immunological or clinical stage of the illness.

Stigma: Unfavorable attitudes and beliefs directed toward someone or something
Discrimination: Includes harassment and occurs when a distinction is made against a person which results in that person being treated by another person or body unfairly, inconsistently with normal practice in any given circumstance

Treatment Buddy: Is a person who supports the HIV positive patient in terms of the patient's HIV treatment and care to encourage compliance to the Anti-Retroviral therapy.

ACRONYMS

3TC	Lamivudine
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ARM	Artificial Rupture of Membrane
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drug)
AZT	Zidovudine (also known as ZDV)
BCG	Bacille Calmette-Guerin
CTX	Co-trimazole
DBS	Dried Blood Spot
EFV	Efavirenz
EP	Empower Pacific
EPI	Expanded Immunization Programme
HIV	Human Immunodeficiency Syndrome
NNRTI	Non-Nucleoside Reverse Transcriptase
NRL	National Reference Laboratory
NRTI	Nucleoside Reverse Transcriptase
NVP	Niverapine
PCSS	Pacific Counseling and Social Services
PITC	Provider Initiated Testing and Counseling
PLWHA	People Living with HIV and AIDS
PPTCT	Prevention of Parent to Child Transmission of HIV and AIDS
STI	Sexually Transmitted Infections
TB	Tuberculosis
TDF	Tenofovir
UNICEF	United Nations Children's Funds
WHO	World Health Organization

2. VISION STATEMENT:

All Fijian Children are born free of HIV in Fiji.

3. MISSION STATEMENT:

To provide the best service to the people of Fiji through a committed workforce with benevolent partners working together to stop HIV in its track and reduce/stop transmission so that the people now and in the future are protected & free from HIV.

4. VALUES:

The Ministry of Health strives to uphold customer focus, respect for human dignity, quality, equity, integrity, responsiveness and faithfulness as paramount values for the achievement of its mission and vision.

5. PREAMBLE

This policy aims to promote and ensure that universal access to services for Prevention of Parent to Child Transmission of HIV is provided to all parents, women and child in need for it. It promotes to ensure that adequate, affordable, accessible services are made available to all families in need of the PPTCT services to ensure that all babies born to HIV positive mothers are negative and remain negative for life.

6. BACKGROUND/INTRODUCTION (WITH EVIDENCE)

The HIV epidemic in Fiji cannot be readily classified into any of the three main categories used globally to describe HIV epidemics, that is, generalised, concentrated or mixed. Fiji's HIV epidemic is not 'generalised' because the prevalence has not reached 1% in pregnant women, which is seen as a proxy for the general population. The infection rate in the general adult population (15 to 49 year olds) is estimated to be approximately 0.12%. It is not a 'concentrated' epidemic because the HIV prevalence is not greater than 5% in any key population.

At the end of 2012, a cumulative total of 482 HIV infections had been detected in Fiji since 1989, of which 414 (85%) were reported to be heterosexually transmitted, 13 (approximately 2.5%) were transmitted through male-to-male sex, 1 ((0.2%) through injecting drug use and 24 (5%) through perinatal transmission.

An operational plan to eliminate new HIV infections in children was developed in 2012. All pregnant women are offered an HIV test, with pre and post-test counselling at their first antenatal visit with a right to opt-out. To date over 98% of pregnant women counselled opt to take the HIV test. HIV testing and counselling services have been decentralized to sub-divisional level clinics using three rapid HIV test algorithm. Since May 2012, all HIV+ pregnant women are offered Antiretroviral Therapy for life (Option B+). Infants of HIV+ mothers are given Antiretroviral prophylaxis as per WHO guidelines and blood taken for Early Infant Diagnosis (EID).

About 10% of pregnant women do not attend ANC before they deliver (unbooked mothers), so there is no opportunity to counsel and test them for HIV. HIV testing and counselling services are not available in remote and rural clinics. Lack of PCR testing capability at Central Laboratory to enable EID in the country leads to delays in diagnosing infants. Few men attend ANC clinics with female partners, so there is no opportunity for couple counselling about safer sexual behaviours during pregnancy and breastfeeding.

In 2012, Spectrum estimate of the number of HIV+ pregnant women was 22, however the number of HIV+ pregnant women detected through ANC testing was 15. Using the Spectrum estimate, 68% of HIV+ pregnant women received ART in 2012. Equivalent numbers for 2011 and 2010 were 70% and 67% respectively. Therefore over the last three years the proportion of pregnant women receiving ARV prophylaxis or therapy has remained steady at about 70%. The ultimate measure of the success of a PPTCT program is number of new paediatric HIV infections a year.

The collaboration between the Ministry of Health (supported by UNICEF Pacific), and EMPOWER Pacific (formerly known as Pacific Counselling and Social Services (PCSS)), an NGO specializing in counselling and social support, to provide this service at ANCs ensures that the HIV test is accompanied by pre- and post-test counselling and informed consent. Approximately 90% of pregnant women attend antenatal care at least once in their pregnancy. All are offered HIV screening as part of Antenatal Care and, in 2012, ANC HIV screening reached over 80% of pregnant women.

Since 2010, over 80% of pregnant women have been screened for HIV infection. In May 2012, with technical support from UNICEF, Fiji opted to provide Option B+, lifelong ART, to all HIV+ pregnant women to protect the mother's health and prevent infection to the infant. Early Infant Diagnosis of children born to HIV+ mothers is available, with testing provided by the National Reference Laboratory (NRL) in Melbourne, Australia.

7. RATIONALE:

Prevention of mother to child transmission of HIV has contributed to the reduction in the number of vertical transmission in Fiji. There has been an increasing focus on prevention of parent to child transmission (PPTCT) with the provision of HIV testing to pregnant women attending antenatal clinics (ANCs). Globally and nationally we have seen PPTCT services reduce HIV infections in children.

The need for Prevention of Transmission of HIV from Parents to Child is paramount for the Ministry to achieve its targets of Zero New HIV Infections which prevents transmission of HIV from Parent to Child, and secondly to reduce maternal deaths secondary to any AIDS related illness, which contributes to Millennium Development Goal 5 and Zero AIDS related deaths Goals by UN.

PPTCT in Fiji has come a long way since the beginning more than 10 years ago. The health facility services have changed significantly. There wasn't treatment before for mothers who were HIV positive but since the program of PPTCT came into the picture HIV positive families are able to have children who are negative for HIV. We have seen many success stories in the country.

Quote: "In 2009, five women in Fiji and 263 women in Papua New Guinea received treatment to prevent parent to child transmission. Of the 25 women interviewed, 4 had taken ART to prevent transmission of HIV to their child either in utero or during delivery. Three of these women had HIV negative babies while one woman's baby had not yet been tested." Unquote.

Having PPTCT in Fiji brings hope to women and families, some women during a research said, "I have no children, but I want to have children. I feel very alone at home, it is just me and my husband...In the future I would like to try and have children, but I have not discussed any of this with my doctor. But Sometime I think of having a baby, but that (HIV) Stops me from wanting a baby cause I feel sorry for the baby because it might get HIV too. (35 year old Fijian Women).

In 2012, there were 5 paediatric HIV cases. This was the highest annual number of infected children recorded, and followed two years (2010 and 2011) when no HIV infections in infants were recorded. The number of infections was unexpected because the PPTCT program is operational in all parts of the country, although both the proportion of pregnant women screened for HIV (80%) and the proportion of HIV+ pregnant women receiving ART (67%) were not as high as would be preferred. The paediatricians and PPTCT specialist analysed the cases to understand what went wrong.

8. GOAL:

To prevent the transmission of HIV from a HIV positive parent to their child during pregnancy, labour, delivery or infant feeding and to ensure that the HIV negative patient remains negative.

9. OBJECTIVES:

The below objectives were developed based on the 4 prongs (elements) of PPTCT services:

- 9.3** To ensure that HIV positive women and men have access to quality reproductive health advice and family planning services, including access to modern contraceptives, to prevent unintended pregnancies.
- 9.4** To ensure that women and her partner have access to quality testing for HIV infection and other STIs, supported by appropriate voluntary or provider initiated and confidential counselling support services
- 9.5** To ensure that all HIV positive pregnant women and infants have access to antiretroviral prophylaxis and therapy.

10. GUIDING PRINCIPLES:

- 10.1** This Policy re-affirms the ethics of respecting the rights of individuals to confidentiality of medical information. The results of HIV testing should only be shared with the person being tested, and it is that person's decision whether to share the result with others, e.g. partner and family.
Section 26, Sub-section 1 & 3 of the HIV Decree 2011, page 10.
- 10.2** In addition to that, the policy is directed the following guiding principles:
 - Supportive leadership
 - Ensure equity and equality
 - Effective communication
 - Evidence informed
 - Capacity building
 - Effective partnerships

11. POLICY STATEMENTS :

11.1 DIAGNOSIS OF HIV INFECTION

- 11.1.1** Provider Initiated Testing and Counselling (PITC) for HIV should be available at all major health facilities in the divisions and subdivisions offering antenatal care (ANC), utilizing group pre-test information session and individual post-test counselling.
- 11.1.2** Health Centers that conduct ANC must provide PITC or else refer ante natal mothers to their sub-divisional or divisional hospitals for HIV test and counselling and other routine blood tests.
- 11.1.3** All pregnant women should be provided HIV testing during the first ANC visit with the right to opt out. Written informed consent for HIV testing should be obtained prior to testing from all pregnant women.
- 11.1.4** Pre- and post-test counselling by a MOH certified counsellor should always be done with HIV testing.
- 11.1.5** Rapid testing kits for HIV and other STIs (e.g. syphilis) should be made available in all maternity or delivery health facilities for on-site testing for women with unknown status.

11.1.6 Testing for HIV should follow the sub-divisional and divisional algorithms.

11.1.7 Every confirmed HIV positive pregnant woman should be screened for syphilis, hepatitis B, full blood count including haemoglobin, CD4 (or total lymphocyte count if CD4 is not available) and TB co-infection.

11.1.8 All HIV positive women, partners, couples and families should receive comprehensive support for HIV prevention, including:

- Preventive education and risk-reduction counselling;
- Condom use education
- Adequate condom supply;
- Support for disclosure of HIV positive status to family members and the community;
- Partner referral for testing and counselling;
- Counseling for couples to reduce risk of transmission between discordant partners
- Referral to other services if necessary (TB, STI, Family planning, etc)

11.2 PREVENTION OF UNINTENDED PREGNANCY IN HIV POSITIVE WOMEN

11.2.1 Unintended and unplanned pregnancy must be avoided in HIV positive women through provision of reproductive health and family planning information, contraceptive advice and services.

11.2.2 All HIV positive individuals, couples and families should be offered counselling on available informed choices of reproductive health and family planning.

11.2.3 All health facilities providing sexual and reproductive health services should ensure that reproductive health commodities are available and accessible to clients at all times, e.g. condoms (both male and female types), and modern forms of contraceptives.

11.3 INTEGRATION OF TREATMENT AND CARE WITH PREVENTION

11.3.1 Care, treatment and support for People Living with HIV and AIDS (PLWHA) must be linked closely to preventive services within the sub-divisional and divisional health services infrastructure. Informed consent should be obtained from the clients.

11.3.2 A divisional HIV core team (comprised of physician, obstetrician, pediatrician, STI hub doctor, pharmacy and laboratory, ANC sister) should be established and meet quarterly within the overall frame work of HIV Prevention, Diagnosis, Treatment and support for PLWHA.

11.3.3 The core Function of the Divisional HIV Core Team is to ensure that all HIV positive patients, and their families get the ultimate care needed for HIV and issues surrounding stigma and discrimination.

11.4 NON-STIGMATIZING ANTENATAL CARE ENVIRONMENT

11.4.1 Antenatal care for HIV positive pregnant women should be provided in a convenient, user-friendly, individualized manner.

11.4.2 Comprehensive antenatal care, wherever possible, should be provided by an obstetrician, a midwife or a nurse, and a counsellor using a multi team approach.

11.4.3 Antenatal care should be supported by the additional involvement of:

- A treatment “buddy” at home, and
- A trained counsellor and/or registered nurse who would also supervise adherence to any home based treatment and prophylaxis.

11.4.4 Antenatal care should include counselling regarding options for infant feeding and post-natal management of the baby.

11.5 CLINICAL MANAGEMENT TEAM

11.5.1 Clinical management will be undertaken by respective disciplines in consultation with the core team.

11.5.2 Complete, accurate and timely dissemination of case reports to all who are directly involved in the care of the patient should be done monthly between clinics, laboratory, pharmacy, dietetics, STI Hub, health information unit and the national program manager to ensure quality of care, availability of testing reagents and drugs, and timely reporting for monitoring purposes.

12. LEADERSHIP/GOVERNANCE AND SERVICE DELIVERY:

12.1 The Ministry of Health is mandated to deliver the contents of this policy for the people of Fiji to Eliminate HIV amongst children born to HIV positive parents or women

12.2 The Prevention of Parent to Child Transmission of HIV Core Team and the Family Health Unit will take the governance and leadership role, under the guidance of the Deputy Secretary Public Health, to ensure that the services of PPTCT is made available to all parents and women of Fiji regardless of geographical location, ethnicity, religion or age.

12.3 The PPTCT core team at the national level needs to meet quarterly or earlier if need be to address issues pertaining to this Policy and ensuring that service delivery is appropriate and in line with the Ministries mandate of decentralization.

12.4 The PPTCT core team is made up of:

- Paediatrician
- Obstetrician
- HIV/STI Hub Center Medical Officer in Charge
- Counselling Representative from the Counseling Unit

- A positive person from the Positive Network in Fiji
- Physician
- Lab Technician
- National Family Health Advisor
- Pharmacist

12.5 The Role of the PPTCT core team would be too:

- Meet on a regular basis to ensure that service delivery for PPTCT is rolled out well and service is maintained in Fiji
- To ensure that all families or women and Child receive all the services in terms of PPTCT

13. HUMAN RESOURCES:

The Ministry of Health will equip necessary staff in the Divisions and Sub-Divisions for the adequate delivery all PPTCT services in Fiji. The necessary staff in this context are namely Medical Officers in Charge of Maternity Units and Maternity Unit Staff and Mid Wives. Capacity building of service providers will be ensured through regular trainings by the PPTCT team using the Fiji national PPTCT manual.

14. SUPPLIES [MEDICINES, CONSUMABLES, EQUIPMENT]

All anti-retroviral therapy for patients in need including paediatric prophylaxis are available through the Ministry of Health Pharmacies or the Hub Centers in the three Divisions. These medications are made available to the respective PPTCT sites in the country for initiation when needed.

It is the mandate of the MOH to provide these medications and services free of any cost associated to its recipients of the services.

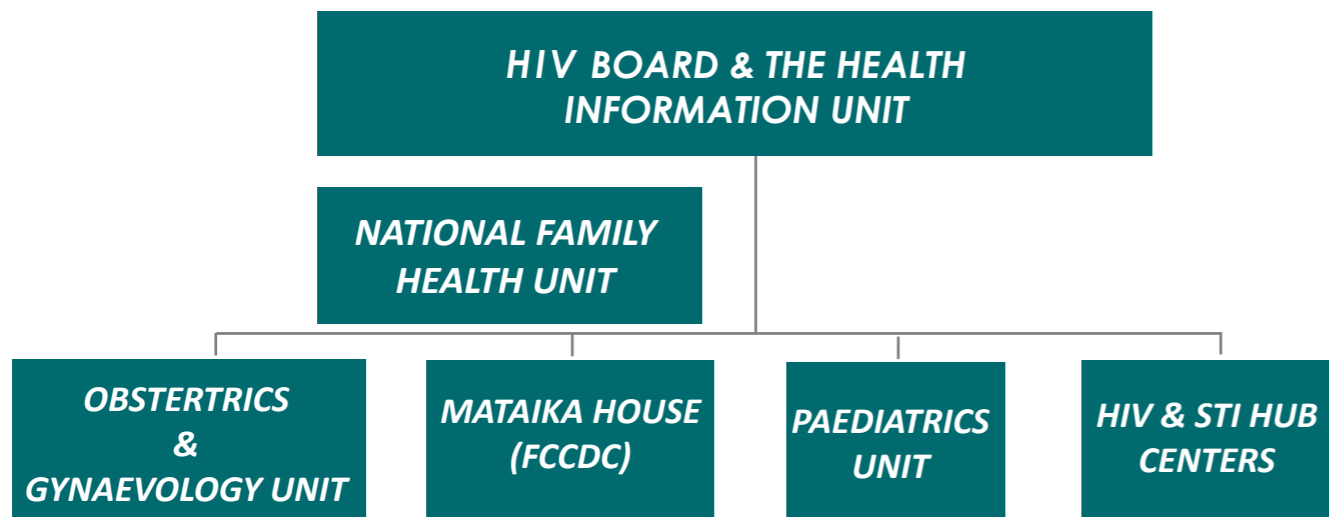
Testing commodities and equipments are provided to the Divisional sites on a regular basis as a part of the MOH Lab service provision.

15. INFORMATION SYSTEMS:

Reporting of PPTCT cases taken place from the PPTCT counterparts which include, paediatricians, Obstetricians, ANC and Hub Centers.

The PPTCT program will align all reporting of PPTCT in country to international requirement standards. This report will be oversights by the Health Information Unit and the HIV Board of Fiji under the HIV Decree 2011.

It is the responsibility of the Family Health Unit to ensure that all reports are collected and submitted on a quarterly basis to the Health Information Unit and presented to the HIV Board during the quarterly meetings for endorsement of release of data.



16. CLINICAL MANAGEMENT/THERAPY/PROCEDURES:

16.1 Antiretroviral therapy and antiretroviral prophylaxis in PPTCT.

16.1.1 A monitoring and management plan – including careful supervision of adherence to medications – should be developed for every HIV positive pregnant woman taking antiretroviral treatment.

16.1.2 In pregnant women with confirmed HIV infection, the initiation of ART for maternal health is commenced immediately and continued for life, irrespective of the WHO clinical staging and immunological status.

16.1.3 If the first-line ART regimen is two nucleoside reverse transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse-transcriptase inhibitor (NNRTI).

TDF + 3TC (or FTC) + EFV as a fixed-dose

If TDF + 3TC (or FTC) + EFV is contraindicated or not available, one of the following options is recommended:

- AZT + 3TC + EFV
- AZT + 3TC + NVP
- TDF + 3TC (or FTC) + NVP

16.1.4 Infants of mothers who are receiving ART should receive six weeks of infant prophylaxis with twice daily Zidovudine irrespective of feeding option*. Infant prophylaxis should begin at birth or when HIV exposure is recognized postpartum. 13

(*this is due to the high number of infants who have deranged transaminases at two weeks of being on niverapine and the limitation of ART regimes for pediatric cases.)

The above ARV treatment and infant prophylaxis regimens are attached as Annex 1.

16.2 Risk Management

16.2.1 Decision about the mode of delivery should be made according to the specific situation depending on clinical indicators of viral load level and other conditions of the woman with consideration for the interest of both mother and the unborn baby.

16.2.2 All HIV positive pregnant women should deliver in hospitals with easy access to facilities for Caesarean Section. If this is not possible then they should consult the obstetric and paediatric teams at the divisional hospital or medical officer at the HUB center.

16.2.3 If patients are tested positive for HIV while being seen by a Private Obstetrician, they will need to be referred to the Public Hospital or to another private Obstetrician who can carry out PPTCT services as per the policy. The Private Clinician needs to have undergone PPTCT training and at the same time seek assistance of the PPTCT core team for appropriate management.

16.2.4 If a HIV Positive patient wishes to have a private Obstetrician for her

pregnancy she may do so with the provision that the obstetrician is trained with PPTCT and will have regular consultation with a paediatrician for Infant Feeding Counseling, Infant Prophylaxis and Early Infant Diagnosis.

- 16.2.5 The Private Obstetrician will need to report the case to their Divisional Core team de-identified and a identified case report to the HIV Programme Manager under the HIV Decree who in this case will be the National Advisor Family Health.
- 16.2.6 The Ministry of Health will provide Anti-Retroviral therapy for the private patients including CD4 count and Viral Load tests if available in the country. Any other tests for the private patient will be carried out at her own cost.
- 16.2.7 Paediatric Prophylaxis and Early Infant Diagnosis in the Private Clinic, can be facilitated by the Paediatric Unit via the divisional hospitals without any cost to the child.
- 16.2.8 To gain understanding and appropriate training of PPTCT the private obstetrician/clinicians can work closely with the Government Sector to get training for PPTCT either at the National Level or in their Divisional Trainings. This opportunity will be provided to Private Practitioners free of charge within reason.
- 16.2.9 For HIV positive mothers with good adherence to antenatal ARV therapy, a cautious approach to planned normal vaginal delivery is recommended, with early Caesarean Section for prolonged labour or ruptured membranes of more than 4-6 hours' duration.
- 16.2.10 Women with poor immune function or presumed high viral load should be selected for elective Caesarean Section.
- 16.2.11 Artificial rupture of membranes (ARM) and instrumental or assisted delivery should be strictly avoided.
- 16.2.12 Vigorous suctioning of the baby's oropharynx after delivery should be strictly avoided.

17. INFANT FEEDING

- 17.1 Counselling for "best feeding choice" where the mother is HIV positive, the best feeding option is Exclusive Breastfeeding with infected mothers on ARV therapy. This is in alignment with Fiji's national policy on Breastfeeding.
- 17.2 For those opting for replacement feeding, the criteria listed in the WHO Infant Feeding Guideline Recommendation 5 should be fulfilled.
- 17.3 Close supervision of adherence to the chosen method of infant feeding should be provided during the post-natal period.
 - 17.4 Mixed feeding should be strictly avoided as it carries a very high risk of HIV sero-conversion in the baby (i.e. of the baby becoming infected with HIV eventually).
 - 17.5 Wet-nursing is prohibited

18. CLINICAL FOLLOW-UP OF THE HIV EXPOSED INFANT

- 18.1 A paediatrician should review all infants of HIV positive mothers at 2, 6, 10 and 14 weeks; every 3 months from 14 weeks to 2 years or until status is confirmed.
- 18.2 Adequate nutrition support, including vitamins and minerals should be encouraged.
- 18.3 HIV exposed infants should be given cotrimoxazole prophylaxis from 4-6 weeks for the prevention of opportunistic infections and to be continued until the baby is confirmed negative.
- 18.4 Immunization for HIV Infected babies and mothers is aligned with the revised National EPI Policy:
 - 18.4 Infants with HIV infection can receive all immunizations according to the current immunization schedule.
 - 18.5 As for any severely ill child, a severely ill HIV-infected child should not be vaccinated.
 - 18.6 Recommendations for vaccination with BCG for infants born to mothers who are HIV Positive in line with the revised National EPI Policy.
 - 18.7 Exclusion of HIV infection through antigen-based testing:
 - 18.8 Initial testing of infants exposed to HIV should be performed between 4 and 6 weeks of age or at the earliest opportunity thereafter using one of the following virological assays (HIVDNA on whole blood specimen or dried blood spots, HIV RNA on plasma or dried blood spots, p24 Ag on plasma or DBS).1
 - 18.9 In infants with an initial positive virological test result, it is strongly recommended that ART be started without delay and, at the same time, a second specimen be collected to confirm the initial positive virological test result. Do not delay ART. In infected infants immediate initiation of ARVT saves lives and commencement of ARVT should not be delayed while waiting for the results of the confirmatory test
 - 18.10 If the first virological testing of HIV exposed infant is negative and the infant is clinically well, a second confirmatory virological test should be after 3 months (if not breastfeeding) or 6 weeks after cessation of breastfeeding (if breastfeeding)
- 18.11 Exclusion of HIV infection through HIV antibody testing:
 - 18.12 Due to passive transfer of maternal antibody, antibody-based tests should be deferred until the infant is at 18 months of age
 - 18.13 Two negative tests at least 1 month apart (taken at 18 months of age) can reasonably exclude HIV infection provided there are no clinical evidence of HIV infection, the infant has not breast fed for at least 6 weeks, and no future breast feeding takes place
 - 18.14 HIV infection would be definitely excluded if the infant is well and the HIV antibody test is negative at 18 months of age, provided that the infant is not breastfed in the last 6 weeks and no future breast feeding takes place
- 18.15 Children who are above 18 months of age and born to HIV infected mothers should

undergo an antibody test provided they are not being breastfed. For those still breast feeding, this test should be conducted 6 weeks after cessation of breastfeeding, 1 PCR technology is available in Mataika House.

19. FINANCING & PAYMENT

The funding support towards the Prevention of Parent to Child Transmission (PPTCT) is via:

- 19.1 UNICEF Funding:
 - A Biannual Work Plan needs to be developed and signed off prior to the year beginning of implementation.
- 19.2 Ministry of Health:
 - Under the PPTCT work plan would be the Financial Support for the programme. Though the Ministry of Health becomes the main implementing partner for the PPTCT programme.
 - A report needs to be submitted by the PPTCT core team with the necessary acquittals for the implementing year

20. REGULATION:

The service provision and the implementation of the PPTCT policy needs to happen in line with the HIV Decree which has been Gazetted on the 4th of February 2011, and amended on the 26th August 2011. Also, the PPTCT policy should be in line with the technical and programmatic recommendations of the 2013 WHO Consolidated Guidelines on the use of antiretroviral; drugs for treating and preventing infections.

21. RESPONSIBILITY:

The implementation of the Policy comes under the Family Health Unit of the Ministry of Health to ensure that all parts of the Policy is followed.

The National Advisor Family Health in partnership with the support of the Paediatrics, Obstetrics Unit, HIV/STI Hub Centers, Pharmacy, and Laboratory make the key personals to implement and ensure that all practices in the country for PPTCT is closely followed and implemented accordingly to the set budget lines.

22. RESEARCH

The Ministry of Health acknowledges that research is critical in provisioning evidence based decision making and in the implementation of evidence based interventions in the prevention and management of HIV services in the country.

The Ministry of Health mandates and supports research in HIV subject to adherence to research protocols and processes of the NHRC and the FNRERC.

All such research conducted in the Republic of Fiji must have the Ministry of Health or its representative as a counterpart and must ensure that a written and presented report is made available to the PSH and the MFH within 6 months of the completion of the research.

All data requests for the purpose of HIV research are to be within the processes mandated by the Health Information Policy of 2011.

All data and research must be used to set priorities and to develop strategies to ensure that all decisions are based on evidence and are defensible.

23. COMMUNICATION

The Ministry of Health communication channels [internal and external] will be followed:

Health Service Provider to Patient

The health service provider will communicate all applicable and necessary information to the patient in a language that the patient can comprehend and understand, in an ethical manner, with appropriate information to enable autonomy of patient decisions and precise comprehension of the disease status of the patient. No form of coercion will be utilized to hinder the autonomy of the patient.

Patient to Health Service Provider

The patient is encouraged to communicate all necessary information that will assist in the management of his or her condition to the health care providers. The patient must be able to communicate all concerns and decisions on treatment without coercion or fear of victimization.

Health Service Provider to Health Service Provider

All patient information will be utilized and relayed from one health care provider in an ethical manner, with patient information being discussed only for the purpose of management, better health outcomes and improved quality of life for the patient.

Health Service Provider to Administration

The health service provider will communicate to the administration regular updates of aggregate analyzed data for PPTCT patients and management issues as deemed necessary for ensuring adequacy of resources for optimal management of patients and for predicting futuristic needs, innovations and improvements in health service delivery.

Provision of Public messages on PPTCT

The PPTCT core team is responsible for development of evidence informed public health messages nationwide.

24. REPORTING

All reports are to be provided in a complete, timely, reliable, relevant manner to the respective authorities and the Health Information Unit.

The following reports must be provided using the approved PPTCT report forms:

REPORT	PROVIDER	INTENDED RECIPIENT	TIME FRAME
<i>PPTCT report from Divisional Paediatrics Unit</i>	<i>Paediatrics Unit</i>	<i>National Advisor Family Health</i>	<i>Quarterly</i>
<i>PPTCT report from Divisional Obstetrics Unit</i>	<i>Obstetrics Unit</i>	<i>National Advisor Family Health</i>	<i>Quarterly</i>
<i>PPTCT follow up patient report from Hub Centers</i>	<i>Hub Centers</i>	<i>National Advisor Family Health Quarterly</i>	
<i>Individual Case Reports</i>	<i>All Units Mentioned above</i>	<i>National Advisor Family Health</i>	<i>Within two weeks of a notification of a new case</i>
<i>Forecasting/Budgeting</i>	<i>Fiji Pharmaceutical Services</i>	<i>National Advisor Family Health Quarterly</i>	<i>Quarterly</i>

25. MONITORING & EVALUATION

- Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status
- Percentage of pregnant women attending antenatal care whose male partner was tested for HIV
- Percentage of HIV-positive pregnant women who receive ARVT to reduce the risk of mother-to-child transmission
- Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
- Percentage of infants born to HIV-infected women receiving antiretroviral prophylaxis for prevention of mother-to-child transmission (PMTCT) in the first 6 weeks
- Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth
- Percentage of infants born to HIV-infected mothers who are HIV infected

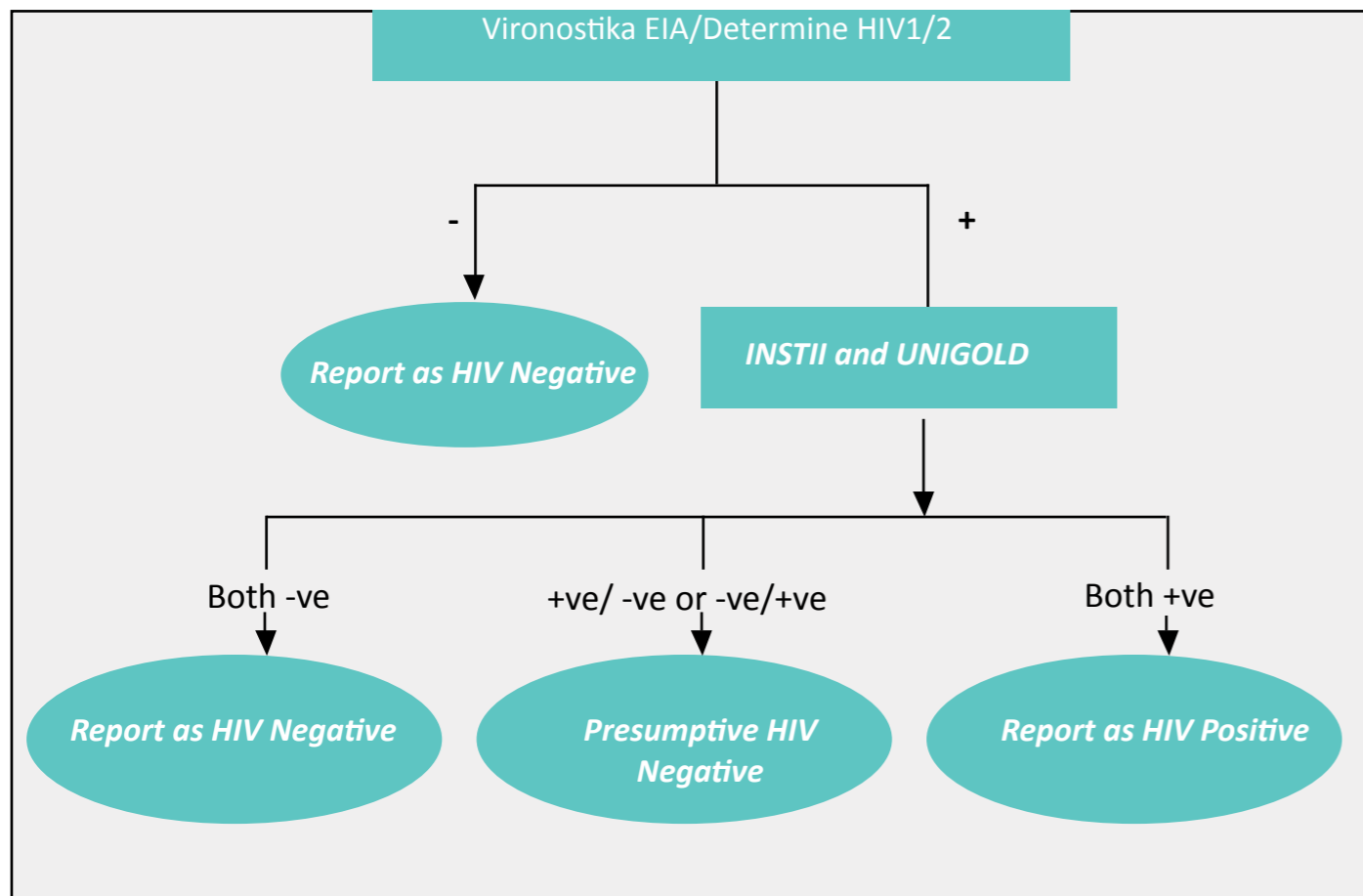
26. REFERENCES

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- HIV Decree 2011, Decree No. 5 of 2011, Published by Authority of the Fiji Government, Vol 12, Friday 4th February 2011, No.12 <http://www.health.gov.fj/pdfs/Decree%205%20-%20HIV-AIDS%20Decree.pdf>
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- PPTCT Trainers Consultative Workshop The Pearl, Pacific Harbor 24th-26th May 2012
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28. REVIEW

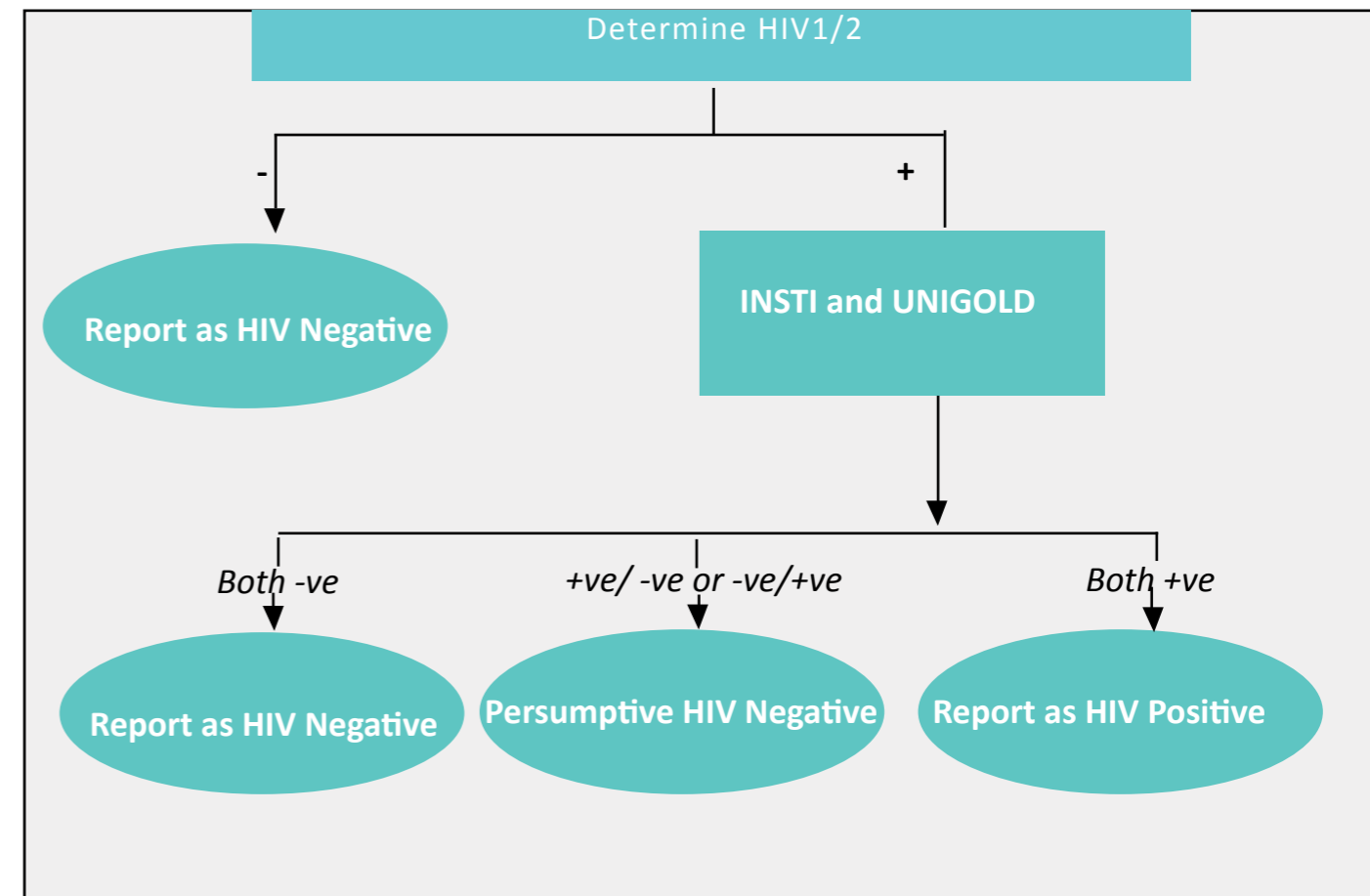
Due to the rapidly evolving approaches to aspects of HIV/AIDS diagnosis, treatment and care, this policy is to be reviewed every two years or earlier if necessary.	Director PPDU:	
	Programme Head Signature	
	PSH/MFH signature	
	Date:	
Date of Next Review August of 2015		

ANNEX 1 HIV TESTING ALGORITHM FOR FIJI DIVISIONAL HOSPITALS



TEST RESULTS			REPORT	COMMENT
VIRONOSTIKA/ DETERMINE	UniGold	INSTI		
-	TNR*	TNR	Anti-HIV Negative	HIV antibody not detected
+	-	-	Anti-HIV Negative	
+	+	-	Presumptive Anti-HIV Negative	Most likely HIV negative. There is a small possibility that these may indicate early HIV infection. Refer to Mataika House for quality assurance and confirmatory testing. It is strongly recommended that another sample be drawn in 4-6 weeks for testing to confirm these results.
+	-	+		
+	+	+	Anti-HIV Positive	Reactivity in HIV tests indicative of HIV infection. Refer to Mataika House for quality assurance purposes. Should the Mataika House result differ a second sample should be drawn as soon as possible for further testing at National Reference laboratory.

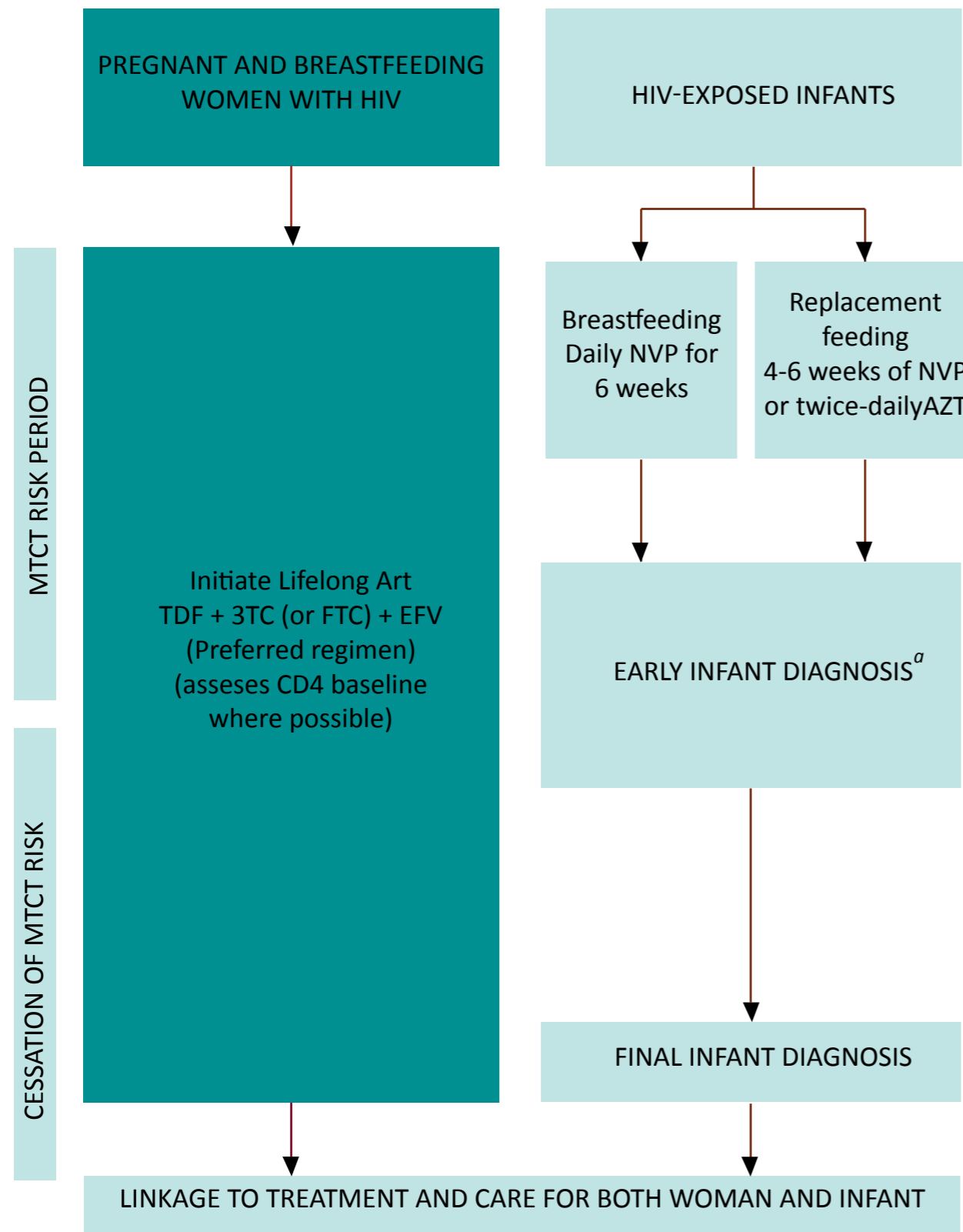
ANNEX 2 FIJI HIV TESTING ALGORITHM AT THE SUB-DIVISIONAL LEVEL HOSPITALS



TEST RESULTS			REPORT	COMMENT
DETERMINE	UniGold	INSTI		
-	TNR*	TNR	Anti-HIV Negative	HIV antibody not detected
+	-	-	Anti-HIV Negative	HIV antibody not present, false positive screen. Refer to Mataika House for quality assurance
+	+	-	Presumptive Anti-HIV Negative	Most likely HIV negative. There is a small possibility that these may indicate early HIV infection. Refer to Mataika House for quality assurance and confirmatory testing. It is strongly recommended that another sample be drawn in 4-6 weeks for testing to confirm these results.
+	-	+		
+	-	+	Anti-HIV Positive	Reactivity in HIV tests indicative of HIV infection. Refer to Mataika House for quality assurance purposes. Should the Mataika House result differ a second sample should be drawn as soon as possible for further testing at National Reference laboratory.

ANNEX 3. ALGORITHMS FOR THE 2013 RECOMMENDATIONS FOR PREGNANT AND BREASTFEEDING WOMEN

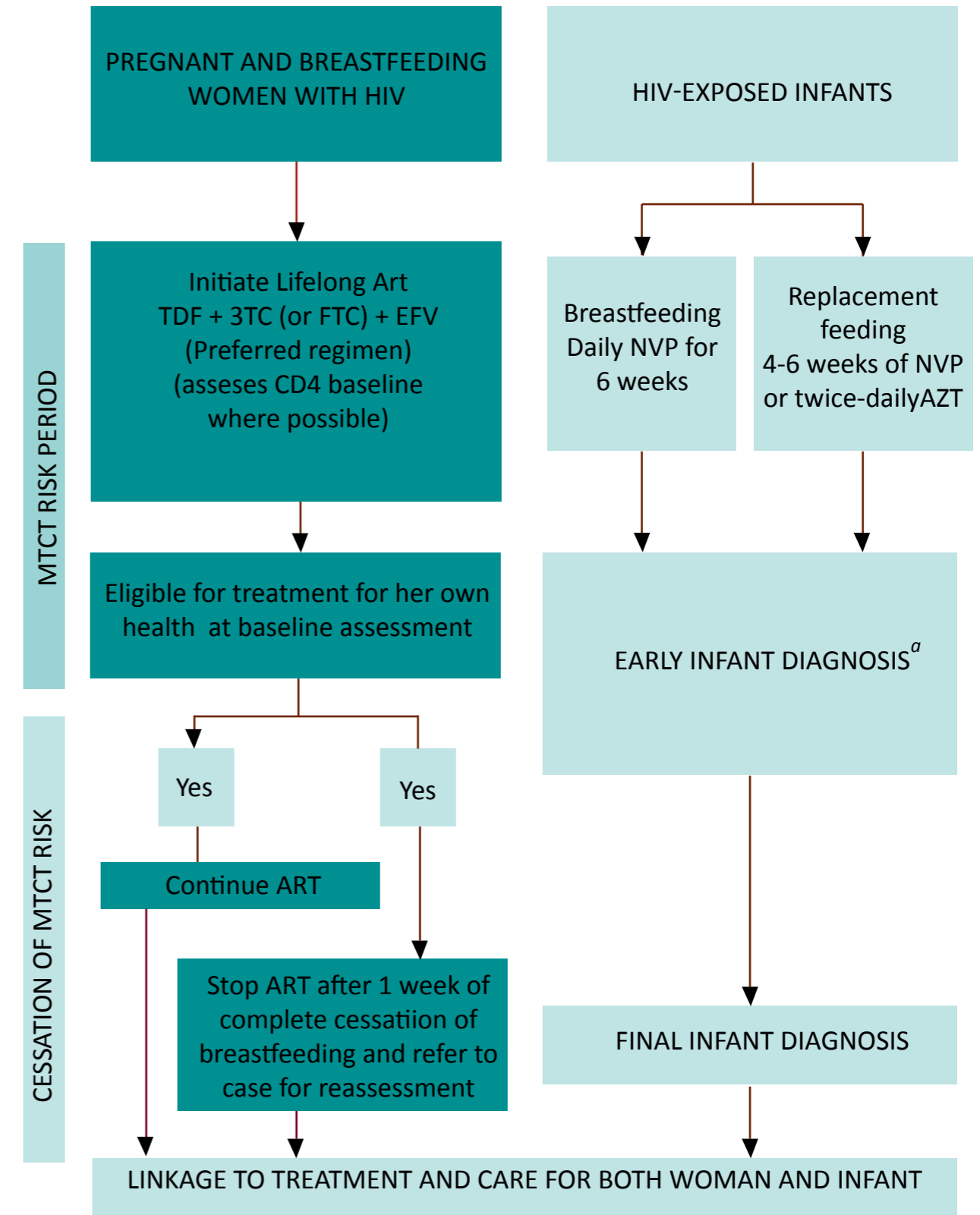
Lifelong ART for all pregnant and breastfeeding women with HIV (Option B+)



N.B Fiji is using AZT instead of NVP as first choice for prophylaxis for babies.

ART FOR WOMEN WITH HIV DURING PREGNANCY AND BREASTFEEDING (OPTION B)

Lifelong ART for all pregnant and breastfeeding women with HIV (Option B)



ANNEX 4: WHO Infant Feeding Guideline Recommendation 5

Recommendation .5

Conditions needed to safely formula feed

Mothers known to be HIV-infected should only give commercial infant formula milk as replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when specific conditions are met:

- a. safe water and sanitation are assured at the household level and in the community; and
- b. the mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; and
- c. the mother or caregiver can prepare it clearly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and
- d. the mother or caregiver can, in the first six months, exclusively give infant formula milk; and
- e. the family is supportive of this practice; and
- f. the mother or caregiver can access health care that offers comprehensive child health services.

(Strong recommendation, low quality of evidence)

Remarks

The group strongly endorsed this recommendation while acknowledging that the quality of direct evidence from HIV-exposed infants and their mothers was limited. (GRADE profile 5, Annex 4) Furthermore, there is no possibility of conducting a clinical research study that would deliberately expose infants without the conditions listed above, to the risks of replacement feeding. It would be unethical to do so. However, the group considered the health outcomes of HIV-exposed infants that indirectly reported on the influence of these household, environmental and social factors on child survival (7,12,40). The importance of high quality counselling to assist mothers make appropriate choices about infant feeding practices were noted (16,41).

The group also drew from programmatic experience and evidence from non-HIV populations in which there is considerable observational data that quantify the risks of not breastfeeding (1,2) and using commercial infant formula milk in settings that are sub-optimal.

The group also chose to explicitly define the conditions, using common everyday language, rather than referring to the acronym AFASS that was adopted in previous recommendations. It was felt that more carefully defining the environmental conditions that make replacement feeds a safe (or unsafe) option for HIV-exposed infants will improve HIV-free survival of infants. It was considered that such language would better guide health workers regarding what to assess, and to communicate this to mothers who were considering if their home conditions would support safe replacement feeding. Using these descriptions does not invalidate the concepts represented by AFASS.