

**FIJI POLICY ON PREVENTION OF PARENT TO CHILD TRANSMISSION  
(PPTCT) OF HIV**

**1. Goal**

- 1.1 To prevent the transmission of HIV from a HIV positive parent to their child during pregnancy, labour, delivery or infant feeding.

**2. Objectives**

- 2.1 To ensure that women of reproductive age and their male partner have access to accurate information on HIV/AIDS/STIs and know how to use condoms correctly and consistently to prevent HIV/STI infection.
- 2.2 To strengthen primary prevention, ensuring that the HIV negative pregnant women and their partner stay negative during the current or future pregnancies.
- 2.3 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.
- 2.4 To ensure that women and her partner have access to quality testing for HIV infection and other STIs, supported by appropriate voluntary and confidential counselling and support services.
- 2.5 To ensure that all HIV positive pregnant women have access to antiretroviral prophylaxis and therapy
- 2.6 To ensure that all centres providing HIV treatment and care have a clear ARV Supply Plan to enable uninterrupted supply of drugs for patients on ART or for prophylaxis purposes
- 2.7 To ensure that HIV positive mothers, her male partner, and support persons have appropriate comprehensive long term care and support regarding infant feeding and comprehensive care for all children born to HIV infected mothers irrespective of the child's HIV status.

**3. Policy Review**

- 3.1 Due to the rapidly evolving approaches to aspects of HIV/AIDS diagnosis, treatment and care, this policy is to be reviewed every three years.

#### 4. Diagnosis of HIV Infection

- 4.1 Posters and brochures on HIV/AIDS/STIs should be made available at all these health facilities:
  - 4.1.1 Maternity units of the 3 divisional hospitals
  - 4.1.2 Antenatal clinics of all subdivisional hospitals
  - 4.1.3 Antenatal clinics of major health centres
  - 4.1.4 STI Hubs of Lautoka, Labasa and Suva
  - 4.1.5 SRH clinics of subdivisional hospitals
  - 4.1.6 SRH clinics of major health centres
  - 4.1.7 Any other facility designated Voluntary Confidential Counseling and Testing (VCCT) and/or Provider Initiated Testing and Counselling (PITC).
- 4.2 VCCT and PITC for HIV should be available at all major health facilities in the divisions and subdivisions offering antenatal care (ANC), utilising group pre-test counseling and individual post-test counselling.
- 4.3 Nursing stations and Health Centres that also conduct ANC should either provide VCT if they have the capacity or else refer ante natal mothers to their subdivisional or divisional hospitals for VCCT and other normal routine blood tests.
- 4.4 All pregnant women should be offered 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.
- 4.5 Pre- and post-test counselling by an appropriately trained and competent health care provider or counsellor should always be done with HIV testing.
- 4.6 Rapid testing kits for HIV and other STIs (e.g. syphilis) should be made available and conducted on-site in all maternity or delivery health facilities once formally adopted as a testing guideline procedure in Fiji.
- 4.7 Laboratory testing for HIV should follow the two-step algorithm using Determine as the screening assay for rapid antibody testing and two rapid tests (Uni-Gold and Insti) done in parallel as the confirmatory test.
- 4.8 Any discordant results arising from the two parallel confirmatory tests (Uni-Gold and Insti) should be repeated after 4 weeks with new blood sample from the client
- 4.9 All confirmatory tests using Uni-Gold and Insti should be done at the three divisional hospital laboratory under technical oversight from Mataika House (NPHRL).

- 4.10 Every HIV positive pregnant woman should be screened for syphilis, hepatitis B, Chlamydia, full blood count including haemoglobin, CD4 (or total lymphocyte count if CD4 is not available) and TB co-infection.
- 4.11 All HIV positive women, partners, couples and families should receive comprehensive support for HIV prevention, including:
- Prevention education and risk-reduction counselling;
  - Condom use education and 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.).
- 4.12 This Policy re-affirms the ethics of respecting the human 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. core health team for continuing care and support.

## **5. Prevention of Unintended Pregnancy in HIV Positive Women**

- 5.1 Unintended and unplanned pregnancy must be avoided in HIV positive women through provision of reproductive health and family planning information, contraceptive advice and services.
- 5.2 All HIV positive individuals, couples and families should be offered counselling on available informed choices of reproductive health and family planning.
- 5.3 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.

## **6. Integration of Treatment and Care with Prevention**

- 6.1 Care, treatment and support for PLWHA must be linked closely to preventive services within the sub -divisional and divisional health services infrastructure.
- 6.2 A team approach should be set up within the overall framework of care and support for PLWHA through the Reproductive Health/Adolescent Health Development Clinics or the Care & Support Subcommittee of NACA.

## **7. Non-stigmatizing Antenatal Care Environment**

- 7.1 Pregnancy in an HIV positive woman should be managed according to the current WHO guidelines.<sup>1</sup>
- 7.2 Antenatal care for HIV positive pregnant women should be provided in a convenient, user-friendly, individualised manner in their preferred health facility.
- 7.3 Comprehensive antenatal care, wherever possible, should be provided by an obstetrician, a midwife or a nurse, and a counsellor using a multi team approach.
- 7.4 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.
- 7.5 Antenatal care should include careful counselling by a trained health service provider (including paediatrician and a dietitian or nutritionist) regarding options for infant feeding and post-natal management of the baby.

## **8. Antiretroviral therapy and antiretroviral prophylaxis in PMTCT.**

- 8.1 A monitoring and management plan – including careful supervision of adherence to medications – should be developed for every HIV positive pregnant woman taking antiretroviral treatment or prophylaxis.
- 8.2 In pregnant women with confirmed HIV infection, the initiation of ART for maternal health is recommended for all women with CD4 cell counts of  $\leq 350$  cells/mm<sup>3</sup>, irrespective of the WHO clinical staging, and for all women in WHO clinical stage 3 or 4, irrespective of the CD4 cell count.
- 8.3 HIV-infected pregnant women in need of ART for their own health should start ART as soon as feasible regardless of gestational age and continue throughout pregnancy, childbirth, breastfeeding (if breastfeeding), and thereafter.

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<sup>1</sup> World Health Organisation. *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Recommendations for a Public Health Approach*; Geneva: WHO (2010)

- 8.4 In pregnant women in need of ART for their own health the preferred first-line ART regimen should include an AZT + 3TC backbone combined with an NNRTI: AZT + 3TC + NVP or AZT + 3TC + EFV. Alternative recommended regimens are TDF + 3TC (or FTC) + EFV and TDF + 3TC (or FTC) + NVP. (Note: avoid the use of EFV in the first trimester and use NVP instead.)
- 8.5 All infants (regardless of whether breastfeeding or receiving only replacement feeding) born to HIV-infected women receiving ART for their own health should be given daily NVP or twice-daily AZT from birth or as soon as feasible thereafter until 4 to 6 weeks of age.
- 8.6 HIV-infected pregnant women who are not in need of ART for their own health require effective ARV prophylaxis to prevent HIV infection in their infants. ARV prophylaxis should be started from as early as 14 weeks of gestation or as soon as feasible during pregnancy, labour and delivery or thereafter.
- 8.7 For HIV-infected pregnant women who are not in need of ART for their own health, ARV prophylaxis consists of antepartum twice-daily AZT, plus sd-NVP at the onset of labour, plus twice daily AZT + 3TC during labour and delivery and continued for 7 days postpartum.
- 8.8 In breastfeeding infants, daily administration of NVP to the infant from birth until 1 week after all exposure to breast milk has ended, or for 4 to 6 weeks if breastfeeding stops before 6 weeks (but at least 1 week after the early cessation of breastfeeding), is recommended.
- 8.9 In infants receiving only replacement feeding, daily administration of NVP from birth or sd-NVP at birth plus twice-daily AZT from birth until 4 to 6 weeks of age is recommended.

## **9. Method of Delivery**

- 9.1 Decision about the mode of delivery should be made according to the specific situation depending on viral load level and other conditions of the woman with consideration for the interest of both mother and the unborn baby.
- 9.2 All HIV positive pregnant women should deliver in a divisional hospital with 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 centre.
- 9.3 For HIV positive mothers with good adherence to antenatal ARV prophylaxis, 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.

- 9.4 Women with poor immune function or presumed high viral load should be selected for elective Caesarean Section.
- 9.5 Artificial rupture of membranes (ARM) and instrumental or assisted delivery should be strictly avoided.
- 9.6 Vigorous suctioning of the baby's oropharynx after delivery should be strictly avoided.

## **10. Infant Feeding**

- 10.1 Counselling for "best feeding choice" where the mother is HIV positive, the safest options for infant feeding are:
  - 10.1.1 replacement feeding, provided it is feasible, acceptable, safe, sustainable and affordable and that the MOH should provide the baby's milk up to 12 months of age.
  - 10.1.2 In all other cases, exclusive breast feeding with rapid weaning at 6 months is still recommended and also is in harmony with Fiji's national policy for Baby Friendly Hospital Initiatives.
- 10.2 Close supervision of adherence to the chosen method of infant feeding should be provided during the post-natal period.
- 10.3 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).

## **11. Clinical Follow-Up of the Baby**

- 11.1 A paediatrician should review all infants of HIV positive mothers monthly during the first six months of life, and then every three months until 2 year of age.
- 11.2 Adequate nutrition support, including vitamins and minerals should be encouraged.
- 11.3 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.
- 11.4 Immunisation for HIV Infected babies and mothers is aligned with the revised National EPI Policy:
  - 11.4.1 Infants with HIV infection can receive all immunisations according to the current immunisation schedule except for BCG and the yellow fever vaccine

11.4.2 The decreased immune response to vaccines with increasing age for HIV-infected children emphasises the need for immunisation as early in life as possible for children born to HIV-infected women.

11.4.3 As for any severely ill child, a severely ill HIV-infected child should not be vaccinated.

11.4.4 Recommendations for vaccination with BCG for infants born to mothers who are HIV Positive are listed in Table 11.4.

**Table 11.4: Immunisations for infants born to mothers who are HIV Positive\***

Maternal HIV Status	Infant HIV Infection Status		BCG Administration
	Symptoms or signs suggestive of HIV	Early HIV Testing	
Unknown or Negative**	None	Not available	Give birth dose of BCG
If known HIV Positive or Positive Mother has chosen to exclusively Breastfeed	None	Not available	Give BCG but follow up closely for complications***
If know HIV positive	None	Available but not yet done	Defer BCG
If know HIV positive	Yes	Not available	Do not give BCG
If know HIV positive	None	Available and positive	Do not give BCG

- \*If unsure about whether to administer BCG - Contact Paediatric team for advice
- \*\* includes those who refuse antenatal testing
- \*\*\* Paediatric follow up essential

#### 11.5 Exclusion of HIV infection through antigen-based testing:

11.5.1 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 (HIV DNA on whole blood specimen or dried blood spots, HIV RNA on plasma or dried blood spots, p24 Ag on plasma or DBS)..<sup>2</sup>

11.5.2 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.

<sup>2</sup> None of these tests are available in the Pacific, so specimens would need to be referred to a reference laboratory in New Zealand or Australia although PCR technology is being done in Fiji for Chlamydia testing.

In infected infants immediate initiation of ART saves lives and commencement of ART should not be delayed while waiting for the results of the confirmatory test

11.5.3 If the first virological testing of HIV exposed infant is negative and the infant is clinically well, the next HIV virological test should be an HIV viral after 3 months (if not breastfeeding) or 6 weeks after cessation of breastfeeding (if not breastfeeding)

11.6 Exclusion of HIV infection through HIV antibody testing:

11.6.1 Due to passive transfer of maternal antibody, antibody-based tests should be deferred until the infant is at 18 months of age

11.6.2 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

11.6.3 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

11.6.4 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 breastfeeding, this test should be conducted 6 weeks after cessation of breastfeeding

## **12.0 Clinical Management Team**

12.1 A core clinical team should be set up in each division to establish oversight on overall care and management of all patients on ART and prophylaxis

12.2 Complete, accurate and timely dissemination of case reports to all who directly care for 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



### **13. Monitoring and performance indicators**

- 13.1 Number of educational materials on HIV/AIDS/STI reaching out to women of child bearing age (15-49 years) and their partners.
  - 13.1.1 Number of BCC materials available
- 13.2 Number of contraceptives accessed by women of child bearing age (15-49 years) and their partners.
  - 13.2.1 Number of different contraceptives available
- 13.3 Proportion of pregnant women who booked within first trimester.
- 13.4 Proportion of pregnant women who had more than 4 visits during the pregnancy before delivery
- 13.5 Proportion of pregnant women who are accompanied by their partner to the clinic during booking
- 13.6 Proportion of pregnant women who received VCCT and/or PICT.
- 13.7 Proportion of pregnant women who received counselling but declined HIV testing
- 13.8 Number of pregnant women who are positive for HIV on confirmatory testing.
- 13.9 Number of HIV positive pregnant women who deliver by Caesarean section.
- 13.10 Number of pregnant women enrolled for antenatal PMTCT regimen who choose to practise exclusive formula feeding.
- 13.11 Number of babies born to HIV positive women who complete postnatal course of ART.
- 13.12 Number of babies born to HIV positive women who are tested for HIV at 18 months.
- 13.13 Number of babies born to HIV positive women who are HIV positive at 18 months.
- 13.14 Number of stock outs experienced at ante natal clinics in the year for either testing reagents or drugs for PMTCT.

## **REFERENCES**

1. World Health Organization. Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Recommendations for a Public Health Approach; Geneva; WHO 2010
2. UNICEF Manual: Prevention of Mother to Child Transmission. Fiji, Vanuatu, Kiribati and Solomon Islands PMTCT Training Package. Participants Manual. April 2008 UNICEF.
3. The PMTCT Divisional Consultation Working Groups November 2009 to September 2010. Ministry of Health.
4. Fiji National Immunisation Policy 2009-2012, Ministry of Health Fiji

Scope and Application	This CPG is intended for use by all health care workers in their daily care of patients/individuals to whom guideline applies
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Supercedes Policy Number	Not applicable
Review Responsibilities	Public Health Network in consultation with the National Adviser Reproductive Health
Further Information	National Adviser Reproductive Health
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