Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific

An advocacy toolkit
Welcome to the advocacy toolkit on eliminating new paediatric HIV infections and congenital syphilis in the Asia Pacific. This advocacy toolkit has been produced by the Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (AP UN PPTCT Task Force), to galvanise action in-country in the Asia Pacific region to achieve elimination goals.

The AP UN PPTCT Task Force consists of representatives from the World Health Organisation - Western Pacific Regional Office (WHO WPRO) and South-East Asia Regional Office (WHO SEARO), United Nations Children's Fund - East Asia and Pacific Regional Office (UNICEF EAPRO) and the Regional Office for South Asia (UNICEF ROSA), the United Nations Joint Programme on HIV and AIDS – Regional Support Team for Asia and Pacific (UNAIDS-RSTAP), the United Nations Population Fund (UNFPA) and other partner agencies.


The toolkit consists of handouts aimed at four principal audiences: policy makers, programme implementers/service providers, the community of people accessing services/networks of PLHIV and lastly the media. The handouts support communication and advocacy with these key actors. It lays out available evidence, existing global commitments, the rationale for why the time is right to aim for elimination, recommendations for maximizing national public health systems and convincing examples from across the region that demonstrate that a dual elimination goal is possible by galvanizing action from various stakeholders.

The toolkit equips advocates with knowledge and action points in the form of:

- One-pagers containing **key messages** adapted from the conceptual framework for key stakeholders.
- Short briefs with **action points** aimed at the four key audiences including promising case studies from several countries in the region.
- **Links to multiple resources** that audiences can use in their advocacy efforts.

**Photo disclaimer:** Individuals featured in the photographs used in this toolkit are not affected by HIV and AIDS or Syphilis and images have been used after acquiring consent.
Key Messages

✓ Why use this toolkit? ...Because getting to zero is possible.

✓ What does the conceptual framework tell us? ...Getting to zero through a targeted approach.

✓ What do we need to keep in mind? ...A snapshot of the guidelines of the framework.

✓ What is the story in numbers? ...Key facts and figures.

✓ Why now? ...Global initiatives that make an elimination agenda timely.
Why use this toolkit?...Because getting to zero is possible

• In 2009 an estimated 22,000 children were newly infected with HIV in the Asia Pacific region, with over 90% of these transmitted from parent to child.

• An estimated 600,000 pregnant women in the Asia Pacific region are infected with syphilis (a sexually transmitted infection) every year. Without treatment, an estimated 69% of pregnant women with syphilis can experience outcomes such as stillbirth, neonatal death and newborn infection (congenital syphilis).

• These new infections are entirely preventable. Existing prevention strategies work and are implementable.

• Elimination of new paediatric HIV infections and congenital syphilis can contribute greatly to reaching maternal, infant/child health and HIV targets spelt out in the Millennium Development Goals.

• This toolkit tells us how.
Is it possible to make every child born in the Asia Pacific free from HIV and syphilis? The answer is yes. It requires commitments and action from multiple actors within the health provision and policy sector. This framework is designed to provide the Asia Pacific region with a common and systematic approach to the elimination of new paediatric HIV infections and congenital syphilis, and the improvement of maternal and child health and survival in the context of HIV and STIs.

The vision: Women and children alive and free from HIV and syphilis.

The goals: To eliminate new paediatric HIV infections and congenital syphilis AND thereby contribute to the improvement of maternal and child health and survival in the context of HIV and STIs

The OVERALL TARGETS to be met by 2015 through the application of the framework:
1. Reduce new paediatric HIV infections by 90% by 2015 (from a 2009 baseline)
2. Reduce parent-to-child-transmission of HIV to less than 5% (from a 2009 baseline )
3. Reduce the incidence of congenital syphilis (CS) to below 0.5 cases per 1,000 live births.

The specific PROGRAMMATIC TARGETS:
1. 50% reduction of HIV incidence among women 15-49 years of age (from a 2009 baseline).
2. Zero unmet need for family planning for women living with HIV.
3. More than 90% of pregnant women access ante-natal care services and skilled care at birth.
4. More than 90% of pregnant women know their HIV and syphilis sero-status.
5. More than 90% of HIV positive mothers and exposed infants receive effective ARVs for PPTCT.
6. More than 90% of syphilis sero-positive mothers and infants receive appropriate treatment.
7. More than 90% eligible HIV positive women remain on ART for 12 months after giving birth.
8. More than 90% eligible HIV infected children (0-14 yrs) receive ART.

The BUILDING BLOCKS spell out what various actors in the healthcare sector can do.
1. Ensure commitment to reach goals.
2. Enhance comprehensive, linked services between HIV/STI and MNCH programmes.
4. Improve coverage and advocate for equitable access.
5. Promote health systems development and enhance community involvement.
6. Improve measurement of programme performance and impact.
Conceptual Framework for the Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific

VISION: Women and children alive and free from HIV and syphilis

GOAL: To eliminate new paediatric HIV infections and congenital syphilis and improve maternal and child health and survival in the context of HIV/STI

OVERALL TARGETS:
1. Reduce new paediatric HIV infections by 90%
2. Reduce PTCT of HIV to ≤5%
3. Reduce incidence of congenital syphilis to ≤0.5 per 1,000 live births

PROGRAMMATIC TARGETS:
1. 50% reduction of HIV incidence among women 15-49 years
2. Zero unmet need for family planning among women living with HIV
3. ≥90% of pregnant women access ANC and skilled care at birth
4. ≥90% of pregnant women know their HIV and Syphilis status
5. ≥90% HIV-positive mothers and exposed infants receive effective ARVs to reduce PTCT
6. ≥90% syphilis sero-positive mothers and exposed infants receive effective treatment
7. ≥90% eligible HIV-positive pregnant women remain on ART for 12 months post-partum
8. ≥90% HIV-infected children (0-14 years) receive ART

Building Blocks

Ensure COMMITMENT to achieve goals
Enhance COMPREHENSIVE LINKED SERVICES between HIV/STI and MNCH
Employ HIGHLY EFFECTIVE INTERVENTIONS for HIV/STI prevention and treatment
Improve COVERAGE and advocate for EQUITABLE ACCESS
Promote HEALTH SYSTEMS DEVELOPMENT and enhance COMMUNITY INVOLVEMENT
Improve MEASUREMENT of programme performance and impact.
1. **Optimising existing public health systems:** Countries in the Asia Pacific should ensure access to high quality PPTCT and ECS interventions at the population level and aim to provide the best standard of care with optimal use of resources.

2. **Using a rights-based approach:** It is vital to ensure equitable access to services, especially for individuals in key affected and other marginalized populations, including the key affected populations of women and girls. Current standards of ethical care and human rights benchmarks must be followed.

3. **Keeping gender at the centre, ensuring male involvement:** Programmes and services must be tailored to accommodate the highly variable gendered and sexual realities of vulnerable populations. An engagement of men in the primary prevention of HIV/STIs among women must be promoted.

4. **Improving overall maternal and child health services and outcomes:** The elimination of paediatric HIV infections and congenital syphilis can greatly contribute to broader maternal, neonatal and child health (MNCH) goals, including ensuring the delivery of quality integrated MNCH services.

5. **Integrating HIV/STI services with maternal and child health services:** Any intervention must be seen as part of a continuum of services already available in the public health sector targeting maternal and child health requirements.

6. **Developing country-specific and community owned strategies:** The elimination framework will have to be adapted for each country based on its specific epidemiological characteristics and needs as well as existing health systems. The affected communities will have to be involved in target and agenda setting initiatives.

7. **Thinking big and setting ambitious targets:** Current available opportunities, including clear global commitments to achieve targets on maternal and child health and getting to the number zero in the context of HIV, provide a clear opportunity to think big and set ambitious targets.

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*No child should be born with HIV; no child should be an orphan because of HIV; no child should die due to lack of access to treatment.* Ebube Sylvia Taylor, an eleven year old girl born free of HIV talking to world leaders at the 2010 United Nations Millennium Development Goals Summit
THE REGIONAL EPIDEMIOLOGY

In 2009, **22,000 children were newly infected with HIV.** More than 90% of these infections are due to parent to child transmission.

About **50% of these children would have died** before their second birthday without treatment.

**600,000 pregnant women are newly infected with syphilis** each year in the region.

Without treatment nearly **three out of four women affected by syphilis** will experience adverse outcomes such as stillbirth, neonatal death and newborn infection (congenital syphilis).

PPTCT/STI SCREENING PRACTICES AND COVERAGE

Only **17% of all pregnant women received an HIV test** in 2009 in the region.

Only **one in three pregnant women living with HIV** received some form of anti-retroviral prophylaxis in order to prevent PTCT.

Only **one in three children** exposed to HIV in the region received any anti-retroviral prophylaxis in order to prevent PTCT.

**Less than 10% of the countries in the region implement Early Infant Diagnosis** and coverage varies from 86% in some countries to as low as 10% in some.

Antenatal **syphilis screening practices vary** across the region. Only a few countries in the region routinely conduct syphilis testing.

KEY AFFECTED POPULATIONS OF WOMEN AND GIRLS

A growing proportion of women are infected through sex with their spouse or intimate male partner and violence in intimate relationships is now recognized as a risk factor.

Women now constitute **30-40% of HIV infections** in India, Myanmar and other countries in the region.

MATERNAL, NEONATAL AND CHILD HEALTH IN THE REGION

Maternal mortality ratio: 190 per 100,000 live births in 2008, with significant variations among countries in the region, ranging from 41 in East Asia to 280 in South Asia

71% of pregnant women attended ANC at least once in 2008, but only 58% of women have an institutional delivery. There are significant variations among countries.

Infant mortality ratio (probability of an infant dying between birth and one year of age) stands much higher at 39 per 1000 live births in the region, with figures ranging from 21 deaths per 1000 live births in East Asia to 55 per 1000 live births in South Asia.
The AP UN PPTCT conceptual framework builds on existing comprehensive approaches and commitments articulated by the international development community.

A: UN Comprehensive approach to PPTCT: Countries can achieve dramatic reductions in new paediatric infections through a comprehensive approach to prevention and treatment, that has four key prongs:

- Prong 1: Primary prevention of HIV among women of childbearing age
- Prong 2: Prevention of unintended pregnancies among women living with HIV
- Prong 3: Prevention of HIV transmission from a woman living with HIV to her child
- Prong 4: Providing appropriate treatment, care and support to women living with HIV and their children and families.

B: The WHO Global Strategy for the Elimination of Congenital Syphilis (ECS): The strategy outlines how syphilis transmission from mother to child can be prevented through strengthened antenatal care (ANC) systems. This strategy has four key elements:

- Ensure advocacy and sustained political commitment
- Increase access to and quality of maternal and newborn health services
- Screen and treat pregnant women and partners
- Establish surveillance, monitoring and evaluation systems to track progress

Why now? ...Global initiatives that make an elimination agenda timely
C: Millennium Development Goals (MDGs): The MDGs adopted by the UN General Assembly in 2000 committed the international community to reduce child mortality (MDG 4), improve maternal health (MDG 5) and combat HIV/AIDS, malaria and other diseases (MDG 6) by 2015. The targets:

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<thead>
<tr>
<th>Millennium Development Goals</th>
<th>Targets</th>
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<tbody>
<tr>
<td>MDG 4: Reduce Child Mortality</td>
<td>4.A: Reduce the under five mortality rate by two-thirds between 1990 and 2015</td>
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<td></td>
<td>5.B: Achieve by 2015 universal access to reproductive health</td>
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<tr>
<td>MDG 6: Combat HIV/AIDS, Malaria and other Diseases</td>
<td>6.A: Have halted, by 2015 and begun to reverse the spread of HIV/AIDS</td>
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To make the MDGs a reality several global initiatives are focused on improving maternal and child health. They include the Partnership for Maternal Neonatal and Child Health (PMNCH) launched in 2005, the Health 4 Initiative – a multiagency effort to support countries to achieve the goals which recommended in 2010 that HIV and STI services should be integrated and the UN Secretary General’s Global Strategy for Women and Children’s Health released in 2010 that also endorses the delivery of a comprehensive integrated package of essential services including family planning, ante-natal care, skilled attendance at birth and prevention of HIV/STIs.
Briefs
aimed at four key audiences

✓ What is the role of the policy maker? Setting national targets to eliminate new paediatric HIV and congenital syphilis by 2015

✓ What is the role of the programme implementer? Translating policy into action by implementing comprehensive programmes that integrate HIV, STI and MNCH services

✓ What can the media do? Telling the stories behind elimination to mobilize various actors

✓ Yes your voice counts! What can networks of PLHIV and the community of people seeking maternal and child health services do in order to aid elimination?
What is the role of the policy maker? Setting national targets to eliminate new paediatric HIV and congenital syphilis by 2015

**AUDIENCE:** Policy makers at regional, national and sub-national levels working in Ministries of Health, Family Welfare, Women and Child Development, National AIDS Agencies, National Planning bodies and others

**BACKGROUND: WHY IS IT IMPORTANT TO AIM FOR ELIMINATION?**

Prevention strategies for HIV and syphilis among newborns are similar and can be easily adapted to fit national maternal, newborn and child health platforms. Efforts to prevent new paediatric HIV and CS rely on the successful implementation of maternal, neonatal and child health (MNCH) services. Therefore attention to national MNCH coverage and practices is essential to achieving PPTCT and ECS targets. On the other hand, a focus on PPTCT and ECS has the potential to improve national maternal, neonatal and child health related practices and figures. Commitments from the national policy making structures is essential to improve coverage and ensure equitable access to a wide range of service seekers. The existing global climate in terms of commitments and initiatives both towards improving maternal and child health and reduce HIV prevalence makes it imperative for countries to set ambitious targets and strive towards the dual elimination goals. The scale-up of PPTCT interventions in recent years in the Asia Pacific region has led to a significant drop in new HIV infections among children and makes the region a potential to be the first to reach elimination targets. Every nation counts, every mother counts and every child counts.

**HOW DO INVESTMENTS IN PPTCT AND ECS FOSTER PROGRESS TOWARDS THE MDGs?**

The Millennium Development Goals (MDGs) are inextricably linked and advances in one leads to progress in other goals. A lower burden of HIV/AIDS can contribute to greater progress in maternal and child mortality indicators and positively impact broader development goals.

Reducing HIV infections among parents and children contributes to the development agenda. Parents are able to live healthy and productive lives, leading to a decrease in household vulnerability to poverty and enabling children to live to their full potential, receive education and thrive in a safe environment when they are not ill or orphaned by HIV.
**Millennium Development Goals Contributions of investing in PPTCT*/ECS**

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<tr>
<th>Millennium Development Goals</th>
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| MDG 3: Promote gender equality and empower women | ✓ Reduces women and girls vulnerability and risk of exposure to HIV, syphilis and other STIs  
✓ Enables women to remain economically productive or have access to education  
✓ Reduces women’s burden of becoming care givers for HIV + family members  
✓ Lessens burden and social stigma on women by including males  
✓ Provides access and service coverage to marginalized and vulnerable women and girls, particularly key affected populations |
| MDG 4: Reduce child mortality | ✓ Reduces infant and child morbidity and mortality  
✓ Reduces incidence of low birth weight and improves nutrition  
✓ Enables children to live healthier lives and access education opportunities  
✓ Frees children of paediatric HIV and congenital syphilis |
| MDG 5: Improve Maternal Health | ✓ Improves the health and well-being of women  
✓ Lowers maternal death, stillbirths and spontaneous abortions  
✓ Prevents women and young girls from infection  
✓ Enables making informed reproductive choices  
✓ Improves MNCH/SRH/STI systems |
| MDG 6 Combat HIV/AIDS, Malaria and other diseases | ✓ Reduces HIV and syphilis infection in parents through primary prevention  
✓ Eliminates paediatric HIV and congenital syphilis  
✓ Reduces opportunistic infections such as TB, a leading cause of HIV related death |

**KEY ACTION POINTS FOR POLICY MAKERS TO OPERATIONALISE THE CONCEPTUAL FRAMEWORK**

What can you, the policy maker at regional, national or sub-national level do to make the elimination goal a reality?

**Show leadership** in committing to the elimination agenda.
- Develop targets appropriate for national and sub-national levels through the collection of current evidence and the development of a baseline.
- Define funding requirements
- Develop a timeline and an operational plan

**Show leadership** in articulating an ambitious national/sub-national integration agenda by developing a comprehensive, integrated, people-centred package of MNCH services that routinely include PPTCT and ECS interventions.
- Define the components of a comprehensive package of integrated SRH, MNCH, PPTCT and ECS services at every level of the public health system in-country.
- Ascertains key areas of synergy between various programmes and the key barriers.
- Support coordination between various actors within the health system involved in delivering HIV/STI, SRH and MNCH services.

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1 Adapted from Achieving the MDGs: Why the AIDS response counts http://www.unaids.org/en/resources/presscentre/featurestories/2008/september/20080924achievingmdg/
**Improve systems** for better tracking and monitoring of programme implementation.

**Ensure communication** of the integration agenda to all levels within the health sector. Efforts should include training and information/communication activities.

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**Impetus provided by a conducive policy environment in Karnataka, India: A sub-national success story**

An initiative was undertaken to integrate HIV and RCH services in 2008 in Karnataka, a high prevalence state in India. The initiative included universal coverage of HIV counseling and testing in all antenatal clinics, integrating with existing systems of institutional deliveries, early initiation into ART/ARVs for pregnant women and tracking and addressing HIV infection in children. The strategy included public private partnerships, the involvement of multiple stakeholders (coordination between the Karnataka Department of Health and Family Welfare and the State AIDS Prevention Society), leveraging existing cashless delivery services available in the public health system and the optimal use of existing resources such as the Yeshaswini scheme, whereby a fixed amount is given to a hospital for a delivery as part of the public health system. The initiative saw the uptake of HIV testing increasing from 242,021 pregnant women tested in 2007-2008 (before the implementation of this programme) to 9,40,310 cases in 2012. Approximately 9500 auxiliary nurse maids and 2000 medical officers in the state form the backbone of the programme.

**What worked:**

- Process was entirely owned and managed by the state government of Karnataka, who developed a detailed plan and enumerated clear roles and responsibilities for various actors.
- PPTCT was positioned as an essential component of the MNCH programme.
- A sustainable model that used existing human resources, without adding new staff.
- A horizontal programme that promoted joint ownership of the programme rather than vertical programme.
- A system of awarding high performing districts, hospitals and medical officers created an ownership impetus.
- Good monitoring of both systems as well as performance.

“Making HIV services as an integral part of the RCH programme, particularly in rural areas has increased the participation of the community in accessing the HIV prevention and care services. The response and the accessibility of community to the voluntary counseling and testing, prevention of mother to child transmission, and ART treatment services demonstrate the community’s satisfaction.”

Dr. E.A.V. Ramanna Reddy, IAS, Secretary to Government of India, Department of Health and Family Welfare

Promote health systems development and create platforms for networks of PLHIV and the community to be involved. Encourage stock-taking exercise in partnership with civil society actors and PLHIV/WLHA community.

A national success story: Almost 100% pregnant women receive an HIV test in Thailand

Thailand has an impressive national PPTCT programme, boasting over 90 per cent coverage. Building on pilots from the mid 1990s, a national policy on PPTCT was developed in Thailand in 2000. This resulted in a rapid decline in the PTCT rate, based on the provision of increasingly effective regimens and a policy of no breastfeeding for HIV-infected mothers. In 2009 of the 800,000 pregnant women 99.7 per cent received an HIV test, of those who tested positive 93.5 per cent received ARV and 99.6 per cent of the children born to these women received ARV. The focus of the national response has been on counseling and systems strengthening.

Key lessons from Thailand include strong national management, integration with maternal and child health (MCH) services, strong success both in providing more effective regimens and reducing the number of HIV-infected pregnant women. The challenge is in reaching the hardest-to-reach women who do not access antenatal care (ANC) or do so very late in pregnancy. Thailand revised and updated its PPTCT guidelines in October 2010, based on “Option B” (highly active antiretroviral therapy [HAART] prophylaxis or treatment for all) and aims to scale up the adoption of the revised guidelines nationally. Targets for 2011 included an HIV prevalence of 0.65 per cent among pregnant women and a 3.5 per cent national MTCT rate.


USEFUL LINKS

- WHO Global Strategy for the Elimination of Congenital Syphilis
  (http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf)


- The conceptual framework to Eliminate CS and new paediatric HIV infections
  (http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf)

- AP UN PPTCT TF Website: http://www.eptctasiapacific.org/: For country specific data fact sheets and key targets
Why is it important to aim for elimination?

The availability of more efficacious drug regimens for HIV and rapid testing for syphilis provides an unprecedented global health opportunity to achieve the elimination goals. With the scale-up of PPTCT interventions in the region, there has been a significant drop in new HIV infections among children in the Asia Pacific. Available knowledge and practices can be leveraged so that the region becomes the first to eliminate paediatric HIV and congenital syphilis by 2015.

There has been a renewed commitment and endorsement to meet the elimination goal by 2015, that comes in the footsteps of the UNAIDS call for the virtual elimination of mother to child transmission (MTCT) of HIV in 2009. In 2010, the Asia Pacific UN PPTCT Task Force, with the endorsement of over 150 delegates from 20 countries, adopted the goal of eliminating all new paediatric HIV and CS infections in the region by 2015. This bold declaration strives to garner support and build momentum towards meeting the dual elimination goals and contributing to the UNAIDS zero vision, Universal Access goals and the MDGs that target maternal, infant/child health and HIV goals.

The AP UN PPTCT elimination targets build upon the UN comprehensive approach to PPTCT and the WHO global strategy to eliminate congenital syphilis that recommends that by 2015 at least 90% of pregnant women be screened for syphilis and that at least 90% of pregnant women with syphilis receive adequate treatment.
The Eight Programmatic Targets Correlate to the Four Prongs of the Comprehensive Approach to PPTCT

### Before Pregnancy
- **TARGET 1:** 50% reduction in HIV incidence in women of childbearing age
- **PRONG 1:** Prevent new HIV infections in women of childbearing age

### Pregnancy
- **TARGET 2:** ZERO unmet need for FP among women with HIV
- **PRONG 2:** Prevent unintended pregnancies in women with HIV

### Birth
- **TARGET 3:** ≥90% Pregnant women access ANC and skilled care at birth
- **TARGET 4:** ≥90% Pregnant women know HIV and syphilis status
- **PRONG 3:** Prevent vertical transmission of HIV and syphilis

### Infancy, Childhood
- **TARGET 5:** ≥90% HIV + mothers and exposed infants receive ARVs for PPCTC
- **TARGET 6:** ≥90% syphilis sero-positive mothers and infants receive treatment
- **TARGET 7:** ≥90% eligible HIV + pregnant women remain on ART for 12 months post-partum
- **TARGET 8:** ≥90% HIV-infected children (0-4 years) receive ART
- **PRONG 4:** Provide care and treatment to women and children with HIV

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**Childbearing Women**
**Women Living with HIV**
**Pregnant Women with HIV**
**Mothers and Children with HIV**
KEY ACTION POINTS FOR PROGRAMME IMPLEMENTERS TO OPERATIONALISE THE CONCEPTUAL FRAMEWORK

Each of the eight programmatic targets correlates to one of the four prongs of the comprehensive approach to PPTCT. These targets address the key issues along the entire spectrum of sexual and reproductive health, HIV and STI related services that a woman might access. The targets give entry points to operationalise the framework.

Design programmes that prioritise integration and that offer the entire spectrum of services from family planning, screening for HIV and STIs at ante-natal clinics, follow-up with women who test positive for either infection, treatment for women who test positive, proper care through the pregnancy, skilled attendance at birth, proper follow-up, both clinical and counseling, with women and children to reduce the incidence of HIV and CS.

Priority Actions to Employ Highly Effective Interventions for HIV/STI Prevention and Treatment

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<tr>
<th>Comprehensive Approach to PMTCT and ECS</th>
<th>Priority Actions</th>
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| Prong 1: Primary prevention of HIV and syphilis among women of childbearing age | • Integrate HIV and STI prevention for women of reproductive age in any setting where women and their male partners access ANC services  
• Strengthen HIV primary prevention services for male and female KAPs and enhance HIV counseling and testing for female partners of male KAPs  
• Ensure that PPTCT and STI counseling is part of harm reduction interventions for women in key at risk populations, including PWIDs and SWs  
• Prioritise male involvement in the primary prevention of HIV among women, particularly in the prevention of Intimate Partner Transmission.  
• Integrate PPTCT and SRH counseling for men and women in any setting where HIV testing and counseling is provided |
| Prong 2: Prevention of unintended pregnancies among women living with HIV | • Standardise the delivery of routine FP services for women attending services in HIV care settings  
• Enhance male involvement in routine SRH and MNCH services |
| Prong 3: Prevention of HIV or syphilis transmission from a pregnant woman to her infant | • Prioritise expansion of routine HIV and syphilis testing in all ANC settings  
• Implement and expand usage of highly efficacious combination ARV regimens and ART for women who need treatment  
• Promote safe infant feeding practices and support adherence to ARV prophylaxis during breastfeeding  
• Expand use of same day testing (RPR or rapid) and treatment (STAT) for syphilis in ANC settings. |
| Prong 4: Provision of appropriate treatment and care to mothers living with HIV and their children | • Early CD4 assessment for treatment eligibility and prompt linkage to ART for women who require it for their own health  
• Early HIV diagnosis and co-trimoxazole in exposed infants and linkage to early ART for HIV – positive infants |
Communicate key programme advances to programme implementers and service providers on a regular basis to create a community of learning and practice.

Ensuring that services are gender-sensitive, in reaching a wide spectrum of people with varied gendered identities as well as involve men more squarely in MNCH programmes.

Involve the community of health service seekers as well as networks of PLHIV in design and delivery of programmes.

An innovative example of integration from PNG

Mingende is a little town in the Kerowagi district of Simbu province, Papua New Guinea. The St Joseph Rural Hospital, also known as the Mingende Rural Hospital (MRH) is run by a dedicated team that works tirelessly to enhance the quality of lives of the people they serve. In 2003 MRH started work on HIV and AIDS and PPTCT was a major component of the programme. PPTCT was also seen as an entry point to strengthen MCH services. In 2012, with a programme that combines strengthened ante-natal services that are integrated with PPTCT, the hospital has witnessed 41 success stories. Since 2009 all 25 mothers who participated in the PPTCT programme have delivered HIV negative babies. This proves that proper implementation of PPTCT services at ANC centres can lead to impressive results and are worth scaling up.

What worked in Mingende:
1. Strong leadership
2. The PPTCT programme was used to strengthen the MCH programme and integration efforts were comprehensive
3. Good record keeping practices resulted in proper follow-up with women who were pregnant
4. The involvement of PLHIV garnered support from the community and allowed access to HIV positive mothers.
5. Clear roles and responsibilities were charted out for various team members
6. Strong linkages with support services such as rural health centres and aid posts reduced loss of mothers to follow up
7. Satisfaction with hospital management and a high morale among staff members translated into high quality care for patients visiting the various clinics

The CS elimination drive in Sri Lanka: An example of integration that works

Sri Lanka has been a pioneer in the south Asia region in preventing congenital syphilis. It has had a national STD control programme since 1952 which later became the National STD AIDS Control Programme (NSACP). From the very inception the programme has focused on preventing and controlling venereal diseases, with services such as serological testing for syphilis for expectant mothers to prevent congenital syphilis.

Antenatal venereal diseases screening for pregnant women has been offered routinely since early 1950s, with the majority of the testing being done in the public health care system. A highly effective system has been put in place through strong integration measures between various government departments. Both maternal and child health services and the NSACP come under the Deputy Director General of Public Health Services (DDG PHS). At the national level the Family Health Bureau (FHB) which is responsible for maternal and child health, has played an active role in initiating multiple programmes in partnership with NSACP. The links are obvious even at the primary health care level and the district STD clinic where the provincial team consists of a medical officer for maternal and child health and a medical officer for the STD clinic. The commitment to elimination is further demonstrated through the emphasis in training programmes on routine antenatal screening.

The pregnant women who test positive for venereal diseases are treated in STD clinics with confirmatory testing followed by comprehensive care for both mother and child. An obstetrician in a tertiary care unit is involved in the process. The newborn babies are given prophylactic Benzathin penicillin just after delivery and follow-up arranged in consultation with paediatricians. The smooth functioning of the programme depends on the involvement of several stakeholders. While MCH staff are responsible for collecting blood samples, the STD clinic provides testing facilities treatment and follow-up for mothers with syphilis. Continuing advocacy among key players including authorities is also an essential component in the programme.

In the course of the last two decades the annual number of new cases of infectious Syphilis cases has decreased markedly. After 1986 the incidence has remained low and reached the lowest in 1998 and since then has remained static. In Sri Lanka the rate of congenital syphilis is around 0.03 per 1000 births which is much lower than the global and regional target for elimination (5 per 1000 births).

Advocate with governments at national and sub-national levels to support the integration agenda.

USEFUL LINKS

- The conceptual framework to Eliminate CS and new paediatric HIV infections (http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf)
- For country specific data fact sheets and key targets, a short video about the elimination framework and other resources.
  - AP UN PPTCT TF Website: http://www.uptctasiapacific.org
  - WHO Global Strategy for the Elimination of Congenital Syphilis (http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf)
- For country specific fact sheets and data
  - http://www.aidsdatahub.org/
- For regional epidemiology and strategic guidelines from UNAIDS
- For links to costing tools
  - http://www.uptctasiapacific.org/funding-resource-needs
AUDIENCE: The print and electronic media in the Asia Pacific region

BACKGROUND: The Asia Pacific region is home to several new HIV and syphilis infections among newborns every year. In 2009, 22,000 children were newly infected with HIV, over 90% of these were due to transmission from parent to child. Half of these children would not have lived to see their second birthday, because of lack of treatment to both mothers and newborns during pregnancy and childbirth. 60,000 pregnant women in the region are affected by syphilis and without proper treatment, three out of four of these women can experience negative outcomes including newborn infection (congenital syphilis), stillbirth and neonatal death. These tragic outcomes can be avoided. Existing knowledge regarding prevention and commitments at international decision-making forums provide the right atmosphere to entirely prevent these deaths. The MDGs clearly articulate goals to bring down both maternal and infant mortality ratios. The good news is that most countries in the region have maternal and child health programmes/infrastructure that can integrate services so that new paediatric HIV infections and congenital syphilis are prevented. This is possible if commitments are made at the national policy level in countries in the region and programmes are designed to make the policies a reality. The media has a key role to play in this process. With coordinated action it is possible to eliminate CS and new paediatric HIV by 2015.

RENEWED ATTENTION TO ELIMINATION FROM THE AP UN PPTCT TASK FORCE

The Asia Pacific UN PPTCT Task Force is a regional technical forum comprising representatives from various international agencies, national level policy makers and programme managers, PPTCT technical experts and regional networks. The Task Force advocates for and supports national leadership and actions to eliminate new HIV infections in children and congenital syphilis. The task force consists of UNAIDS, UNICEF, UNFPA and WHO and international partners such as the National Centre for Global Health and Medicine, Japan (NCGM); Family Health International (FHI); International Planned Parenthood Federation (IPPF); and the Asia Pacific Network of Positive People (APN+) among others.
KEY ACTION POINTS FOR THE MEDIA TO CREATE AN ENABLING ENVIRONMENT

Here are a few pointers for the media to galvanize public opinion and share knowledge.

**Presenting key national and regional data pictures** that show national level prevalence data on new paediatric infections, prevalence of congenital syphilis, the targets that need to be reached to meet the MDGs as well as the goals articulated by the WHO Global Strategy for the Elimination of Congenital Syphilis and the UN comprehensive approach to prevent parent to child transmission of HIV (see key messages folder in this toolkit).

In partnership with national and regional partners such as UNICEF country and regional offices, the WHO regional offices and national governments information can be presented in the media. Examples could be:

- A serialised country data snapshot – one country featured every week.

- Opinion pieces by key influential policy makers or public health practitioners with a large credibility base.

**Creating a forum for the community of health seekers** and networks of people living with HIV to voice their opinions and demand integrated services.

**Highlighting innovations and success stories** from countries in the region to demonstrate to policy makers that elimination is possible. This could be presented as feature stories/short features in the electronic media.
Pakistan explores a different pathway to identify at-risk women and children

In 2010 the National PPTCT programme in Pakistan, with the support of UNICEF, began to pilot a district model approach. This model seeks to identify families at risk of or affected by HIV in high-prevalence districts and provide comprehensive counseling, treatment and care services. As part of the initiative district level hospital staff were trained to identify suspected HIV positive cases and refer them for VCT and PPTCT services. A team of trained lady health workers (LHW) identified women at risk using various parameters (history of blood transfusions in self or spouse, a spouse working abroad or a spouse who is an IDU). Women meeting the risk criteria were referred either directly to NGOs, treatment and care centres or “Family Health Days” (FHDs) at the rural health centre (RHC) level in each district where women were given nutritional supplements and offered VCT and PPTCT services. Children were also tested if considered at risk and offered paediatric AIDS care if HIV positive and families affected by HIV were provided community home based care (CHBC) and integrated support services.

This approach has now been piloted in two high-risk districts with a high concentration of HIV positive people, mostly male returning migrant workers. Results show that this approach has been more effective at identifying women at risk than through integrating PPTCT services at tertiary ANC centres. Based on demonstrated results the district model was scaled up to eight high risk districts in 2012 including those with sizeable number of IDUs, returning migrant workers and people involved with multiple concurrent sexual partners. Since 2010 trainings on HIV/PPTCT have been held in hospitals in both districts with seven orientation sessions covering 175 LHWs and several hundreds of women, men and children at risk have been screened.

Community based strategies:  
• Outreach cadres to identify at-risk in target districts

Target group based strategies  
• Migrant workers  
• Prisoners  
• NGOs w/high risk populations

Facility based strategies:  
• Paeds, TB, urology, dermatology (STIs)

Identification of HIV positive women or women at risk, men  

Integration into regular MNCH Activities  

General Prevention for women  

DHQ Capacity Building  

District Model  

Care and support for HIV positive families  

Paediatric AIDS Treatment  

Support scale-up through capacity building and systems development  

• Support decentralising components of family centred HIV Service delivery (PPTCT, paediatric AIDS and treatment care and support)  
• Support establishment of CoC with CHBC
“I am on the PPTCT programme to protect my child from HIV infection”

A 28 year-old mother, pregnant with her third child at the Mingende Rural Hospital, Papua New Guinea.

Mingende is a little town in the Kerowagi district of Simbu province, Papua New Guinea. The St Joseph Rural Hospital, also known as the Mingende Rural Hospital [MRH] is run by a dedicated team that works tirelessly to enhance the quality of lives of the people they serve. In 2003 MRH started work on HIV and AIDS and PPTCT was a major component of the programme. PPTCT was also seen as an entry point to strengthen MCH services. Since 2009 all 25 mothers who participated in the PPTCT programme have delivered HIV negative babies. This proves that proper implementation of PPTCT services at ANC centres can lead to impressive results and are worth scaling up.

This is the story of a 28 year old mother....

The first time she came to Mingende was in 2009 when her second child got sick with TB. She and her child both tested positive. When she became pregnant again in early 2010, she came to the hospital as instructed by the nurses, and was immediately started on the PPTCT programme. “It is a terrible experience bringing up a child with HIV,” she says with great sadness, “I have to be there with the baby all the time to ensure he gets his drugs.”

Now that she knows about the PPTCT programme, having heard about it during one-on-one counseling sessions when she tested positive, she is here to protect her third child from being infected. She has seen the care that other mothers have received and has heard about the hospital’s success stories. She is taking antiretroviral drugs (ARVs) and is confident that her baby will be safe. She has seen it happen here; it is not a miracle, it is sheer discipline, and all about adhering to a prescribed regimen.


USEFUL LINKS

- The conceptual framework to Eliminate CS and new paediatric HIV infections (http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf)
- For country specific data fact sheets and key targets, a short video about the elimination framework and other resources.
  AP UN PPTCT TF Website: http://www.eptctasiapacific.org
- WHO Global Strategy for the Elimination of Congenital Syphilis (http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf)
- For country specific fact sheets and data
  http://www.aidsdatahub.org/
- For regional epidemiology and strategic guidelines from UNAIDS
Yes your voice counts! ...What can networks of PLHIV and the community of people seeking maternal and child health services do in order to aid elimination?

AUDIENCE: Networks of people living with HIV, members of self-help collectives and other platforms used by women at the community level to seek information and services.

WHY IS THERE A FOCUS ON ELIMINATION?

“Inside every mother lives a dream that her child will be born healthy. Inside every mother breathes a hope that her child will live a better life than hers. Deep in her heart are embedded fears and anxieties for her baby. And should the mother test HIV-positive, her worries know no bounds”

The Asia Pacific United Nations PPTCT Task Force has put a spotlight on eliminating new paediatric HIV and congenital syphilis in the region. HIV can be passed on from parent to child during pregnancy and childbirth. Similarly syphilis, a sexually transmitted infection – if present in a mother can be passed on from mother to child if not identified and treated. The task force has prepared a conceptual framework that spells out key targets for the region so that both new paediatric HIV infections and congenital syphilis can both be eliminated by 2015. This framework builds upon existing commitments made on international platforms towards maternal and child health and HIV and AIDS.

The actors at national, regional or global levels involved in public health service delivery know what needs to be done to make this dream a reality. The knowledge exists, yet what is holding countries back? The uptake of services such as ante-natal check-ups, routine testing for STIs, skilled attendance at birth remains variable across countries in the Asia Pacific region. Some countries fare better than others. Some countries in the region have better health services that have the potential to reach all tiers of the population, some others are far behind. Barriers such as access to services, knowledge regarding standard good practice, wide-spread stigma specially in the context of HIV make it very challenging for women to utilize existing services. Yet enough is known about what a comprehensive package of maternal and child health services (including PPTCT) should look like. Further there are multiple examples from across the region that give us innovative models of service that can be replicated and learnt from so that more women, children and families are able to access services. As a key voice of the community you represent, you are in a unique position to use the framework to demand better services so that countries can inch closer to elimination targets.

KEY ACTION POINTS FOR MEMBERS OF THE COMMUNITY SO THAT TARGETS SPELT OUT IN THE CONCEPTUAL FRAMEWORK ARE ACHIEVED

Information is power: The key messages folder in this toolkit familiarizes you with the key elements of the framework as well as the key evidence from the region. The AP UN PPTCT website...
gives country specific information and data. You can leverage this information as a community member either in your own country or as a representative of any networks you represent on regional and global platforms.

**Demand commitments from policy makers** and programme implementers so that national programmes consider integration of services and programme implementers design programmes that maximize the potential for integration of HIV/STI and maternal and child health services.

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**Involving injecting drug users to identify families at risk and providing a continuum of care in Pakistan**

In 2008 Nai Zindagi (Pakistan’s largest HIV prevention programme for street based injecting drug users) piloted an initiative (with the support of the Swiss Development Corporation) aimed at providing HIV prevention, diagnostics, treatment, care and support services to people injecting drugs, their wives and children in Lahore. It is a unique initiative as it uses the entry point of a drug user to identify families at risk and provides comprehensive care to the whole family. A package of services was developed to provide HIV prevention services targeted at married couples where at least one partner was using drugs. This was developed based on needs assessments and NZ’s extensive experience of working with people using drugs. All couples and children registered with the NZ/SDC project had access to these essential services.

Two packages of services were developed with the following criteria:

**PACKAGE I:** An HIV prevention package of services for all married persons injecting drugs, their wives and children.

**PACKAGE II:** A specialized package of services in addition to Package I for married persons injecting drugs, their wives and children where at least one or more were HIV positive.

Package I in particular aimed to address the HIV, STI and SRH service needs of the whole family through integrated services.

In all 549 families of people injecting drugs benefitted from the services offered during the project period. Following the success of this intervention model, Nai Zindagi is now scaling up this initiative in several districts of Pakistan with support from the Global Fund.

*Source: Final technical report: HIV prevention, HIV and AIDS diagnostics, treatment, care and support services for married injecting drug users, their wives and children. Nai Zindagi. 2008*
Make community members aware of their rights and equip them to demand better services. As a key member of your community/network you are in a unique position to take information to people/women/families who are likely to need and use services.

Saving lives in Battambang, Cambodia through early infant diagnosis of HIV

Van Kunthea*, who is 2 years old, is HIV positive. A few years ago, many HIV positive children like Kunthea didn’t live to see their second birthday. Fortunately, Kunthea was diagnosed within the first six weeks of being born and ever since she has been taking anti-retroviral drugs which prevent the HIV virus from destroying her immune system. Kunthea is healthy and has no symptoms of HIV, and her mother Sao Rasy*, takes her to Battambang Referral Hospital every month for a check-up and a supply of medication. Kunthea is one of about 375 children with HIV who are receiving antiretroviral treatment free of charge at the hospital in Battambang province, seven hours away from Cambodia’s capital, Phnom Penh. With UNICEF support, the hospital ensures that babies born to HIV positive mothers are tested for the disease immediately after birth so that those who need it receive life-saving treatment as early as possible.

Dry Blood Spot testing

The test involves obtaining a spot of blood from the newborn’s heel and applying it to specially manufactured absorbent filter paper. After being air-dried it is sent to the laboratory where an early infant diagnostic test - also known as a Polymerase Chain Reaction (PCR) test – can detect the DNA or genetic material of HIV. The test has several major benefits: samples do not require refrigeration, the test is not invasive, and it does not produce a false positive result. This test has saved many lives, says Doctor Chea Pov, who is in charge of the paediatric ward at the hospital. “Before 2008, the HIV test that could be given at 6 weeks of life was very expensive. We didn’t have the money to pay for it, so we had to use the [HIV rapid antibody] test at 18 months which was cheap,” he said. “[But] by then, most of the HIV positive children had died, or they had become really sick as the disease spread.” Studies show that without life-saving drugs, 30 per cent of HIV positive children die before they turn 1, while 50 per cent do not live to see their second birthday. In view of this, early diagnosis of infants’ HIV status is critical to their survival.

*Names changed to protect identities.
You can be an inspiration. If you have a story to tell that you are comfortable sharing and that others will find useful then use whatever platforms are available to you to share your story. If you are comfortable talking to the media please use available platforms as even one story has the power to change.

Community members take the lead: An Innovation in Accham in Nepal

In 2005, the government of Nepal initiated PMTCT services in hospital settings. However, the most disadvantaged pregnant women living in remote areas could not reach these hospitals, given the harsh terrain in a country dominated by mountains. UNICEF supported the government to implement a decentralized, community based PMTCT service model that had integrated maternal and child health components too. This model has been implemented in one of the highest HIV burden districts of Nepal in collaboration with FHI and community based organizations led by women living with HIV. The service is provided through government health facilities and an intricate web of service providers give information and referral services to pregnant women. This model has ensured equitable access to services to a wide range of health service seekers and it has contributed to the national achievement of MDG targets. The model has been replicated in two other districts. The PMTCT service utilization in these three districts is much higher than the national average. While the ante-natal service access figures have shown improvement, the HIV testing and counseling services have shown a huge improvement – from 8% in 2008 to 40% in 2011 and infant ARV coverage went up from 57% in 2008 to 85% in 2011. The success of this model lies in the fact that it combines state of the art services with an outreach model that engages community members in the heart of the programme.

Bishnu and Nanda are a couple living in Achham. Nanda is a migrant worker who returned home. Bishnu was convinced by a Female Community Health Volunteer to use ante-natal care and HIV testing and counseling services in the 12th week of her pregnancy. The couple tested positive. While the couple was shattered by the news they agreed to go to the district hospital, a two-day journey way, and received further counseling: the importance of an institutional delivery and treatment both during the pregnancy and during child birth. Here they received care and treatment and Bishnu delivered a baby. After the both they were referred to a community based home care team who followed up on treatment regimens and counseling. The child tested negative at two months. Their experience has motivated the couple to disclose their HIV status and counsel other couples of attend ANC and PPTCT services.

Source: Unicef Nepal Country office

USEFUL LINKS

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- For country specific data fact sheets and key targets, a short video about the elimination framework and other resources.
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- WHO Global Strategy for the Elimination of Congenital Syphilis (http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf)
- http://www.aidsdatahub.org/: For country specific fact sheets and data.