This technical guidance intends to provide practical guidance to consultants and country teams working on the development of Global Fund proposals on how to ensure integration of the PMTCT sub-component into the AIDS component of the applications.

The guidance provides overview of the core information on PMTCT programming and the process of the proposal development, as well as the key messages and concrete examples for various technical areas that the country teams will find helpful in elaborating details of the Service Delivery Area.

Table of Contents

A. Introduction and development of the proposal
B. Analysis of the Current Situation and the National Response to MTCT
C. Formulating the PMTCT SDA section within the country application
   C1. Rationale for including PMTCT in the proposal – key messages
   C2. Addressing PMTC issues while describing the national prevention, treatment, care and support strategies
   C3. Linking PMTCT to the proposal objective
   C4. Setting SMART targets for the PMTCT response
   C5. Defining implementation strategies - Decentralized approach to implementation
   C6. Main activities to be considered
   C7. Key programme interventions
   C8. Key indicators
   C9. How gender, human rights and equity issues should be addressed in implementing this SDA
D. Health system strengthening in the context of PMTCT
   D1. Improving basic maternal, newborn and child health care
   D2. Improving laboratory capacity
   D3. Innovative approaches to addressing health financing issues and human resource constraints
   D4. Strengthening procurement and supply chain management systems
   D5. Monitoring and evaluation, quality assurance and operational research
E. Costing the activities
F. Key implementing partners to be considered
G. Types and sources of technical assistance which might be required during implementation
A. Introduction

Most countries have programmes to prevent mother-to-child transmission (MTCT) of HIV and are scaling-up their programmes to provide comprehensive prevention, care and support to women, their children and their families. WHO recently revised its guidelines on the use of antiretroviral drugs (ARVs) to prevent MTCT and on HIV and infant feeding. The revised recommendations propose earlier initiation of ART for larger group of HIV-infected pregnant women to benefit both the health of the mother and maximally reduce HIV transmission to her child. In addition, they recommend provision of one of two highly effective ARV prophylaxis options earlier in pregnancy for HIV-infected pregnant women who do not need ART for their own health. Particular emphasis is given to provision of ARV prophylaxis to the mother or the child to reduce the risk of HIV transmission during the breastfeeding period.

In the context of the development of the proposal, countries need to define the status of implementation of the PMTCT programme, and identify financial and implementation gaps. This will ensure additionality and complementarity of the potential resources from GFATM to the various in-country initiatives and funding opportunities from the national government and partners.

The national PMTCT technical working group should brings together Sexual and Reproductive Health (SRH), Maternal, Newborn and Child Health (MNCH), national HIV and Nutrition programme managers as well as the civil society, NGOs, persons living with HIV and key donors and implementing partners. A sub-set of this group should be tasked full-time with developing the health sector strengthening (HSS) component to be included in the general proposal. The PMTCT technical working (TWG) should work as a subgroup of the larger team in charge of developing the HIV/AIDS proposal.

The work of the TWG as a consultative and inclusive process is very useful in conducting the situation and response analysis. Before starting the development of the proposal, it is essential to review the comments of the technical review panel (TRP) on the previous proposals. This will help to identify and analyse the weaknesses of the previous proposal and to properly address the issues raised in the current proposal.

B. Analysis of the Current Situation and the National Response to MTCT

It is important to identify key programmatic issues related to PMTCT that may need to be addressed in the proposal:

This situation analysis is a critical step in the development of the GFATM proposal. The main objectives of the analysis are:

- To define the magnitude of the HIV epidemic among women and children and the status of implementation of the PMTCT programme at policy, normative and service delivery levels
- To inform the specific programme strategy for the proposal
- To map out partners supporting the national programme and their specific contributions
- To identify policy, programmatic and funding gaps
- To identify health system bottlenecks on PMTCT and other related programme performance
- To identify gender, equity and rights issues as impediments for scaling-up PMTCT
- To identify the level of performance and technical issues related to the implementation of previous GFATM grants
- To identify and analyse reasons for failure of previous GFATM proposals
The following should be considered in the situation and response analysis

### B1. Baseline demographic and epidemiological data for the proposal

- Proportion of persons living with HIV who are women *(please include sex ratio – Underscore the feminisation of the epidemic – Show trends if any among women)*
- Number of pregnant women or annual births
- Proportion of people living with HIV on ART who are women
- Background infant mortality rates
- Number of children infected with HIV and the proportion of persons living who are children
- Estimated number of pregnant women living with HIV giving birth each year
- HIV prevalence among pregnant women or women attending antenatal care
- Proportion of pregnant women attending antenatal care settings (at least once - \( \geq 4 \) times)
- Number and proportion of children living with HIV in need of treatment
- Number and proportion of children living with HIV in need of treatment who receive it
- Proportion of deliveries assisted by a skilled birth attendance
- Rate of mother-to-child transmission of HIV in the absence of any interventions
- Proportion of women practicing exclusive breastfeeding/mixed feeding/replacement feeding up to age of 4-6 months
- Number of health facilities providing integrated PMTCT, MNCH and RH services
- Number of districts with strengthened DHMT on leadership and management of health systems

### B2. Review of the national response to MTCT

1. Summary of the nationally adopted goals, targets and strategic priorities for PMTCT with relevant references to the major guiding documents (National strategic plans, Health sectoral programmes, national health policies, national PMTCT policies or guidelines, national PMTCT scale up plans, policies on health services integration etc.)

---

**Basic questions to be kept in mind**

1. What? (Magnitude of the problem – programmatic and financial gaps)
2. Who (Target / beneficiary populations)
3. When (Timelines)
4. Where (geographical coverage – catchments areas)
5. How (Programme strategies to address the issues)
2. Status of PMTCT response: analysis of the current status of the national PMTCT response and trends in reaching the set national goals/targets; current response based on the following facility- and population-based indicators for PMTCT summarized in table 1.

**Table 1. List of Indicators for PMTCT**

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Facilities</strong></td>
</tr>
<tr>
<td>Total number of facilities nationally providing ANC services</td>
</tr>
<tr>
<td>Total number/percentage of health facilities providing antenatal care services with both HIV testing and ARVs for PMTCT on site <em>(this indicator can be revised to percentage of ANC facilities that also provide HIV testing if there is no intention to provide ARVs at ANC setting)</em></td>
</tr>
<tr>
<td>Total number/percentage of facilities nationally providing ANC which also provide a more efficacious combination regimen for PMTCT <em>(this indicator could be added if a country plans to introduce new regimen; the definition of &quot;more efficacious regimen&quot; should be specified)</em></td>
</tr>
<tr>
<td>Total number/percentage of health facilities that provide virological testing (e.g. PCR) for infant diagnosis, on site or from Dried Blood Spots (DBS)</td>
</tr>
<tr>
<td><strong>ANC / Labour and delivery</strong></td>
</tr>
<tr>
<td>Total number/percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)</td>
</tr>
<tr>
<td>Total number/percentage of pregnant women who tested HIV positive <em>(including those with already confirmed HIV infection)</em></td>
</tr>
<tr>
<td>Total number/percentage of HIV-infected pregnant women assessed for ART eligibility (CD4 cell count or clinical staging)</td>
</tr>
</tbody>
</table>
| Number and percentage of HIV-infected pregnant women who received ARVs for MTCT. *Broken down accordingly:*  
  - Antiretroviral therapy for HIV-infected pregnant women eligible for treatment  
  - Maternal triple ARV prophylaxis  
  - Maternal AZT  
  - Single-dose nevirapine only |
| Total number/percentage of infants born to HIV-infected women (HIV-exposed infants) receiving ARV prophylaxis to reduce the risk of peripartum mother-to-child transmission |
| Percentage of infants born to HIV-infected women (HIV-exposed infants) who are breastfeeding and covered by an antiretroviral prophylaxis intervention to reduce the risk of HIV transmission during the breastfeeding period. |
| Percentage of HIV-exposed infants who are receiving exclusive breastfeeding, replacement feeding or mixed feeding at DPT3 visit *(remember to pilot test if not yet collecting)* |
| Total number/Percentage of infants born to HIV-infected pregnant women receiving a virological test for HIV diagnosis within two months of birth |
| Total number of infants born to HIV-infected pregnant women started on co-trimoxazole prophylaxis within two months of birth |
| Percentage of HIV-infected children aged 0-14 who are currently receiving antiretroviral therapy |
| **Service providers**                                                                          |
| Number of health care providers trained on PMTCT                                               |
| Number of peers/lay counsellors trained for the provision of PMTCT interventions               |
| Number of peer support groups formed in the context of PMTCT                                   |
| **Other**                                                                                      |
| Existence of national policies and guidelines consistent with international standards for the prevention of mother-to-child transmission of HIV |
| Percentage of HIV-positive women of reproductive age attending HIV care and treatment services with unmet need for family planning services *(remember to pilot test if not yet collecting)* |
| Percentage of infected infants born to HIV-infected women - estimated transmission rate        |
3. Description of the national policies, guidelines and protocols in place for PMTCT within the overarching context of the reproductive and child health programmes. These may include:

- Antenatal, childbirth and post-partum care (including any policies on free care)
- Postnatal care for infants and children
- General policies and standard operational procedures for PMTCT services, including the description of the ARV regimens adopted for the national PMTCT programmes
- HIV testing and counselling in the context of PMTCT (PITC in antenatal, delivery and postnatal care settings)
- Human resource management including task shifting in the context of PMTCT
- Infant and young child feeding
- Sexual and reproductive health (SRH) for women living with HIV
- Policies on gender mainstreaming for health programmes, integration of services if any

Where relevant highlight the strengths and opportunities of the current policy and normative context, as well as the critical gaps in national policies/guidelines/protocols hindering progress of the PMTCT programme in the country.

C. Formulating the PMTCT SDA section within the country application

C1. Rationale for including PMTCT in the proposal – key messages:

- Women make up about half of the burden of people living with HIV globally. Use national figures
- HIV contributes to overall maternal mortality and morbidity. PMTCT will help countries in achieving MDGs 4, 5 and 6. Use national figure (e.g. HIV is one of the main causes of maternal mortality – HIV/AIDS is the first cause of mortality among adults)
- Over 90% of new infections in infants and young children occur through mother-to-child transmission. Without any interventions, between 20% and 45% of infants may become infected, but this risk can be reduced to less than 2% in a non-breastfeeding population by a package of evidence-based interventions. Use national data.
- Large scale implementation of PITC in the context of PMTCT in most resource-limited countries is the unique opportunity for a majority of women to know their HIV status. It also provides the opportunity to recommend HIV testing and counselling to their male partners, their children and families.
- PMTCT is not only about the provision of ARV prophylaxis. Through implementation of its 4 components there is an unique opportunity to address HIV prevention, care, treatment and support needs of women, their infants and families. Comprehensive PMTCT is an opportunity to improve maternal, newborn and child health and survival.
- Effective integration and implementation of PMTCT interventions within MCH services will strengthen the health system and improve outcomes in all mothers and children in the community
- PMTCT is the main gateway to HIV care and treatment for women (Section on HSS cross-cutting interventions)
- Adopting and supporting the revised WHO recommendations for HIV and infant feeding can improve feeding practices among all infants and reduce serious morbidity and contribute to improved child survival in the entire population.

C2. Addressing PMTCT while describing the national prevention, treatment, care and support strategies

1. Guiding principles of the national programmes
   a. Improved coordination (coordination bodies and mechanisms involving key national programmes, the civil society/NGO, persons living with HIV and partners)
   b. Decentralization of PMTCT services to primary facilities and community level: e.g. scaling-up based on a district-based approach
c. Integration of HIV prevention, care and ART with MNCH services: HIV, TB, MNCH services including child health (particularly EPI), Nutrition and Sexual and Reproductive Health services (especially FP)

2. Institutional framework and national strategic orientations
Briefly describe
a. the national coordination bodies and mechanisms
b. key elements of the national response focusing on the national health policy and national strategic plan – Specify how PMTCT is positioned as a priority in the national strategic plan
c. How the country is performing with respect to MDGs and UNGASS goals and target?
d. Local and regional initiatives (How PMTCT and the broader issue of women and children needs are positioned in these initiatives?)
e. Describe partners supports/contribution to the national support (make sure supports to PMTCT and paediatric HIV care, treatment and support are mentioned)

C3. Linking PMTCT to the proposal objective
Under the broader proposal goal, the SDAs should have specific or broad objectives that cover PMTCT and linked to proposed M&E framework (Attachment A indicators) - for example

- To prevent HIV infection among pregnant women, mothers, their children and families
- To reduce maternal mortality and morbidity
- To reduce HIV transmission among children
- To reduce infant mortality related to diarrhoea and malnutrition secondary to inappropriate feeding practices
- To increase prevention among women of childbearing age
- To reduce stigma and discrimination among PLWHIV
- To increase the number of women who know their HIV status through the implementation of HIV testing and counselling

C4. Setting SMART targets for the PMTCT response
Please keep in mind the relevant geographic or population-based indicators while setting targets for the PMTCT response within a specific time period. Ideally national targets should be population-based. It is worthwhile to provide the geographical reach of the proposal and the size of the population

Example: At least 90% of all pregnant women attending ANC (11,500) in the selected 150 health facilities serving 70 health districts will be tested for HIV and 80% of those tested positive receive ARVs (ARV prophylaxis or ART) by 201

C5. Defining implementation strategies – Decentralized approach to implementation
Empowering sub-national bodies as the driving forces is essential in ensuring national ownership, defining targets, improving coordination of partners and engaging communities, to ensure implementation of national programmes. Many countries have developed national scale-up plans which are used to guide and leverage and mobilize necessary resources for scaling up national programmes. In this process, health districts are required to develop district plans for implementation of PMTCT, infant feeding and paediatric HIV care, treatment and support.

The scale-up strategy should be based on a district-driven approach and use districts as baseline units to determine national targets, map partners and available resources, identify financial and programmatic gaps, and overall needs to be addressed through the proposal (See the box above).
C6. Main activities to be considered
The key principles and key entry points of the comprehensive PMTCT programmes are outlined below. Refer to Table 5, for the interventions/activities to be considered in defining the PMTCT Service Delivery Area.

The UN promote a comprehensive approach to the prevention of HIV infection in infants and young children which addresses a broad range of HIV-related prevention, care, treatment and support needs of pregnant women, mothers, their children and families. This comprehensive approach includes:

Element 1: Primary prevention of HIV infection among women, especially young women
Element 2: Prevention of unintended pregnancies among HIV-infected women
Element 3: Prevention of HIV transmission from HIV-infected women to their infants through the provision of prophylactic antiretroviral drug regimen for HIV-infected pregnant women and their newborn, safe obstetric practices and counselling and support for HIV-infected pregnant women on infant feeding options adopted by national authorities, and
Element 4: Provision of care, support and treatment for HIV-infected mothers and infants and families

At health sector level, PMTCT services are provided in facilities targeting pregnant women, mothers and children.
1. All women (including adolescents) → primary prevention of HIV infection
2. HIV-infected women → prevent unintended pregnancy
3. HIV-infected pregnant or breastfeeding women → prevent HIV transmission
4. HIV-infected women +their infant +family → provide care and support
5. Males, particularly the partner → provide prevention, care and support

Key entry points include ANC, MCH, FP, HIV care and treatment (for adults and children), sexually transmitted infections. Additional entry points may include child immunization; gender-based violence; youth-friendly, community-based outreach; prevention and treatment for drug users; support groups of people living with HIV, tuberculosis, well-baby follow-up, post-abortion care, workplace, etc.

Table: Key activities to be considered within the context of a comprehensive approach
Although these services are primarily provided at health facility level their full implementation requires strong linkages with communities. Some of these interventions/services will even be delivered within the communities through various approaches.

<table>
<thead>
<tr>
<th>Elements/prongs</th>
<th>Key activities to be considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention of HIV infection among women of</td>
<td>▪ HIV information and education in ANC, delivery and postnatal care settings</td>
</tr>
<tr>
<td>reproductive age</td>
<td>▪ HIV testing and counselling (Provider Initiated Testing and Counselling) – This includes couple HIV testing and counselling</td>
</tr>
<tr>
<td></td>
<td>▪ Retesting of pregnant women in high prevalence settings (and where and when feasible)</td>
</tr>
<tr>
<td></td>
<td>▪ Safer sex practices, including dual protection - Promotion and distribution of condoms</td>
</tr>
<tr>
<td></td>
<td>▪ STI screening and treatment (especially in ANC settings)</td>
</tr>
<tr>
<td></td>
<td>▪ Prevention with positives (couple testing and counselling, condom promotion and distribution of condoms)</td>
</tr>
<tr>
<td>Prevention of unintended pregnancies among HIV-infected women</td>
<td>▪ FP counselling and services (Point of service provision to be considered: ANC and post-partum care settings; FP clinics; HIV care/ ART centers/clinics)</td>
</tr>
<tr>
<td></td>
<td>▪ Introduction of HIV testing and counselling in RH/FP services</td>
</tr>
<tr>
<td></td>
<td>▪ Safer sex practices, including dual protection (condom promotion and distribution)</td>
</tr>
<tr>
<td></td>
<td>▪ Prevention with positives (couple testing and counselling, condom promotion and distribution of condoms)</td>
</tr>
<tr>
<td>Prevention of HIV transmission from HIV-infected</td>
<td>▪ Quality antenatal and delivery care (all components) – including prevention and treatment of Malaria, diagnostic and treatment of tuberculosis, and congenital syphilis, isoniazid preventive therapy after excluding active TB</td>
</tr>
<tr>
<td>women to their infants</td>
<td>▪ Provider initiated HIV testing and counselling in antenatal and delivery care settings</td>
</tr>
<tr>
<td></td>
<td>▪ Clinical (staging) and immunological (CD4) assessment of pregnant women testing positive (Where, when and by whom services will be provided?)</td>
</tr>
<tr>
<td></td>
<td>▪ ART for pregnant women eligible for treatment for their own health</td>
</tr>
<tr>
<td></td>
<td>▪ ARV prophylaxis for MTCT prevention for women not eligible for ARV treatment</td>
</tr>
<tr>
<td></td>
<td>▪ Safer obstetric practices, birth planning and emergency preparedness</td>
</tr>
<tr>
<td></td>
<td>▪ Infant feeding counselling and support</td>
</tr>
</tbody>
</table>
### Package of services for mother

- ART for women eligible for treatment
- Co-trimoxazole prophylaxis
- Continued infant feeding counselling and support
- Nutritional counselling and support
- Post-natal care within 4-6 weeks
- Sexual and reproductive health services including FP
- Psychosocial support
- Screening for TB
- Isoniazid preventive therapy after excluding active TB

### Package of services for HIV-exposed children

- Routine child health care services:
  - Routine immunization and growth monitoring and support
  - Continued infant feeding counselling and support
  - Screening and management of congenital syphilis
  - Screening and management of tuberculosis
  - Prevention and treatment of malaria

### HIV-related package of interventions:

- ARV prophylaxis
- Co-trimoxazole prophylaxis starting at 6 weeks
- Early diagnosis with virological tests if available
- Antibody testing at 9-12-18 months where virological testing is not available
- ART for eligible HIV infected children
- Symptom management and palliative care if needed
- Nutrition care and support
- Psychosocial care and support

### Health systems strengthening

Improve the organization and management of health services focusing on human resources for health, health technologies (equipment, medicines) health information, health financing, and leadership and management

### Community systems strengthening

- Establishing peer support group
- Community outreach activities
- Building capacity of civil society, associations of PLWH
- Working with media, including at local and sub-national levels
- Strengthening linkage between health facilities and community level interventions
- Intervention of community-based workers at health facility level

Consider involvement of community-based worker in the provision of services related to HIV testing and counselling, infant feeding and counselling, co-trimoxazole prophylaxis and early infant diagnosis

### C7. Key programme interventions

#### Example of how the regimen could be described in the proposal

**Criteria for indication of ART in pregnant women**

- Women with CD4 < 350 cells/mm$^3$ regardless of clinical stage
- Women with clinical stage 3 or 4 regardless of CD4

- All eligible HIV-infected pregnant women (20-25% of all HIV-infected pregnant women) according to the national guidelines will receive ART for their own health. The first line ART regimen recommended for these women is: *(include national ART regimen)*. In the case of major side-effects, the recommended alternative regimens are: *(include national regimen)*. Infants born to HIV-infected women on ART will receive *(include national regimen)*.

- All HIV-infected pregnant women who are already on ART when they get pregnant will continue with ART. Do not give EFV in the first trimester.

- HIV-infected pregnant women not eligible for an ART yet, will receive a combination prophylactic regimen for the prevention of MTCT. The combination regimen consists of *(include national regimen)*. The child will receive *(include national regimen)* depending on the national infant feeding policy.
Example of Infant feeding counselling and support

• All women attending antenatal clinics will be advised regarding the infant feeding practice and associated antiretroviral drug interventions that will be supported through the maternal and child health services. HIV-infected mothers will be counselled on the effectiveness of ARV interventions to reduce post-natal transmission and how breastfeeding can improve the chances for HIV-exposed infants to survive while remaining HIV uninfected. HIV-infected mothers will be supported to take or provide ARV interventions to prevent HIV transmission and also practice optimal infant feeding practices.

Example how to describe the Co-trimoxazole prophylaxis guidelines in the proposal

According to the national guidelines which are in line with WHO guidelines:

• All HIV-infected pregnant women will receive co-trimoxazole prophylaxis (include national regimen)
• All HIV-exposed children (children born to HIV-infected mothers) starting at 4-6 weeks of age until they are no longer breastfed and HIV infection has been definitively excluded

C8. Key indicators

A manual entitled “Monitoring and Evaluating the Prevention of Mother-to-Child Transmission of HIV: A Guide for National Programs” developed by WHO in collaboration with other United Nations and key partner agencies, presents a list of core and additional PMTCT indicators. Please refer to Table1 for the list of the indicators to be considered for the PMTCT-SDA. This guide also discusses methods and tools for measurement of national PMTCT indicators; specific issues to consider when implementing national systems for monitoring and evaluating PMTCT; use of data for monitoring progress; and choice of indicators for more detailed monitoring of services in facilities and sub-national level (e.g. in provinces, districts and communities).

C9. How gender, human rights and equity issues should be addressed

It is essential to increase equitable access to prevention, treatment, care and support service and decrease stigma and discrimination in order to achieve the ultimate goal of programmes. In most settings, PMTCT interventions are provided based on the assumption that women are empowered to make an independent decision as to whether or not to take advantage of these interventions. In reality, women confront a number of obstacles to which include:

• Lack of power to negotiate safer sexual practices (for example condom use)
• HIV-positive women may not be able to negotiate the use of contraceptive methods to avoid unintended pregnancies or to decide on limiting pregnancies
• Women may not be able to access antenatal, delivery and postnatal care for several reasons (e.g. no transportation resources and fees to pay for care; cannot leave young children at home to travel to the health center)
• Fear of repudiation, domestic violence, stigmatization and rejection may prevent women from taking an HIV test, attend extra visits and adopt safer infant feeding options (exclusive breastfeeding; replacement feeding)
• Women do not have access to intervention because of the financial (lack of money for transportation and fees) and social conditions (urban versus rural), their religion or their behaviour (CSW; IDUs).

How PMTCT can help to address gender and human rights issues

• Ensure access to basic antenatal including PMTCT-related interventions, and delivery care for all women
• Increase women’s ability to negotiate sex and safer sex; and access SRH services and negotiate utilization of contraceptive methods
• Support women in disclosure of their HIV status, provide couple counselling, promote partner participation
• Promote and support engagement of communities, including male sexual partners and PLWH, with special attention to community outreach activities
• Provide post-test support for all and provide care, treatment and support to all HIV-infected mothers, their children and families

For example: in improving ANC access equally to rural area/urban area, ensuring affordable access to minimum quality care including PMTCT (free testing, counselling and ARV/ART) services through basic benefit packages or alternative insurance mechanisms (public/private)

D. Health system strengthening in the context of PMTCT and paediatric HIV care, support and treatment

Antenatal care is a unique opportunity for the delivery of a comprehensive PMTCT intervention and multiple programmes. These include prevention of maternal and neonatal tetanus, congenital syphilis, prevention and case management of maternal malaria, prevention of maternal anaemia and malnutrition, prevention of sexually transmitted infections (STIs) and mother-to-child transmission of HIV. Inadequate care and poor patient-provider relationship during prenatal period have a negative impact on the continuum of care during the childbirth and postnatal period and adversely affect mothers, infants and children.

Performance results from various programmes show an important drop off of women enrolled in PMTCT from the time of their identification as HIV-positive to the time of delivery. The declining trends in the uptake of PMTCT interventions (HIV testing and counselling, ARV prophylaxis for mothers and infants, post-natal interventions) reflects to some extent the baseline situation where ANC coverage (>=1 visit) is relatively high but where there is a low proportion of institutional deliveries.

Implementation of comprehensive PMTCT must contribute to:
• Improving access, quality and utilization of MNCH services through upgrading the existing infrastructure and equipment for ANC, childbirth and post-partum/postnatal care
• Improving referral and data reporting systems to ensure better continuum of care
• Addressing human resource shortage within the MNCH systems or in a broader national health system context through reorganization of the service delivery, appropriate referrals, task shifting, etc.
• Improving the national M&E capacities through capacity building and technical support for harmonization and integration of the M&E indicators and systems
• Improving procurement and supply chain management systems through upgrading and equipping the systems and capacity building
• Addressing health financing constraints to improve financial access and health services

Integrated Management of Adolescent and Adult Illness (IMAI) which is an integrated approach to scaling up and decentralizing comprehensive HIV care, treatment and prevention within primary health care is designed to strengthen the health system in resource constrained settings. IMAI and the related IMCI (Integrated Management of Childhood Illness) and IMPAC (Integrated Management of Pregnancy and Childbirth) tools support an integrated approach to HIV, TB, malaria and PMTCT/MCH services within primary health care, covering the full life cycle. This offers a concrete blueprint for the realization of ambitious scale-up targets including those of PMTCT by integrating simplified clinical management of these key interventions into the routine work of existing health services with strong community support.
**D1. Improving basic maternal, newborn and child health care**

Improving working condition of health care providers within antenatal and delivery care settings and the quality of care will benefit all women, especially vulnerable women and HIV-infected pregnant women.

The HIV epidemic has changed the pattern and cause of maternal mortality. HIV/AIDS-related complications are now among the leading causes of maternal mortality in most high-burden countries. HIV/AIDS can be the direct cause of maternal mortality through post-partum haemorrhage, puerperal sepsis and complications of caesarean sections. Indirect causes include the natural evolution of the disease itself and opportunistic infections such as tuberculosis and toxoplasmosis.

The following activities should be considered, noting that this is not an exhaustive list:

1. **Provision of comprehensive care, treatment and support services to increase access to and uptake of MNCH services:**
   - Facility as well as community-level activities including communication strategies
   - Early newborn care
   - Nutritional support and infant feeding support
   - Care during pregnancy, labour and postpartum period
   - Anaemia screening and management
   - Screening for STI (including syphilis) and care
   - TB screening and treatment
   - Malaria prevention and treatment

2. **Equipment of antenatal and delivery rooms**
   - Antenatal and delivery kits
   - HIV rapid test kits and commodities
   - Gloves for examination and deliveries, fetal stethoscopes
   - Impregnated bed nets
   - Equipment for midwifery and obstetric care – i.e. delivery/labour beds, refrigerators, chairs, light source, delivery gowns for midwives
   - TV/video equipment for health education/information
   - Equipment and supplies for medical waste disposal/management
   - Supplies for infant and young child feeding – e.g. ARVs for preventing postnatal transmission

- Escalating maternal mortality since the advent of the HIV epidemic (e.g. AIDS is the leading cause of death among women of reproductive age; Rates of maternal mortality have increased X-fold over the past Y decades; Maternal mortality rates have increased X times in parallel with the increasing HIV/AIDS epidemic)
- Potential direct causes include post-partum haemorrhage, puerperal sepsis and complications of caesarean sections
- Potential indirect causes include AIDS itself and opportunistic infections such as tuberculosis and toxoplasmosis and pneumonia
3. Upgrading/renovating existing facilities (e.g. counselling rooms) to accommodate the delivery of PMTCT interventions

Infrastructure necessary for group counselling and information sessions, individual HIV post-test counselling, antenatal care examination, delivery and postnatal care are often inadequate. Provision of equipment is also critical to improve the quality of care and uptake of the wide range of services. Upgrade/renovation of existing facilities is critical to:

- Ensure quality ANC and delivery care
- Ensure a minimum of privacy and confidentiality for HIV testing and counselling
- Provide quality rapid testing, immunological assessment (CD4) and PCR/DBS
- Provide quality infant feeding counselling and support

4. Strengthening service delivery systems for the delivery of postnatal services for mothers and their children

Quality care includes the delivery of co-trimoxazole prophylaxis, early infant diagnosis and infant feeding counselling and support as integral component of routine postnatal care for mothers, infants and children. The following activities could be considered:

- Equipment of services and improvement of facilities
- Training and clinical mentoring of service providers
- Co-supervision by different programmes (e.g., MCH, HIV, TB, malaria)
- Task shifting
- Involvement of non medical cadres (community health workers, TBAs, NGOs, PLWH,...)
- Development/revision of tools (registers, forms, cards, leaflets, brochures,...). Special attention should be given to activities for the inclusion of HIV information on maternal health cards and under-5 cards (e.g. revision of the cards, validation workshops, printing and dissemination, and rollout).
D2. Improving laboratory capacity

For monitoring of combination ARV prophylaxis and ART

• Haemocue for determination of haemoglobin level in pregnant women. This is important because AZT should not be given to pregnant women and mothers with severe anaemia (Hb<7gm/dl).
• Building capacity or setting up systems to perform CD4 cell counts for all HIV-pregnant women. ART eligibility by CD4 is key to implementing the 2009 WHO recommendations

Specific activities related to early infant diagnosis to be considered
Activities necessary for the scale-up of early infant diagnosis of HIV using PCR and DBS technologies should be considered:
• Identification of reference laboratories for PCR using DBS
• Use immunization clinic "opt-out" testing of young infants
• Facility improvement and equipment of laboratories
• Referral systems for collection and transfer of blood specimens
• Referral systems for return of test results
• Training of service providers for collection and preparation of specimens

D3. Innovative approaches to addressing health financing issues and human resource constraints

Implementation of comprehensive PMTCT and paediatric HIV care, support and treatment (CST) involves various health services across the different levels of the health system and services. Some financial issues may impede the equitable access to health services. The following points should be considered:
• Identification of financial barriers in accessing health services
• Conducting economic viability analysis of innovative health financing approaches
• Designing safety nets for cushioning the poor and vulnerable groups
• Selection of innovative approaches to protect the poor and vulnerable and equity of services
• Support co-sponsorship of key activities by relevant programmes

The main platform and key entry points for the delivery of the core PMTCT interventions is MNCH services such as antenatal, delivery, postnatal (immunization, well baby clinics…) and family planning services. Beyond health facilities, implementation of PMTCT requires active involvement of the civil society and communities.

Implementation of PMTCT and paediatric CST services as integral components of MNCH programmes can result in increased workload for already overstretched health care workers. In general, health care workers are in insufficient number and do not have all the required skills for the implementation of the range of PMTCT and paediatric HIV CST. This may require new skills and additional staff. In order to address these issues, the following activities could be considered:
• Reorganization of the service delivery system including referral for appropriate competences for each level of service
• Orientation of existing health care workers based on assessed skill and knowledge gaps including community actors for the provision of a defined set of activities at community as well as health facility levels
• Strengthening clinical mentoring and supportive supervision to allow continued learning of health workers
• Considering task shifting as an option for filling in existing gaps of required health personnel.
Community actors and volunteers have limited resources and therefore might need financial incentives to support them in doing their work. In the long run, unavailability of financial incentives can hamper their motivation and their ability to support effectively the process.

Development of a human capacity building plan for the health sector, or specifically for PMTCT and paediatric HIV care and treatment, could be included as an activity if the country does not have any. This could help to:

- have clear idea of the baseline number of health care workers at all levels (employed and deployed)
- identify actual needs and
- define appropriate remedial actions including exploring options for results based financing or incentives for retention of key categories of skilled health workers / health teams essential for implementing integrated services including PMTCT

Training of health care workers to deliver PMTCT services and all the other HIV services is usually carried out separately resulting in inadequate knowledge and skills among health workers in providing the HIV positive pregnant woman with comprehensive services. The WHO IMAI/IMPAC clinical course for integrated PMTCT services provides an integrated approach that better serves HIV pregnant women with other needs for care. The training capacitates health care workers on co-management of clinical conditions for HIV-positive pregnant women by providing HIV care/ART, ARV prophylaxis and PMTCT interventions integrated into antenatal, labour and delivery, postpartum and newborn care at primary facility.
D4. Strengthening procurement and supply chain management (PSM) system

Comprehensive PMTCT involves a wide range of health service delivery points. Key issues include policy framework, forecasting, procurement, storage and distribution of commodities which should be an integral part of the existing national PSM system.

<table>
<thead>
<tr>
<th>Description</th>
<th>Supply requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal components</strong></td>
<td></td>
</tr>
<tr>
<td>HIV testing and counselling at antenatal clinic and delivery settings for PMTCT</td>
<td>HIV rapid test kits</td>
</tr>
<tr>
<td>Antiretroviral Treatment for mothers who need it for their own health</td>
<td>Fixed Dose ARV Combinations for at least one year according to national treatment guidelines</td>
</tr>
<tr>
<td>Co-trimoxazole prophylaxis for HIV positive mothers</td>
<td>Co-trimoxazole for at least one year following birth of child</td>
</tr>
<tr>
<td>Antiretroviral prophylaxis for the mother based on the 2009 WHO recommended regimen for PMTCT for pregnant mothers</td>
<td>Maternal AZT for at least 7 months OR Maternal triple prophylaxis for at least 18 months</td>
</tr>
<tr>
<td>Immunological Assessment</td>
<td>CD4-reagents bundle</td>
</tr>
<tr>
<td><strong>Paediatric components</strong></td>
<td></td>
</tr>
<tr>
<td>Antiretroviral prophylaxis for the infant based on the 2009 WHO recommended regimen for infants born to HIV positive mothers</td>
<td>Depending on the prophylactic option chosen: Nevirapine syrup - for either 6 weeks or 12 months Zidovudine syrup - for 6 weeks</td>
</tr>
<tr>
<td>Early diagnosis of paediatric HIV infection</td>
<td>PCR-reagents bundle and Dried Blood Spot bundle</td>
</tr>
<tr>
<td>Diagnosis at the age of 12-18 months (in case PCR not available)</td>
<td>HIV rapid test kits</td>
</tr>
<tr>
<td>Co-trimoxazole prophylaxis for HIV exposed children</td>
<td>Co-trimoxazole for two years (where no virology testing for infants) Co-trimoxazole for 3 months (where virology testing for infants is done)</td>
</tr>
</tbody>
</table>
D6. Monitoring and evaluation, quality assurance and operational research
The purpose is to strengthen the national capacity for monitoring and evaluation, quality assurance and operational research. Specific activities are related to:

- Definition and harmonization of indicators
- Development/revision of M&E and reporting tools
- Training/orientation of programme managers, district management teams, and service providers
- Timely collection and analysis of data, and dissemination of results
- Identification of gaps and bottlenecks
- Development and implementation of corrective measures
- Evaluation and re-evaluation

The table below provides a set of generic activities and items to consider budgeting for the PMTCT service delivery area.

The three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT (including malaria prevention) and TB/HIV is suited for programmes expanding PMTCT coverage by integration of PMTCT interventions with their maternal and child services. The WHO HIV care/ART patient monitoring system has been expanded to support PMTCT and malaria prevention interventions integrated with maternal and newborn care and also TB-HIV interventions delivered within HIV care, linked with the TB recording and reporting system.

As part of the process, identify critical operational research questions aimed at improving implementation of the programme, service delivery, quality and uptake of services.

NB. For the GFATM proposal, countries are recommended to use the 6 building block-model of the Health Systems while analysing the key bottlenecks and the HSS interventions required overcoming the barriers. The building blocks include:

1. Service Delivery
2. Health Workforce
3. Information
4. Medical Products, Vaccines and Technologies
5. Financing
6. Leadership & Governance (Stewardship)
## Generic Activities and Items to Consider Budgeting for the PMTCT M&E Service Delivery Area

<table>
<thead>
<tr>
<th>M&amp;E Area</th>
<th>Generic Activities</th>
<th>Items to Consider Budgeting For</th>
</tr>
</thead>
</table>
| **Routine Programmatic Data Collection and Use** | • Review and revise indicators (align with new ARV guidelines, consider other indicators of interest)  
• Review and propose revisions of tools  
• Pilot-testing new tools (+ instructions) and indicators  
• Review of human resources and recruitment of additional staff necessary for the work planned  
• Printing tools  
• Develop operation manual and train on new tools and indicators  
• Other training to various programmatic and M&E staff at all levels  
• Develop systematic approaches to use data better  
• Feedback mechanism on data collection and reporting  
• Review and revise targets | • Existing and additional staff  
• Stakeholders meeting  
• Workshops  
• Travel and Per diem  
• Computer-related hardware  
• Other materials and supplies  
• Transport mean (e.g. car for supervision visits)  
• Dissemination cost  
• Launch (e.g. of new tools, reports)  
• Technical assistance; consultants  
• Printing cost  
• Tools to facilitate data use  
• Extra data collection |
| **Data Quality and Supervision** | • Identify problems and solutions to improving data quality; prepare and implement solutions; reassess  
• Develop or review data checklist to perform during routine supervision at facilities or sub-national level  
• Annual National PMTCT Data Stakeholders Meeting |                                                                                                                                                           |
| **Special Studies and Periodic Surveys** | • Identify specific topics for further data collection through special studies or operational research  
• Health facility survey  
• Population-based survey (with or without HIV testing) |                                                                                                                                    |
| **Impact Measurement** | • Summarize currently existing data on impact of PMTCT programs  
• Identify what impact to measure  
• Review various ways to measure impact and develop country plan/protocol; Budget for planned activities each year  
• Programme reviews |                                                                                                                                                           |
| **Coordination and Reporting** | • Develop a M&E workplan and review its performance/implementation regularly  
• Periodic meetings to share information and coordinate/synergize work at different levels (e.g. TWG meeting involving all partners; meetings between national and sub-national levels; links with other stakeholders, etc.)  
• Periodic reports with baselines, targets, and actual results  
• Mid-term and end of the year review reports |                                                                                                                                                           |
Table 9 provides a summary of examples of the specific activities across 3 building blocks (Service Delivery, and Health Workforce, Information) that are considered the most relevant to HSS in the context of PMTCT programming. You may refer to the current list for further adaptation based on the country needs.

**NOTE:** The Global Fund will accept all proposals for HSS component, except for the 2 categories: 1. Basic scientific and clinical research aimed at demonstrating the safety and efficacy of new drugs and vaccines, and 2. Large scale capital investments such as building hospitals or clinics.
Table 9. Six Building Blocks of the Health System and Questions and Activities to be considered for GFATM support through HSS for PMTCT

<table>
<thead>
<tr>
<th>Building Block 1: Service Delivery, covering service packages; delivery models; infrastructure; management; safety &amp; quality; demand for care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Equipment/supplies for antenatal and delivery rooms</strong></td>
</tr>
<tr>
<td>- Midwifery and obstetric kits or individual equipment i.e. gloves for examination and deliveries, fetal stethoscopes, barrier gowns / goggles</td>
</tr>
<tr>
<td>- Equipment for midwifery and obstetric care – i.e. delivery/labour beds, refrigerators, chairs, light source</td>
</tr>
<tr>
<td>- TV/video equipment for health education/information</td>
</tr>
<tr>
<td>- Equipment and supplies for medical waste disposal/management</td>
</tr>
<tr>
<td>- Supplies for infant and young child feeding – e.g. ARVs to prevent postnatal transmission, counselling tools / job aids</td>
</tr>
<tr>
<td>- Impregnated bed nets, etc.</td>
</tr>
<tr>
<td>- Syphilis - clinic-based test with same-day treatment of positive results and follow-up of partners.</td>
</tr>
<tr>
<td><strong>2. Improving laboratory capacity for monitoring of combination ARV prophylaxis and ART</strong></td>
</tr>
<tr>
<td>- Haemocrit or haemocue for determination of haemoglobin level in pregnant women.</td>
</tr>
<tr>
<td>- Building capacity or setting up systems to perform CD4 cell count for all HIV-pregnant women. Stress on its importance for the implementation of WHO 2009 guidelines</td>
</tr>
<tr>
<td><strong>3. Upgrade/renovation of existing facilities is critical to:</strong></td>
</tr>
<tr>
<td>- Ensure quality ANC and delivery care</td>
</tr>
<tr>
<td>- Ensure a minimum of privacy and confidentiality for HIV testing and counselling</td>
</tr>
<tr>
<td>- Provide quality rapid testing, immunological assessment (CD4) and PCR/DBS</td>
</tr>
<tr>
<td>- Provide quality infant feeding counselling and support</td>
</tr>
<tr>
<td><strong>4. Strengthening post-natal service delivery systems for mothers and their children.</strong></td>
</tr>
<tr>
<td>- Equipment of services and improvement of facilities</td>
</tr>
<tr>
<td>- Training and mentoring of service providers</td>
</tr>
<tr>
<td>- Task shifting</td>
</tr>
<tr>
<td>- Involvement of non medical cadres (community health workers, TBAs, NGOs, PLWH,...)</td>
</tr>
<tr>
<td>- Development/revision of tools (registers, forms, cards, leaflets, brochures,...). Special attention should be given to activities for the inclusion of HIV information on maternal health cards and under-5 cards (e.g. revision of the cards, validation workshops, printing and dissemination, and rollout).</td>
</tr>
<tr>
<td><strong>5. Specific activities related to early infant diagnosis to be considered</strong></td>
</tr>
<tr>
<td>- Identification of reference laboratories for PCR using DBS</td>
</tr>
<tr>
<td>- Facility improvement and equipment of laboratories</td>
</tr>
<tr>
<td>- Referral systems for collection and transfer of blood specimens</td>
</tr>
</tbody>
</table>
- Referral systems for return of test results
- Training of service providers (collection and preparation of specimens – PCR tests for laboratory technician – SOPs – Job aids...)

### 6. Programme monitoring and supervision

Strengthening the programme monitoring and supportive supervision systems from the central to sub-national levels and from the provincial/district levels down to the health care facilities. Specific activities might include:

- Development/revision of the tools for supportive supervision and performance assessment
- Planning and conducting scheduled supportive supervision visits
- Training at central and sub-national levels including health facilities, and
- Provision of vehicles for regular monitoring and supervisory visits
- Use the IMAI Operations Manual for operational guidance on how to implement the above

**Building Block 2: Health Workforce,** covering national workforce policies and investment plans; advocacy; norms, standards and data

**Consider Innovative approaches to addressing human resource constraints**

- Reorganization of the service delivery system. The *WHO operations manual for delivery of HIV prevention, care and treatment at health centre level in high-prevalence and resource-constrained setting* provide guidance on planning integrated service delivery
- Orientation of existing health care workers as well as community actors (NGOs, PLWH including peers, lay counsellors, community health workers, TBAs...) for the provision of a defined set of activities at community as well as training HIV-positive mothers as lay providers on the clinical team at the health facility level (also called “expert patients” or “mentor mothers”)... Involvement of community actors and trained and paid lay providers on the clinical team can help to take some of work burden off health care workers. They can play critical role by identifying pregnant women in the community, providing counselling and health education, including information on healthy lifestyles, birth planning and the importance of antenatal care and skilled care at birth.
- Task shifting
- Use WHO IMAI/IMPAC training to strengthen human resource capacity to provide comprehensive PMTCT interventions for ANC, childbirth, post natal and newborn at the primary level.
- Performance based incentives for enhancing performance

**Building Block 3: Information,** covering facility and population based information & surveillance systems; global standards, tools

**Strengthening the national capacity for monitoring and evaluation, quality insurance and operational research.** Specific activities are related to:

- Definition and harmonization of indicators
- Development/revision of M&E and reporting tools such as the WHO 3 interlinked patient monitoring systems for HIV care / ART, PMTCT/MCH, and TB/HIV
- Training/orientation of programme managers, district management teams, and service providers
- Collection and analysis of data, and dissemination of results
- Identification of gaps and bottlenecks
- Development and implementation of corrective measures
- Re-evaluation

As part of the process, identify critical operational research questions aimed at improving implementation of the programme, service delivery, quality and uptake of services
E. Costing the activities

Costs are based on country-specific data for selected countries from different regions of the world. In fact the cost could be divided into two different levels: (see Report on the methods used to estimate costs of reaching the WHO target of “3 by 5”). These costs need to be linked to the GFATM cost categories.

Service delivery level costs (non-exhaustive):
- HIV testing and counselling, including distribution of condoms and test kits;
- Provision of antiretroviral (ARV) drugs for prophylaxis;
- Provision of first-line ARV drugs to eligible women and children above the age of 18 months and, in the case of clinical diagnosis of failure, provision of second line drugs;
- Prophylaxis, diagnosis and treatment of opportunistic infections (OIs); cotrimoxazole cost;
- Laboratory tests for regular monitoring and suspected toxicity (for those showing clinical signs of toxicity) and switching individual drugs in case of confirmed toxicity
- Operating costs of CD4, PCR/DBS and viral load monitoring tests
- Palliative care
- Nutrition kits
- Antenatal care and delivery kits

Programme costs (non-exhaustive):
- Improvement of facilities
- Equipment at point of service delivery
- Training and on-going learning of health worker (doctors, nurses, midwives), peer educators, lay counsellor and community-based service provider;
- Health workers job aids and on-the-job reference materials
- Incentive/transportation fees for community actors and community health workers
- Provision of various counselling sessions (HIV, FP, infant feeding, nutritional support etc.)
- Recruitment and training of community health workers and lay volunteers to follow up patients for treatment and adherence support;
- Supervision and monitoring across the levels of the health system (Central level – Provincial level – District level – Facility level);
- Drug distribution and storage systems,
- Equipment of MNCH services
- Universal precautions - Post exposure prophylaxis;
- Laboratory equipment, supplies and management costs (CD4, PCR/DBS)
- Support to referral systems for collection and transfer of blood samples as well as return of test results
- Purchasing vehicles for transportation system
- Test kits
- Technical support in planning, management and monitoring and evaluation of the PMTCT-related systems and services (tools – workshops) – Tools include health cards form mothers and infants/children, registers, forms, leaflets, brochures, etc…

F. Key implementing partners to be considered

- Bilateral, NGOs, quality improvement teams, and academic partners active in supporting or implementing scale up of PMTCT activities in the country, have to be invited and engaged in the process of the proposal writing
- Skilled birth attendants, midwives association, women education/support group, PLWHIV, peer educators, and community groups are important allies to be engaged both in the initial design of the proposals as well as the implementation and M&E of the GFATM
G. Types and sources of technical assistance which might be required during implementation

The following areas could be considered for technical assistance:

- Training and orientation of service providers including community actors
- Development and revision of guidelines, protocols and implementation tools including M&E tools
- Strategic information, including monitoring and evaluation and quality assurance
- Operation research including scale-up methods
- Programme evaluation
- Establishing quality improvement teams and establishing systems for using data-for-action

GFATM encourages that cost for technical assistance from UN organizations be costed and included in the proposal. This may be the only way WHO for example can provide consistent support.
Resources

PMTCT

Rapid Advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. November 2009 (available in English, French and Russian)

WHO expert consultation on new and emerging evidence on the use of antiretroviral drugs for the prevention of mother-to-child transmission of HIV, Conclusions of the consultation - Geneva 17-19 November 2008
http://www.who.int/hiv/topics/mtct/mtct_conclusions_consult.pdf

Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Towards universal access - Recommendations for a public health approach. 2006
http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf

Guidance on global scale-up of the prevention of mother-to-child transmission of HIV
Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. 2007

Scale up Planning Guide for the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care, Treatment and Support. 2007
http://www.who.int/hiv/topics/mtct/meetings/NairobiFeb07ScaleUpGuide.pdf


Strategic Framework for the Prevention of HIV Infection in Infants in Europe. 2004
http://www.who.int/hiv/mtct/PMTCTEURO.pdf

http://www.who.int/hiv/pub/advocacymaterials/glionconsultationsummary_DF.pdf

To access WHO IMAI/IMPAC clinical training course for integrated PMTCT interventions and other IMAI/IMCI/IMPAC materials, tools, wallcharts and briefing package, -please go to www.who.int/hiv/capacity/en/. The IMAI CD or access to the IMAI EZ collaboration site provides access to unpublished material and native files for adaptation or contact imaimail@who.int. The IMAI/IMPAC tolls have been updated to be compatible with the new WHO normative guidelines on PMTCT.

Infant Feeding and HIV

Rapid Advice: revised WHO principles and recommendations on infant feeding in the context of HIV. November 2009.
HIV and infant feeding: new evidence and programmatic experience
Report of a technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV infections in pregnant women, Mother and their Infants, Geneva, Switzerland, 25-27 October 2006

HIV and Infant Feeding: Update (2007)
Based on the Technical Consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, Switzerland, 25-27 October 2006

Community-based strategies for breastfeeding promotion and support in developing countries

HIV and infant feeding: Framework for priority action (English)

HIV and infant feeding: Framework for priority action (French)
Also available in Spanish, Portuguese, Chinese (see web site - http://www.who.int/nutrition/publications/infantfeeding/en/index.html)

HIV transmission through breastfeeding: review of available evidence
Also available in French, Spanish

HIV Testing and Counselling
Guidance on provider-initiated HIV testing and counselling in health facilities

http://www.womenchildrenyhiv.org/wchiv?page=vc-10-00

Integrating HIV Voluntary Counselling and Testing services into Reproductive Health Settings. Stepwise guidelines for programme planners, managers and service providers. UNFPA, IPPF (2004)

Guidelines and training for provider initiated testing and counselling integrated within antenatal, labour and delivery, and post-partum services is provided within the IMAI-IMPAC guidelines and training materials.

Care for HIV Infected Women

Nutrition Counselling, Care and Support for HIV-Infected Women
Guidelines on HIV-related care, treatment and support for HIV-infected women and their children in resource-constrained settings
Standards for Maternal and Neonatal Care
The Standards for Maternal and Neonatal Care consists of a set of user-friendly leaflets that present WHO key recommendations on the delivery of maternal and neonatal care in health facilities, starting from the first level of care.
http://www.who.int/making_pregnancy_safer/publications/en/


http://www.fhi.org/en/RH/Pubs/booksReports/hcandhiv.htm

Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living With HIV/AIDS and their Children in Resource-Constrained Settings
http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf

WHO IMAI-IMCI Chronic HIV Care with ART and Prevention and IMAI Acute Care guideline modules, training materials, and other tools supports comprehensive, integrated care for HIV-infected mothers.

Target Setting, Monitoring & Evaluation

National AIDS Programmes
A Guide to Monitoring and Evaluating HIV/AIDS Care and Support
http://www.who.int/hiv/pub/epidemiology/pubnapcs/en/

National Guide to Monitoring and Evaluation Programmes for the Prevention of HIV in Infants and Young Children (Please note that an updated version will be available in 2007)
http://www.who.int/hiv/pub/prev_care/youngchildren/en/

Overall implementation of activities


Strengthening Health Systems to improve health outcomes.
http://www.who.int/healthsystems/strategy/everybodys_business.pdf

The WHO integrated management tools provide a comprehensive, integrated approach to scaling up decentralized services in limited-resource settings. Many high burden PMTCT countries have already adapted IMAI and IMCI tools and begun IMAI-IMPAC integrated PMTCT training.