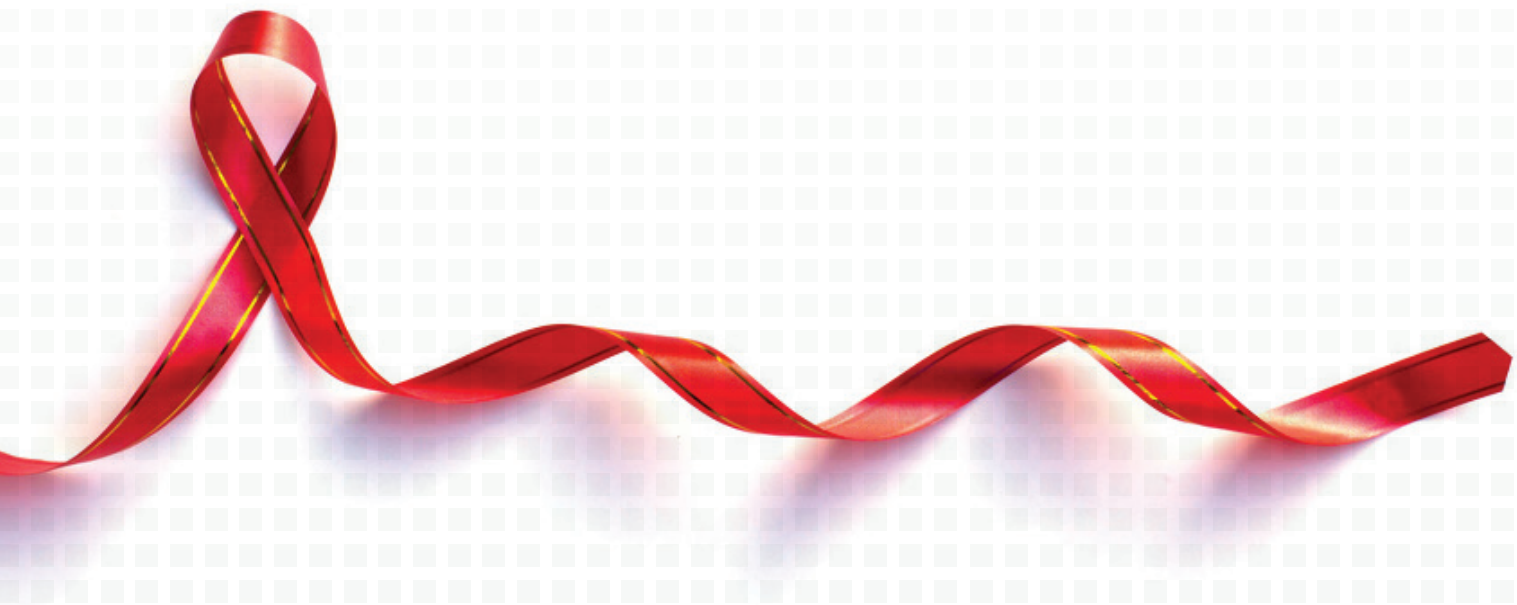
Approved November 2009

Assessment Report on the Status of Mother-To-Child Transmission of HIV Programmes in the SADC region



ORIGINAL IN
ENGLISH

Acknowledgements

This work was made possible through the collaboration of the Southern African Development Community (SADC) Secretariat with Member States and various stakeholders. The Secretariat would like to acknowledge all the contributions. Firstly, Member States of SADC, through their programme managers and other focal points for the prevention of mother-to-child transmission of HIV provided information about Member States programmes, and coordinated discussions with other stakeholders during the field assessments. Additionally, programme managers reviewed drafts and provided valuable technical input and guidance to the report.

Senior government officials in the Communicable Diseases Project Steering Committee, National AIDS Authorities and Members of the HIV and AIDS Technical Advisory Committee reviewed final drafts and made recommendations to facilitate finalisation. This work also benefitted from collaborating partners, including the United Nations Organisations, namely WHO and UNICEF . The SADC Secretariat would like to thank them for their technical inputs in reviewing various drafts of the document as well as participating in technical meetings to discuss the work.

The consultant for this work was the Social Aspects of HIV and AIDS (SAHARA) who collected data from the Member States and produced a situation and response analysis report which informed the development of the minimum standards. Additionally, the consultant provided valuable technical inputs and drafted various drafts of the report.

At the SADC Secretariat this work led by the Directorate of Social and Human Development and Special Programmes under the SADC Communicable Diseases Project led. Lastly, this work would not have been possible if it were not for the financial support provided by the African Development Bank for funding this work through their grant to the SADC Secretariat on the Control of Communicable Diseases (HIV and AIDS, TB and Malaria), Furthermore, the Secretariat would like to acknowledge financial assistance by the Joint Financing and Technical Collaboration for co-funding of the Consensus building workshop.

ISBN: 978-99968-0-180-8

For more Information

Directorate of Social and Human Development
And Special Programs
SADC Secretariat
Private Bag 0095
Gaborone, Botswana
Tel (267) 395 1863
Fax (267) 397 2848
Email: registry@sadc.int
Website: www.sadc.int

Table of Contents

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
AZT	Azido-Thymidine (AIDS drug)
CDC	Centers for Disease Control and Prevention (in the USA)
HAART	Highly-active antiretroviral therapy
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
MoH	Ministry of Health
MTCT	Mother-to-child transmission (of HIV)
NAC	National AIDS council
NGO	Nongovernmental organisation
PITC	Provider-initiated testing and counselling
PMTCT	Prevention of mother-to-child transmission of HIV
SADC	Southern African Development Community
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities and threats analysis
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

Most children who acquire HIV infection through mother-to-child transmission (MTCT) do so during pregnancy, labour and delivery, or breastfeeding. In the absence of any intervention, the risk of HIV transmission from mother to child is 15–30% if the mother does not breastfeed. The efficacy of short-course antiretrovirals (ARVs) for prevention of mother-to-child transmission (PMTCT) of HIV in Africa is estimated at 50%.

Comprehensive delivery of proven interventions can reduce the risk of MTCT of HIV to less than 2%, and institutionalisation of these interventions has already led to the virtual elimination of new paediatric HIV infections in most high-income countries as well as in some low- and middle-income countries.

The main aim of this work was to assess the status of PMTCT policies, protocols and guidelines in Member States with the aim of developing harmonised minimum standards for policies, protocols and guidelines for PMTCT in the SADC region. The process of reviewing PMTCT policies and programmes involved:

- A review of regional, continental, and global literature on PMTCT practices and emerging issues;
- A review and analysis of PMTCT policies, protocols and guidelines in the SADC Member States;
- Development of an inception report outlining the major issues gleaned from the literature;
- A technical meeting of PMTCT experts;
- Field assessments and policy discussions with major stakeholders in the Member States to identify major achievements, challenges and best practices; and
- A consensus-building workshop where stakeholders reviewed the proposed regional minimum standards, endorsed and adopted them.

Uptake of PMTCT is increasing in the region, although it generally falls short of universal access targets. In addition, not all Member States have national PMTCT policies or guidelines. Those national policies and guidelines that do exist, however, generally comply with global or UN standards.

Not all Member States have a PMTCT implementation (and acceleration) plan, but all Member States with generalised HIV epidemics have guidelines and scale-up plans. Most Member States indicated insufficient integration of PMTCT services and insufficient linkages with other health and social services, such as reproductive and child health, antenatal care and antiretroviral therapy (ART).

1. INTRODUCTION

SADC is home to about 199 million people, and comprises 15 Member States: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. One of the main aims of SADC is regional economic and political integration. However, regional efforts are challenged by the adverse effects of AIDS on social, political, and economic development.

In recognition of the devastating effects of the AIDS epidemic, SADC Heads of State and Government made a commitment in the Maseru Declaration to combat AIDS and other deadly communicable diseases. (1) Through the Declaration, they emphasised the need for rapid scale-up of PMTCT programmes, and for ensuring that levels of uptake are sufficient to achieve the desired public health impact. The Declaration also reaffirmed earlier commitments, such as the United Nations General Assembly's 26th Special Session (UNGASS) on HIV/AIDS (2001), which, among other things, committed to stopping the transmission of HIV from mothers-to-children. UNGASS also committed to reducing by 20% (by 2005) and 50% (by 2010) the proportion of infants and children infected with HIV. (2)

Spurred by the above commitments, SADC Member States have developed policies, guidelines, and protocols to address different aspects of HIV and AIDS. However, those efforts vary within countries and regionally. The variations in policies, guidelines, and protocols complicate efforts to achieve a systematic and common approach to combating the disease. A common approach is necessary, especially with movement of people among the SADC states, some of who are already infected and are either in need of treatment or already on a different regimen from those offered in the countries in which they are currently residing.

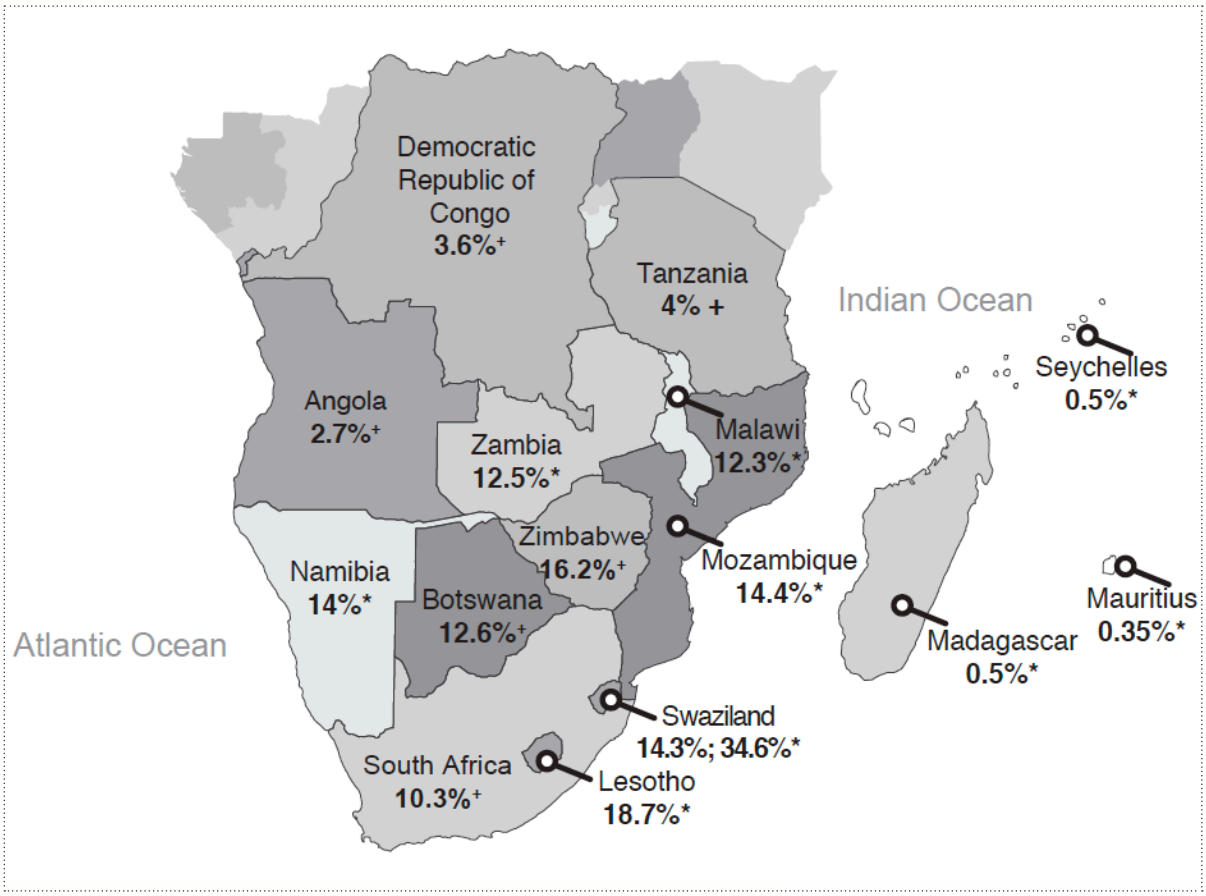
Harmonisation of the regional policies and strategies is, therefore, among the major priorities of the SADC region. The SADC Protocol on Health, which is legally binding, has placed the fight against HIV and AIDS among its priorities. (3) Article 10 of the Protocol calls for the harmonisation of policies for disease prevention and control, including cooperation and identification of mechanisms to reduce the transmission of STIs and HIV infection. The article further calls for the implementation of approaches to HIV and AIDS and sexually transmitted diseases (STIs) in a coherent, comparable, harmonised, and standardised manner. A policy agenda to develop regional harmonised minimum standards for guidance on HIV testing and counselling (HTC) and PMTCT, therefore, goes a long way towards operationalising the *Maseru Declaration,* and responding to the *SADC Protocol on Health.*

1.1 HIV prevalence in the SADC region

There were an estimated 33.2 million people living with HIV in 2007 globally. SADC is the sub-region most severely affected by AIDS. SADC Member States comprise about 4% of the world population, yet they account for more than 37% of all people living with HIV globally. It is estimated that between 11.7 and 18.8 million people in the region are currently living with HIV.

During 2007, HIV prevalence rates among young adults aged 15-24 years (based on population surveys in the SADC region) ranged from 2.7% to 16.2%. Figure 1.1 shows that more than one person in every ten aged 15-24 years is living with HIV infection in some Member States. Those infected will naturally progress to AIDS, require treatment for the rest of their lives, and cause a heavy burden for the Member State and the region as a whole. (4)

Figure 1.1: HIV prevalence among 15-24 year-olds in the SADC region, 2007



Source: SADC Epidemic Update 2007, and various HIV and AIDS reports from Member States, 2007.

** Estimates based on sentinel surveillance data*
+ Estimates based on population based survey data

Sentinel surveillance surveys for 2005 and 2007 show HIV prevalence rates among 15-24 year-olds ranging from 0.4% and 34.6%, depending on the country. It is clear from both sets of data that a significant proportion of young people are infected with HIV.

1.2 PMTCT as a central element in HIV prevention and control

Most children with HIV acquired the infection through MTCT during pregnancy, labour and delivery, or breastfeeding. In the absence of any intervention, the risk of HIV transmission from mother to child is 15–30 percent if the mother does not breastfeed. Non-exclusive breastfeeding may increase the risk by 5-20%. (5) The efficacy of short-course ARVs for PMTCT in Africa is estimated at 50%. Co-infections with herpes simplex virus type 2, other STIs resulting in genital ulcers, and endemic infectious diseases (for example, malaria) may increase the risk of mother to child transmission of HIV. Vertical transmission of drug-resistant viruses has been reported, and the prevalence and effect of transmitted resistant virus on treatment outcomes are under investigation. Obstacles facing PMTCT in resource-limited countries include the lack of healthcare infrastructure, limited human resources, and competing public health priorities within the context of limited health care budgets. (6) Comprehensive delivery of proven interventions can reduce the risk of MTCT of HIV to under than 2%, and institutionalisation of those interventions as the standard of care has already led to the virtual elimination of new paediatric HIV infections in most high-income countries. There, MTCT rates as low as 1% have been achieved. These intervention packages – known broadly as PMTCT services – are becoming increasingly available and affordable even in low- and middle-income countries. Thus, the majority of HIV-related child deaths are now avoidable everywhere. (7) Table 1.1 summarises the efficacy of various PMTCT risk-reduction components.

Table 1.1: Interventions to reduce mother-to-child transmission of HIV

	Pregnancy	Labour & delivery	Postnatal (breastfeeding)
MTCT Risk	5-10%	10-20%	5-15% (and rising)
Intervention Entry point: PITC (enhanced prenatal HIV testing)	PITC Avoidance of HIV infection (woman, partner)	PITC Avoidance of HIV infection (hospital cross-infection)	PITC Avoidance of HIV infection
Intervention Entry point: PITC (enhanced prenatal HIV testing)	ARV prophylaxis or ART (20-30% of women)	ARV prophylaxis or ART	ARV prophylaxis or ART

1.3 Comprehensive PMTCT programme

The United Nations recommends a comprehensive approach to PMTCT programming, based on four prongs:

- Prong 1: Primary prevention of HIV infection among women of child-bearing age;
- Prong 2: Prevention of unintended pregnancies among women living with HIV;
- Prong 3: Prevention of HIV transmission from women living with HIV to their children; and
- Prong 4: Provision of care, treatment, and support to mothers living with HIV, their children, and families. (8)

The activities required in each of these areas are described below.

1.3.1 Prong (1): Primary prevention of HIV infection in women of child-bearing age

This prong includes:

- Health education, information on prevention and care for HIV and STIs (including safer sex practices), pregnancy services (including antenatal care), birth planning and delivery assistance, malaria prevention, optimal infant feeding, family planning counselling, and related services (8);
- HTC, including regular retesting for persons exposed to HIV;
- Couple and partner HTC, including support for disclosure (8); and
- Promotion of safer sex practices, including dual protection.[1*]

1 * *Dual protection implies prevention of unintended pregnancy and STIs, and is generally understood to mean use of a condom (male or female). When condoms are used in combination with other contraceptive measures, this is referred to as double protection or dual method.*

1.3.2 Prong (2): Preventing unintended pregnancies in women living with HIV

This prong recognises that women, including those infected with HIV, have the right to decide which type of contraceptives they prefer. Women generally should have access to condoms, in addition to another contraceptive. The challenge is that most women with HIV in the SADC region may not know their status. It is important that they have increased access to HIV testing and counselling, and that PITC be institutionalised.

1.3.3 Prong (3): Preventing HIV transmission from women living with HIV to their infants

This prong includes promotion of a package of interventions for prevention of mother to child transmission of HIV among HIV positive women who become pregnant. The package includes antiretroviral therapy for the women and their newborns, safe obstetric practices and counselling and support for HIV infected women on safe infant feeding options.

1.3.4 Prong (4): Providing appropriate treatment, care and support to mothers living with HIV and to their children and families

The UN recommends that care and support for those infected with HIV should be integrated with other maternal and child health services, while at the same time being tailored to the needs of women and their children. These services would include sexual and reproductive health, antenatal, obstetric and reproductive health interventions.

2. OBJECTIVES

The main aim of this assignment was to assess the status of PMTCT policies, protocols and guidelines in SADC Member States as a basis for developing regional minimum standards.

The harmonisation of regional policies is in keeping with the spirit of Article 10 of the SADC Protocol on Health, which calls for the harmonisation of policies for disease prevention and control, including cooperation and identification of mechanisms to reduce the transmission of STIs and HIV infection.

3. METHODOLOGY

3.1 Process for reviewing PMTCT policies and programmes

The process for reviewing PMTCT policies and programmes was participatory including Member States, the SADC Secretariat and various stakeholders. The process was also informed by internationally-recognised best practice.

Firstly, a desk review of the current national, regional and global policies relevant to PMTCT was conducted. This was followed by individual country assessments in each Member State, during which key informants within the respective programs, including development partners, civil society organizations and the private sector were consulted to provide information on the state of programmes and policies. The respondents also shed light on some challenges and best practices. Each visit culminated in a country level assessment report which was reviewed and validated by officials from Ministry of Health of each Member State.

The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft regional assessment report was used as a basis for Regional Minimum Standards. Both the draft Regional assessment report and the draft regional minimum standards were then reviewed by a technical team for technical soundness. The team comprised Member States, Technical Partners, Civil society Organizations and the SADC Secretariat. The purpose of the review team was to strengthen the quality of the documents.

Following the technical review and the incorporation of the comments, the documents were then presented to a regional workshop for validation of the situation and response analysis report . All Member States and major stakeholders including regional partners and civil society organisations were invited to the validation and consensus building workshop. The workshop was held on 25-27 May. The meeting made recommendations on the draft report.

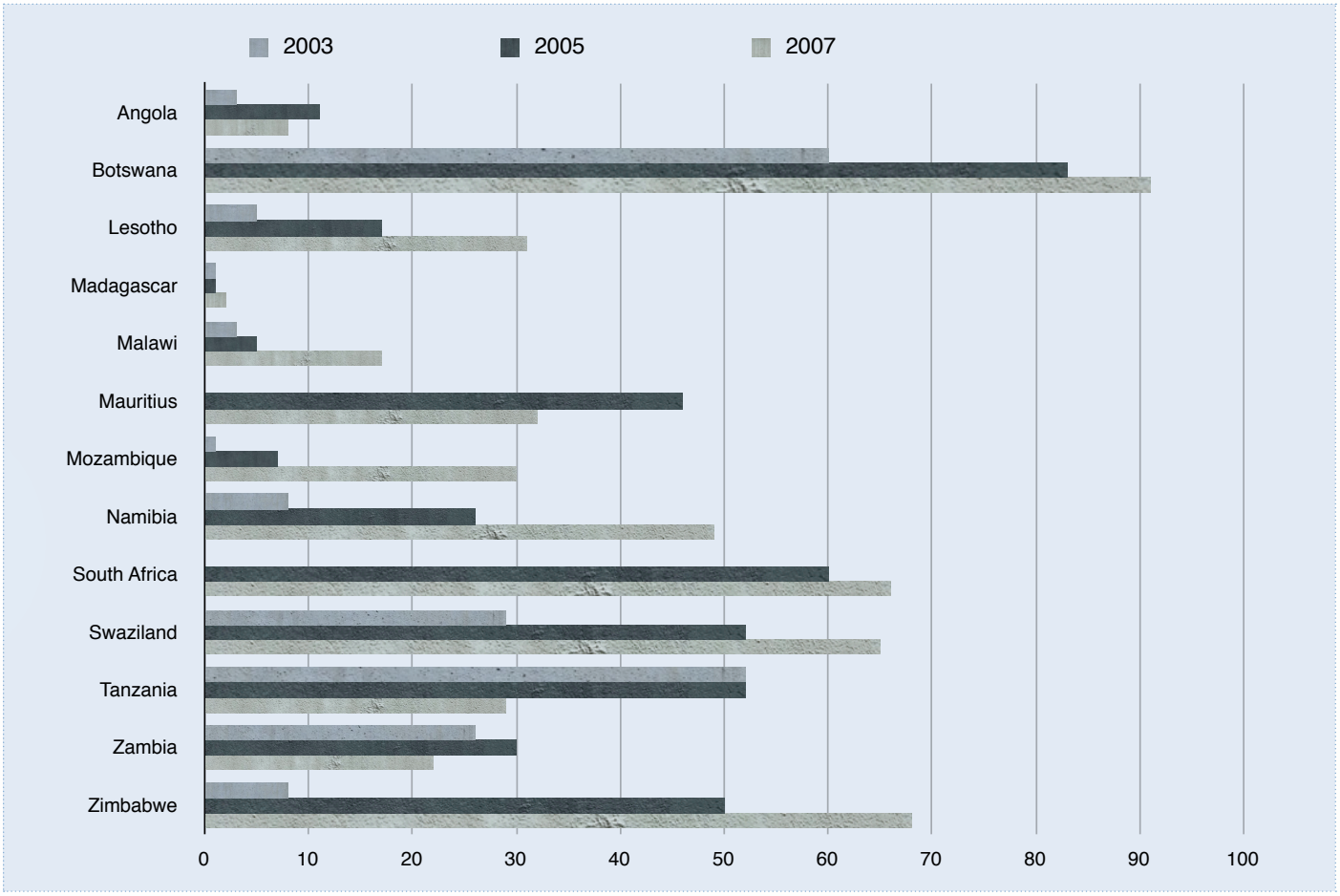
The revised reports were reviewed by the SADC National AIDS Authorities in their meeting of October 2009 for technical soundness and recommendation for finalisation.

4. RESULTS

4.1 Uptake of PMTCT in the SADC region

Thirteen SADC Member States are implementing PMTCT programmes (4), as illustrated in Figure 4.1:

Figure 4.1: Uptake of prevention of mother-to-child transmission of HIV in SADC region, 2003-2007



Source: SADC Member States' HIV and AIDS Epidemic Reports, 2007

The maternal uptake of PMTCT is increasing in the region, although it generally remains below universal access targets. (4) Although universal access targets seem ambitious for some Member States, several may be able to attain them if they maintain the current tempo of implementation. Levels of PMTCT uptake vary widely (from 9% to 91%), but the regional trend is upward. A total of 10 Member States have recorded an increase in the uptake of PMTCT between 2005 and 2007. In 2007, four SADC Member States had at least 50% of HIV-positive pregnant women receiving PMTCT to prevent infecting their infants.

Antenatal care coverage is at least 80% in almost all Member States, and ranges from 80% in Angola to 99% in Seychelles. The percentage of public, missionary and workplace venues offering minimum PMTCT services in most Member States was 65% or more (ranging from 15% in the Democratic Republic of Congo to 100% in Botswana and Seychelles). The percentage of pregnant women who received HIV test results during antenatal care exceeded 60% in most Member States, while the percentage of HIV-infected pregnant women receiving ARV prophylaxis to reduce the risk of MTCT was under 60% in several (ranging from 9% in Angola and Democratic Republic of Congo to 57% in South Africa) and 60% or above in at least six Member States (ranging from 60% in Zimbabwe to 89% in Botswana and 100% in Seychelles). Data from some Member States, however, require further verification (for example, the apparent, dramatic increase of maternal ARV uptake in Zimbabwe from 27% in 2007 to 60% in 2008, and notable declines in coverage in Mozambique and Tanzania).

The percentage of HIV-infected infants born to HIV-infected women was only available for five Member States, and ranged from 3-4% in Botswana to 24% in Zambia. The percentage of infants born to HIV-infected women, who received cotrimoxazole prophylaxis within two months of birth was below 20% in most Member States, and exceeded 75% in only a few. Similarly, the percentage of infants born to HIV-positive women, who received a virological test for HIV diagnosis within two months of birth was below 20% in most Member States and above 20% in only a few (ranging from 28% in Lesotho to 74% in Botswana and 100% in Seychelles). In all Member States for which data are available, children constitute 5% to 10% of people receiving ART (see Table 2 in the Appendix).

4.2 National PMTCT policies benchmarking for the regional minimum standards

Results of the analysis of national PMTCT policies and guidelines are shown in Table 1 (in the Appendix), and indicate that most Member States have national PMTCT guidelines. Almost all Member States with high or generalised HIV epidemics have guidelines and scale-up plans. Additionally, most of the national PMTCT policies and guidelines comply with global or UN minimum standards. National PMTCT policies and guidelines were developed with wide stakeholder consultation, and are available to stakeholders.

Member States agreed that the UN framework for comprehensive approach to PMTCT should be used as the basis for the SADC regional minimum standards, but with adaptation of interventions within each prong. They also recommended that the four prongs of the UN model should be considered in the light of specific situations of the region and countries (for example, appropriateness of caesarean section, cut-off for initiating ART, formula feeding recommendations etc). However, compelling research evidence (such as for the CD4 cut-off point for initiation of ARV) should be taken into consideration.

Results for each of the four prongs are presented in Table 1 in the Appendix; a summary follows here.

4.2.1 Primary prevention of HIV infection among women of childbearing age

Most Member States have national guidelines for PMTCT, although some policies do not include couple HIV testing and counselling, and dual protection. At the first consultative meeting with Member States in December 2008, primary prevention was emphasised. Almost all Member States indicated that primary prevention of HIV had to be strengthened and that those services had to be made more youth-friendly.

4.2.2 Prevention of unintended pregnancies among women living with HIV

Almost all Member States agreed that insufficient attention is given to services for preventing unintended pregnancies, including access to reproductive health commodities.

Some Member States do not include family planning in their guidelines, although a few do mention it in the guidelines, either indirectly (by referring to safer sex) or directly (by mentioning contraceptive options for pregnant HIV-positive women).

4.2.3 Prevention of HIV transmission from a woman living with HIV to her infant

Most Member States include provider-initiated HIV testing and counselling (PITC) in the third prong. For example, Botswana implemented PITC in 2004, following a declaration by the President for universal testing in medical settings.

Several Member States have agreed to gradually scale-up PITC services. Challenges identified included: lack of human resources, the need for infrastructure to be modified to increase counselling space, and the need to increase the demand for testing outside of the antenatal care system (for example, as part of family planning services, and for young people).

Routinely recommended HTC should be introduced in sexual and reproductive health care settings. Rapid testing kits should be used more widely. PITC rapid testing for all pregnant women and counselling and testing should be part of routine health care. A number of Member States do not specifically state HIV retesting in late pregnancy in their policies or guidelines. Retest at late pregnancy should be emphasised. The age of consent for HIV testing ranged from 12 years to 16 years in Member States. However, pregnant young girls or adults, or young people under the age of 16 years who are married, pregnant, parents, or heads of households, and who are engaged in behaviour that puts them at risk or are child sex workers should be considered ‘mature minors’ who can give consent for HIV testing.

4.2.4 Providing appropriate treatment, care and support to mothers living with HIV and their children and families

Most Member States adopted the UN minimum standards in their guidelines (including WHO clinical staging), except for the cut-offs of CD4 cell counts for ART eligibility for mothers and children. CD4 count testing for all HIV infected pregnant women is the target. The ART entry CD4 cell counts differ in various Member States, and range from 200 to 350. In some Member States, less than half of the women have access to a skilled attendant during childbirth, or give birth in a health facility. Provision and uptake of postnatal services are weak links in the continuum of care for women and their babies.

There is generally slow scale-up of early infant diagnosis of HIV. Except in one country, this is largely attributed to the non-availability of polymerase chain reaction testing.

Most Member States use the United Nations AFASS criteria for infant feeding, but many mothers do not meet this standard in one way or another. Countries need to determine how these women can be assisted. Forcing them to breastfeed may not work, in view of their fear for HIV transmission. Letting them to continue with their preferred options may cause other problems, including the deaths of the babies.

4.3 Male Involvement, gender-based violence, and stigma

The PMTCT policies or guidelines of several Member States have nothing or very little to say about gender violence or the involvement of males and people living with HIV. A lack of exact definition of male involvement was also noted.

WHO states that male involvement has been recognised as a priority focus area, which needs to be strengthened in PMTCT. (8) This can be accomplished by encouraging the counselling of couples and mutual disclosure.

The term male involvement includes two aspects: male responsibility and male participation. Male responsibility stresses the need for men to assume responsibility for using contraceptive methods, practicing safe sexual behaviour to protect self and partners from STIs and HIV, and unwanted pregnancies. Male participation refers to men's supportive roles in their families, communities and workplaces, and in promoting gender equity and equality, girls' education, women's empowerment, sharing of household chores and childrearing, and prevention of violence against women and children.

A number of Member States are engaged in efforts to involve men in PMTCT programmes; yet, most agreed that inadequate efforts are made to ensure male engagement. Likewise, they agreed about the impact that gender inequality and gender-based violence have on PMTCT services.

4.4 Research for generating evidence

Good practices in PMTCT, including community involvement, have been noted in some Member States, but these are not necessarily shared with others to benefit the whole region. Operations research could be carried out to validate those practices across a number of states, and the results should be shared with all for wide application.

Preventing unintended pregnancies among women living with HIV is a critical component of PMTCT. However, implementation remains a challenge. Operations research on how it is addressed in practice can facilitate the formulation of policies that can be proposed to other SADC Member States.

5. DISCUSSION

5.1 PMTCT implementation strengths, challenges, needs and opportunities

5.1.1 Strengths

Most Member States indicated the following strengths (see Table 5 in the Appendix for more detail):

- Strong leadership;
- Existence of national PMTCT guidelines;
- Participatory policy development;
- Policy compliance with global minimum standards which have been adjusted to suit country needs;
- Programmes based on context-specific operational research, as well as on international guidelines;
- Existence of a PMTCT implementation or acceleration plan;
- Standardisation of the programme through development of national guidelines;
- Training manuals, standardised training packages and procedures;
- Availability of coordination structures for the response;
- Availability of monitoring and evaluation tools;
- Integration of monitoring indicators in existing registers and patient cards;
- Integration of PMTCT into sexual reproductive health and maternal and child health;
- The use of lay health workers, peer support and counselling; and
- Increasing PMTCT uptake.

UNAIDS identified similar strengths in a regional meeting of nine countries in East and southern Africa. (9)

Stronger governmental commitment was reflected in the development of national scale-up plans for PMTCT, as well as for paediatric HIV care and treatment. It was also evident in attempts to apply the “Three Ones” principle (including in PMTCT and paediatric HIV programmes), and in the development of national guidelines, in line with the latest scientific evidence and best international practices.

Also identified were increased facility-based coverage of PMTCT and paediatric HIV care and treatment services, improved trends of population-based coverage for a select number of indicators (including access to, and uptake of HIV testing among pregnant women), coverage of ARVs among HIV-infected pregnant women to prevent transmission of HIV to their infants, and uptake of paediatric ART.

5.1.2 Implementation challenges, weaknesses and threats

The Global Partners Forum identified several challenges to the scale-up of quality and comprehensive programmes at all levels. (7) Tables 2 and 3 in the Appendix provide an analysis of those challenges and needs across the Members States.

- Most Member States indicated inadequate financial and human resources for the implemenation of PMTCT programmes in their countries;

- Most noted poor partner and sectoral coordination and donor support, which resulted in verticalisation of programmes and poor implementation of national policies;
- A number of Member States indicated low coverage and/or slow rollout of PMTCT (with an emphasis on urban areas), and a lack of distribution of PMTCT services to hard-to-reach populations;
- Stigma and discrimination against people living with HIV still existed in the community and among health care staff;
- Infant feeding support in most Member States is inadequate;
- There was insufficient follow-up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants;
- There was insufficient integration and linkages of PMTCT services with other health and social services, such as reproductive and child health, antenatal care and ART;
- A number of Member States agreed on the need to further decentralise implementation and service delivery, and in particular to focus on developing and strengthening community structures and systems to include PMTCT services;
- Primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities, received insufficient attention and services;
- There were problems with PMTCT programme monitoring, recording and reporting, quality assurance, and impact assessment;
- A few Member States were engaged in efforts to involve men in PMTCT programmes, but most agreed that efforts to ensure male engagement were inadequate. They also agreed that gender inequality and gender-based violence had a negative impact on PMTCT services;
- There was a lack of capacity to cost plans; and
- A number of Member States identified slow scale-up of PITC services. Challenges identified included: lack of human resources (with PMTCT regarded as an extra burden for health care providers), the need for infrastructure to be modified to increase counselling space, and the need to increase the demand for testing outside ANC clinics (for example, in family planning and for youths).

Many Member States identified the following weaknesses (outlined in more detail in Table 5 in the Appendix):

- Inadequate coordination by the Minister of Health (leading to delayed updating of guidelines);
- Not having a separate PMTCT policy;
- A lack of implementation or operationalisation of guidelines;
- Poor coordination of the response;
- A lack of resources for those who want to pursue alternative feeding options, and poor monitoring of infant formula and mixed feeding;
- Low levels of male participation;
- Unfriendly set-ups of health facilities for the involvement of males, adolescents and people living with HIV;
- Weak links between PMTCT and ART;
- Slow integration of PMTCT with others services that provide maternal and child health services;

- Poor referral systems (from antenatal care to ART, and for follow-up);
- Inadequate laboratory equipment, test kits (polymerase chain reaction), medication, supplies and services;
- Staff shortages, high turnover, and inadequate infrastructure; inadequate supervision of policy implementation;
- Inadequate and inaccurate monitoring and evaluation systems;
- Stigma and discrimination; and
- Poor or absent provision for disabled clients.

Member States identified the following threats:

- Inadequate human and financial resources, and high donor dependence (which hinders full implementation of international policy recommendations);
- Incoherent coordination of the HIV response between national AIDS councils and Ministries of Health;
- Poor communication between nongovernmental organisations and Ministries of Health;
- Political instability in some countries;
- Weak supply chains (drugs and test kits); and
- Loss of nursing and medical staff.

At a regional meeting of nine countries in Eastern and Southern Africa, UNAIDS identified similar weaknesses and threats (9):

- Stagnating progress in some of the critical interventions. These included shifting from single-dose to more efficacious ARV regimens, infant ARV prophylaxis (with a growing gap in uptake of maternal and infant ARVs), infant and young child feeding within the context of PMTCT, and low number of children on ART and those on treatment initiating ART late;
- Human resources constraints included shortage of the health care cadres, and gaps in knowledge and skills;
- There was inadequate use of existing opportunities to maximise PMTCT integration into maternal, newborn and child health, and other system linkages, including sub-optimal integration of sexual reproductive health and family planning services into PMTCT and maternal, newborn and child health services; and
- A lack of family/community/facility linkages made it difficult to reduce the loss to follow-up and ensuring effective continuum of care.

5.2 Conclusion and recommendations

PMTCT targets set at the global and Member State levels stipulate the percentage of HIV-infected, pregnant mothers who should receive complete courses of ARVs to avoid infecting their babies. Building on those targets, a target of 80% coverage is recommended for the following:

- All pregnant women attending ANC are provided with information on PMTCT;
- All pregnant women attending ANC are tested for HIV, including those previously confirmed to be living with HIV;
- Pregnant women living with HIV receive ARV prophylaxis or ART to reduce the risk of MTCT;
- Eligible pregnant women living with HIV receive ART for their own health;

- Infants born to women living with HIV receive co-trimoxazole prophylaxis;
- Pregnant women living with HIV receive infant feeding counselling and support at the first infant follow-up visit; and
- Women living with HIV are successfully referred and enrolled in comprehensive longitudinal care and treatment.

REFERENCES

1. SADC. Maseru Declaration on HIV and AIDS. Maseru: SADC; 2003 July.
2. United Nations. Declaration of Commitment on HIV/AIDS. New York: United Nations General Assembly Special Session on HIV/AIDS; 2001 June 25-27.
3. SADC. Protocol on Health. Gaborone: SADC; 2004.
4. SADC Secretariat. SADC HIV Epidemic Report 2007. Gaborone: SADC HIV/AIDS Unit, 2008.
5. De Cock KM, Fowler MG, Mercier E et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into practice. *JAMA.* 2000 Mar 1;283(9):1175-82.
6. Paintsil E, Andiman WA. Update on successes and challenges regarding mother-to-child transmission of HIV. *Current Opinion in Paediatrics.* 2009;21(1):94-101.
7. PMTCT High-level Global Partners Forum. Building Political Momentum Towards Universal Access. Johannesburg, South Africa: PMTCT High-level Global Partners Forum. 2007 November 26-27.
8. WHO. Prevention of Mother-to-Child Transmission of HIV (PMTCT) Briefing Note. Geneva: WHO; undated.
9. UNAIDS. Consultative meeting on evaluating the impact of prevention of mother-to-child transmission of HIV services in low- and middle-income countries in averting new HIV infections in children and improving child survival. Vanderbilt University, Nashville, Tennessee USA; 2009 February 12-13. Available from: http://journals.lww.com/co-paediatrics/secure/pages/purchase.aspx?an=00008480-200902000-00014

Other documents consulted:

Gaud J. Rapport de mission d'harmonisation des protocoles et modules de prise en charge dans les CDAG et les centres de PTME des pays. La Reunion; 2008.

Lesotho Ministry of Health and Social Welfare. Guidelines for the Prevention of Mother-to-Child Transmission of HIV. Maseru: Ministry of Health and Social Welfare ; 2004.

Malawi Ministry of Health. Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care Guidelines. Lilongwe: Ministry of Health; 2008.

Ministere de la Sante Publique. Protocole national: Prevention de la Transmission du VIH de la mere a l'enfant. Kinshasa: Ministere de la Sante Publique; 2007.

Republica de Mocambique, Ministerio da Saude, Programa Nacional de Controle DTS/SIDA Guia para a Prevencao da Transmissao Vertical do HIV. Maputo: Republica de Mocambique, Ministerio da Saude, Programa Nacional de Controle DTS/SIDA; 2002.

SADC. Regional PMTCT Technical Meeting Report. Gaborone: SADC HIV/AIDS Unit; 2004.

SADC. Framework for Developing and Sharing Best Practices in HIV/AIDS. Gaborone: SADC HIV/AIDS Unit; undated.

South African Department of Health. Revised South African PMTCT Policy. Pretoria: Department of Health; 2008. Available from: hhttp://www.doh.gov.za/docs/policy/pmtct.pdf

South African Department of Health. Policy Guideline and Recommendation for Feeding Infants of HIV-positive Mothers. Pretoria: Department of Health; undated.

Swaziland Ministry of Health and Social Welfare. Prevention of Mother-to-child-Transmission of HIV Guidelines. Mbabane: Ministry of Health and Social Welfare; 2006.
WHO. HIV and Infant Feeding: Framework for Priority Action. Geneva: WHO; 2003.

WHO. HIV and Infant Feeding: Guidelines for Decisionmakers. Geneva: WHO; 2003.

WHO. HIV and Infant Feeding: a Guide for Health-Care Managers and Supervisors. Geneva: WHO; 2003. Available from: http://www.who.int/nutrition/publications/infantfeeding/en/index.html.

Zambia National AIDS Council. National Protocol Guidelines Integrated Prevention of Mother-to-Child Transmission of HIV/AIDS. Lusaka: NAC; 2008.

APPENDICES

1: Primary prevention of HIV infection among women of childbearing age	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	SOA	SWZ	TAN	ZAM	ZIM
1.1 [Health education]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1.2 [HIV testing and counselling]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1.3 [Couple HIV counselling & testing]	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1.4 [Safer sex practices including dual protection (condom promotion]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
2: Preventing unintended pregnancies among women living with HIV	**ANG**	**BOT**	**DRC**	**LES**	**MAD**	**MAL**	**MAU**	**MOZ**	**NAM**	**SEY**	**SOA**	**SWZ**	**TAN**	**ZAM**	**ZIM**
2.1 [Family planning]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.2 [HIV testing and counselling]	Y	Y (PI)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.3 [Safer sex practices including dual protection (condom promotion]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3: Preventing HIV transmission from a woman living with HIV to her infant	**ANG**	**BOT**	**DRC**	**LES**	**MAD**	**MAL**	**MAU**	**MOZ**	**NAM**	**SEY**	**SOA**	**SWZ**	**TAN**	**ZAM**	**ZIM**
3.1 [HIV testing and counselling]	Y	Y (PI)	Y	Y (optout)	Y	Y (PI)	Y	Y (PI)	Y (PI, optout)		Y (PI)	Y (optout)	Y (PITC)	Y (optout)	Y (PI)
3.2 [Retesting in late pregnancy]	Y				Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
3.3 [HIV pre-test counselling] [or pre-test education]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y (optout)	Y	Y	Y
3.4 [Post-HIV test counselling]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3.5 [Male involvement]	Y	Y		Y		Y	N	Y	Y	Y	Y	Y	N	Y	minimal
3.6 [Gender-based violence; stigma]			Y	Y		N	N		Y	N	Y	N	Y	Y	N
3.7 [Involvement of PLHIV]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
3.8 [Clinical (staging) and immunological assessment of pregnant women]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3.9 [ART for pregnant women eligible for treatment]	Y	Y (<250)	Y	Y (<350)	Y (<350)	Y (<250)	Y (<350)	Y (<250)	Y (<200)	Y (<350)	Y (<200)	Y (<350)	Y (<350) if stage 3	Y	Y (<350)
3.10 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y	Y (dual)	Y (dual)	Y (dual and triple)	Y (triple)	Y (mono-dual)	Y (triple)	Y (dual)	Y (dual)	Y (triple)	Y (dual)	Y (dual)	Y	Y (dual & triple)	Y (dual)
3.11 [Safer obstetric practices]	Y	Y	Y	Y	Y (elective C/S)	Y	Y	Y	Y	Y (elective C/S)	Y	Y	Y	Y	Y

3.12 [Infant feeding counselling and support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

4: Providing appropriate treatment, care and support to mothers living with HIV and their children and families	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	SOA	SWZ	TAN	ZAM	ZIM
Mothers															
4.1 [ART for pregnant women eligible for treatment]	Y	Y (<250)	Y (<350)	Y (<350)	Y (<350)	Y (<250)	Y (< 350)	Y (<250)	Y (<200)	Y (<350)	Y (<200)	Y (<350)	Y (<350) if stage 3	Y (<350)	Y (<350)
4.2 [Co-trimoxazole prophylaxis]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y (<350)	Y
4.3 [Continued infant feeding counselling and support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.4 [Nutritional counselling and support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.5 [Sexual and reproductive health services including family planning]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.6 [Psychosocial support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.7 [Tuberculosis screening]	Y	Y	Y	Y	Y	N (only symptomatic)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Children	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	SOA	SWZ	TAN	ZAM	ZIM
4.8 [ARV prophylaxis]	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.9 [Routine immunisation and growth monitoring and support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.10 [Co-trimoxazole prophylaxis staring at 4-6 weeks]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.11a [Early diagnosis testing for HIV infection at 4-6 weeks where virological tests are available]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Not yet available	Y	Y	Y	Y	Y
4.11b [Antibody testing for young children at 18 months where virological testing is not available]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.12 [Antiretroviral therapy for eligible HIV infected children]	Y	Y	Y	Y	Y	Y (<250)	Y	Y	Y	Y	Y	Y	Y		Y

4.13 [Continued infant and young child feeding counselling and support]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.14 [Screening and management of tuberculosis and other opportunistic infections]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
4.15 [Prevention and treatment of malaria]	Y			N/A	N/A	Y	N/A	Y	Y	N/A	Y	Y	Y	Y	Y
4.16 [Nutrition care and support]	Y	Y (12 mths)	Y	Y	Y (6 mths)	Y	Y (24 mths)	Y (5 years)	Y	Y	Y (6 mths)	Y	Y (6 mths)	Y	Y
4.17 [Psychosocial care and support]	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
4.18 [Symptom management and palliative care if needed]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.19 [Diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illness (IMCI)]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PMTCT national policy	**ANG**	**BOT**	**DRC**	**LES**	**MAD**	**MAL**	**MAU**	**MOZ**	**NAM**	**SEY**	**SOA**	**SWZ**	**TAN**	**ZAM**	**ZIM**
Existence of national guidelines for the prevention of HIV infection in infants and young children in accordance with international or commonly agreed standards (WHO, 2004a)	Y (3rd review 2008)	2006 being revised; 2008	2007	2008		2008 (rev draft, 2nd ed.)		2004	2008	2008 (revdraft)	2008	2006 (2nd edition)	2007	2008 (revised)	2006
Stakeholder consultation for development national PMTCT guidelines	Y	fully	partly	fully		partly	fully		fully	fully	Fully	fully	fully	fully	fully
Accessibility of PMTCT guidelines/ policies to all stakeholders	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y	partly	Y	Y
PMTCT implementation/ scale-up plan	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y

Note: Y=Yes; N=No; N/A=Not applicable

Table 2: PMTCT indicators

HIV prevalence estimates	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	RSA	SWZ	TAN	ZAM	ZIM
1. Estimates based on sentinel surveillance data, 2007, 15-24 year-olds (SADC, 2008, SDHS, INLS, 2008)	2.1		4.1%	18.7%	0.5%	12.3%	0.35%	12.5%	14.0%	n/a		34.6%	8.2%	12.5%	17%
2. Estimates based on population-based survey data, 2007, 15-24 year-olds (DHS 2004, NDHS, 2006/7; SADC, 2008; ZDHS, 2007)	2.7%	12.6%	3.6%			6.0%		14.4%		n/a	10.3%	14.3%	2.4%	6.5%	16.2%
PMTCT indicators	ANG	BOT	DRC	LES	MAD	MAL	MAU	MOZ	NAM	SEY	SOA	SWZ	TAN	ZAM	ZIM
1. Antenatal care coverage (DHS, 2007; UNICEF, 2008)	80%	97%	85%	90%	80%	92%	--	85%	95%	99%	92%	97%	94%	93%	94%
2. Number and percentage of health care workers newly-trained or retrained in the minimum package during the preceding 12 months (MoH, 2008; WHO, 2004a; THIS, 2007; PNLS 2007)	40%		4152	755 (10.2%)		2185			411		4000		1376	1500	800
3. The percentage of public, missionary and workplace venues (FP and PHC clinics, ANC/ MCH, and maternity hospitals) offering the minimum package of services for the prevention of HIV infection in infants and young children in the preceding 12 months. (Joint UN Report Card 2008; WHO, 2004a; THIS, 2007)	565	100%	15%	90%		83.7%	Only 1 site	70%		100%	95%	77.8%	65%	64%	95%
4. The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling (Joint UN Report Card 2008; WHO, 2004a; THIS, 2007)		96% (March 2009)	67.1%	95%		87.8%			79%	100%	85% (March 2009)	90%	78%	61%	74%

5. The percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards) in the preceding 12 months (MoH, 2008; Joint UN Report Card 2008; INLS, MINSA, 2007)	14%	89%	9%	46.9%	--	90%	--	32%	64%	100%	57% 53% (NVP)	67%	64%	50%	60%
6. The percentage of HIV-positive infants born to HIV-infected women (MoH, 2007; WHO, 2004a; INLS, MINSA, 2007)	2%	3-4%		15%		20%		17.9%		7.7%		23%	1.5%	44.3%	
7. The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (MoH, 2007, 2008; UNICEF, 2008; INLS, MINSA, 2007)	100%	83%	0%	77.2%	0%	12%	--			100%	--	6%	n/a	23%	19%
8. The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within two months of birth (MoH, 2007; MoH, 2007, 2008; Joint UN Report Card 2008;UNICEF, 2008)		74%		28%	0%	3%	--	1%		0%	--	19%	6.9%	25%	2%
9. Percentage of people receiving antiretroviral therapy who are children (MOH, 2008; Joint UN Report Card 2008; WHO/UNAIDS, 2006; MOHSW-HMIS, 2007; INLS, MINSA, 2008)	13.3%	7-10%		7.3%		5%		6%	7%	6%	8%		9%	9%	7%
10. Number of children in need receiving ART (MoH, 2008; Joint UN Report Card 2008; UNICEF, 2008)	1,645	9,496	3,435	1,553	0	10,439	--	6,320	5,283	7	32,060	2,123	11,176	18,040	8,237

Table 3.1: PMTCT implementation challenges in Angola, Botswana, Democratic Republic of Congo, Lesotho

Country	Angola	Botswana	Democratic Republic of Congo	Lesotho
1. Inadequate financial resources, often narrowly earmarked by donors	Human resources; financial resources; infrastructure	Funds are budgeted for management and implementation of PMTCT programme	Funds have been declared by partners but heaviness of payment procedures	Y
2. Inadequate human resources	Y Need for task shifting	Lack of competence in HIV paediatric care, treatment, counselling	Y	Y
3. Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of policies	Y	Inadequate coordination has led to verticalisation of some strategies, for example male involvement	Local NGOs lack resources	Y
4. Low coverage of PMTCT	Low coverage of PMTCT due to difficult access and insufficient human resources. Low ANC uptake	Botswana has 100% coverage as PMTCT services are offered in all health facilities	5%	More in urban, need more in health centres
5. Stigma and discrimination	This is regulated in national guidelines	Declining but still encountered in some areas	Despite awareness campaigns, discrimination and stigmatisation related to HIV-positive status prevails, even among health care providers. Need to generalise new Law protecting rights of PLWHA and AP	Thought to be low due to the fact that more people live openly with their HIV status
6. Inadequate support for infant feeding	Nutritional counselling and support for exposed children mainly after stopping exclusive breast feeding	> 97% formula feed; interrupted formula supply (2006)	The national nutrition programme is not yet widely implemented	Y
7. Insufficient follow-up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	High loss rate of exposed children after birth, low number of tested children or with known HIV test result at 18 months	Lay counsellors, peer mothers and health education assistants used for follow-up of HIV-exposed infants	Y	Y
8. Insufficient integration of PMTCT services and insufficient linkages with other health and social services	Lack of skilled human resources and infrastructure in communities; poor access roads	PMTCT services fully integrated to other related services, including SRH	Y, Reproductive Health Programme not involved in PMCT activities.	Y
9. Need to decentralise implementation and service delivery, and focus on developing and strengthening community structures and systems to include PMTCT services	Decentralisation at provincial level in progress, insufficient coordination between private sector and national implementer structure. Lack of integration with traditional midwifes, weak coordination between health services and community support structures	Inadequate utilisation of community resources for identification, follow-up, and adherence support	Stipulated in guidelines but still very low coverage	Y
10. Insufficient attention to, and services for, primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities		Y	But still very low coverage No integration with SRH	Y

11. Programme monitoring, recording and reporting	Insufficient monitoring system, little interest from health staff to register and analyse data; poor return of information from central to facility health care staff level	Y, Monthly data reporting done	With multiple information gathering tools associated with limited staff numbers	Y, Needs strengthening of data management system
12. Quality assurance and impact assessment	Quality assurance and control not yet fully operational	Y (9.7% Botswana DHS 2006 unplanned pregnancies)	Quality assurance not being met	Quality assurance/ control not yet fully operational; double counting a challenge; testing kits
13. Inadequate efforts to ensure male engagement	Strategies not adapted to socio-cultural realities. Male involvement strategies not adapted	Onoing joint efforts to engage males	Strategies used until now not adapted to socio-cultural realities. Male involvement strategies not adapted	Y
14. Impact of gender inequality and of gender-based violence			Heavily accentuated in rural areas and not yet in areas of armed conflict	Y, Still a challenge as some women are abused due to their HIV-positive status
15. Lack of capacity to cost plans	At provincial and municipal level	Costing is done all the time	Micro-planning in health areas currently underway for the approach package	Y
16. Slow scale-up of provider-initiated testing and counselling services	(PCR – DBS, pilot project in progress in 4 central unites)	Botswana is fully integrating PITC	Very large country, limited number of trained staff – obstacle in applying on a larger scale	Y, Challenge of human resource. Health care providers consider it as extra burden
17. Slow scale-up of early infant diagnosis of HIV	Y	Routine early infant testing rolled out countrywide	PCR only available in 3 main towns: Kinshasa, Kisangani and Lubumbashi	Y, DNA/PCR still done in South Africa

The analysis is based on IATT 2006/2007 and country 2008, 2009 reports

Table 3.2: PMTCT implementation challenges in Malawi, Mauritius, Mozambique, Namibia, Seychelles

Country	Malawi	Mauritius	Mozambique	Namibia	Seychelles
1. Inadequate financial resources, often narrowly earmarked by donors	N	Political commitment and financial resources in budget		Y	Viral load accessories, machine available but not operational for past four years. Unavailability of certain ARVs specific to infants and adults with multiple resistance and for specific pathologies e.g. LEMP, hepatitis C co-infection and drugs for OI.
2. Inadequate human resources	Y	Lack of staff, need capacity building		Y	There should be more training of counsellors
3. Poor partner and sectoral coordination, and donor support, resulting in verticalisation of programmes and poor implementation of policies	N			Y	Inadequate coordination between NGOs and international donor organisations. Country not eligible for donor funds.
4. Low coverage of PMTCT	N	Almost 5% of people using private sector not tested. Poor follow-up	Y	N, Slow roll-out of PMTCT services	Not appropriate for Seychelles. It has 99% PMTCT coverage
5. Stigma and discrimination	Y	HIV & AIDS Act 2006; Civil status act is amended. However, stigma still high	Y	Y	Still a major issue in Seychelles
6. Inadequate support for infant feeding	Y	No problem in infant feeding supply & feeding counselling	Y	Y	Manageable at present, but efforts are needed for sustainability
7. Insufficient follow-up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Y	Follow-up issues with patient. HIV+ bus fare refunded when attending for treatment.		No registration for post-natal care/ follow-up for HIV-positive mothers	PMTCT needs are met, but some women have other issues, e.g. substance abuse, making it difficult to sustain good continuum of care
8. Insufficient integration of PMTCT transmission services and insufficient linkages with other health and social services.	Y, but working on integrating PMTCT into all service delivery points	Good referral service, government takes care all HIV+ pregnant women free of charge		N, Unknown HIV status at delivery is a problem in Caprivi	N
9. Need to decentralise implementation and service delivery, and focus on developing and strengthening community structures and systems to include PMTCT services	Developing a strategy for strengthening community support groups	Government already embarked in this direction by opening 10 new HTC centres this week	Y	Y	Being implemented at community level, however, certain marginalised groups should be fitted in
10. Insufficient attention to, and services for, primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities	Y, e.g. female condoms not easily accessible	N, SRH services are provided free in all health centres which are all within walking distance. More campaigns needed		Y	Availability ,but poor access. Need to increase uptake e.g. among young girls. Age of consent to sex/marriage (15 years) and for treatment and care (18 years) pose policy dilemma
11. Programme monitoring, recording and reporting	Y	Poor. Lack of staff and a need for capacity building	Y, Weak M&E	Y, No assessment to monitor PMTCT service implementation for those trained; irregular monthly reports from health centers; challenges with regard to quality of data capture – how many women are seen in ANC clinics, how many are tested	Improvement needed in programme monitoring, recording and reporting

12. Quality assurance and impact assessment	Y, Routine syphilis screening is an issue, supply chain management	Poor treatment compliance. Continuous training, more needs to be done to track poor compliance		Y	Needs to set up auditing processes to ensure compliance with safe guidelines and protocols
13. Inadequate efforts to ensure male engagement	Y, But male involvement being piloted in 7 districts	Y, More campaigns to enhance male involvement		Y	Needs to encourage, improve and advocate for more male engagement
14. Impact of gender inequality and of gender-based violence	Y	N/A		Y	Women can access services, but gender-based violence issues need to be addressed
15. Lack of capacity to cost plans	Y	Need more training & capacity building		Y	Y
16. Slow scale-up of provider-initiated testing and counselling services	N	Lack of trained staff, but more being done (10 new HTC centres, with total of 25 planned)		Y	Not an issue
17. Slow scale-up of early infant diagnosis of HIV	Y, Only 2 PCR labs national	N/A	Y, Only 2 PCR labs national	N	PCR is needed for early diagnosis

This analysis is based on IATT 2006/2007 and country 2008 reports

Table 3.3: PMTCT implementation challenges in South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe

Country	South Africa	Swaziland	Tanzania	Zambia	Zimbabwe
1. Inadequate financial resources, often narrowly earmarked by donors	Poorly resourced programme, compared to others such as ARV rollout	Most funding comes from partners	Donor dependent Insufficient diagnostic test kits. Insufficient local services (lower level)	Inadequate infrastructure, donor funding not predictable or sustained.	Poor infrastructure, unpredictable funding. Inadequate support for diagnostic services (e.g. CD4), shortage of fuel and vehicles and human resources
2. Inadequate human resources	Y	Y	Shortage of human resources e.g. skilled health care workers. Lack of competency in pediatric care.	HR crisis; low skills base; limit to task shift to lay counsellors	HR crisis and low skills base. Limits to task shifting to lay counsellors. Key challenge is human resource support so health workers can be retained; no support to community workers
3. Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies		Coordination of partners is a challenge	National level is picking up in coordinating PMTCT programme eg existence of National sub committee and Five year scale-up plan , linkage between facilities, care and treatment is very poor. Partner coordination at a regional/district level Programme ownership still a challenge	Policy and implementation is now highly inclusive, harmonised and better coordinated	Very good coordination and partnerships. Policy & Implementation is now highly inclusive, harmonised and better coordinated
4. Low coverage of PMTCT	Only 51.7% of HIV infected mothers receive ARVs. Poor uptake of HCT; poor nevirapine administration rates	Coverage steadily growing	65%	PMTCT services available in all 9l provinces, and all 72 districts. 64% of all ANCs offer testing, counselling and ARVs. 61% of pregnant women tested for HIV, based on population estimates	Good coverage (97%), but low uptake (60%)

5. Stigma and discrimination	Y	Y	Y, especially associated with infant feeding choices	No reliable, validated data on extent and influence	Denial and discrimination exists and inhibits accessing services. Especially prevalent in well-to-do in society,
6. Inadequate support for infant feeding	Formula supply problems	Y	More resources and further education is required. Community structures need to be strengthened	Zambian 2008 PMTCT Guidelines have domesticated the WHO recommendations. But lack of food security makes alternative feeding strategy difficult for most mothers, who tend to opt for breast feeding	Lack of resources for those who want alternative feeding. Poverty makes alternative feeding strategy difficult
7. Insufficient follow-up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Y	Y	Poor follow-up on exposed children within a continuum of adequate care. Train health care workers at under-5 clinics, register follow-up children.	Mother's ANC and child's under-five (Road to Health) cards revised to facilitate tracking and follow-up by recording HIV exposure status. Follow-up for HIV low in the past, but DPT immunisation visit very high at age 6 weeks for babies, and being targeted for HIV interventions	Y, Poor follow-up due to inadequate human resources
8. Insufficient integration of PMTCT services and insufficient linkages with other health and social services	HAART system for pregnant women	Testing mothers for CD4 count in the peripheral clinics. They are referred to next level where the machines are available. This becomes a barrier in identifying mothers eligible for ART	PMTCT not fully integrated into all aspects of RCH and ANC. Need to integrate in SRH and FP. Integration of PMTCT to community centers. Low access to CD4 testing for HIV pregnant women, especially in rural areas	PMTCT part of Integrated Sexual and Reproductive Health. The ISRH is under the District Coordinator for Maternal and Child Health (MCH). At community level, all efforts are being implemented through the Safe Motherhood Action Groups	Y
9. The need to decentralise implementation and service delivery, and focus on developing and strengthening community structures and systems to include PMTCT services	Community involvement lacking	Y	Decentralisation of PMTCT at the district level. Improve community components	District Action Plans for PMTCT have community-level activities for mobilisation. Being utilised to strengthen safe motherhood Action Groups, engage traditional leaderships, and actions for PLWHA	Expand support groups. Programme decentralised, but community support badly needed
10. Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities	Y, Lack of incooperation of family planning into VCT (training)	Y	Y	Family planning services need to be strengthened, expanded and made more youth-friendly	Family planning services need to be strengthened, expanded and made more youth-friendly. Limited services due to inadequate human resources
11. Programme monitoring, recording and reporting	Poor data quality, data challenges in facilities, maternity records silent on HIV status of mothers, CD4 counts not properly documented (filed)	One M&E unit responsible for all HIV data, including PMTCT. Data come from regions to national unit	Y, Existence of M&E framework with data collection and reporting tools. Data from district go to regional and national levels	PMTCT indicators integrated into HMIS since January 1st 2009. Programme also conducts quarterly data audits and feedback activities for all districts and provinces	Y, Reasonable but hampered by poor communication facilities

12. Quality assurance and impact assessment	Y, Poor quality of counselling. Infant feeding choices also dependent on counselling, as indicated by large number of women who are unsure of feeding method	Weak, and must improve. A quality assurance focal person was appointed recently and systems are being put in place	HIV testing done mainly by nurses. There is need for quality assessment from lab personnel, but these are few in number. Poor communication between laboratory personnel and non-laboratory personnel. Lack of test kits. Inconsistent supply of drugs for HIV-positive mothers. Lack of supervision	Low staffing levels remain a challenge. A system for supportive supervision, mentoring and reorientation to new guidelines is ongoing. Impact assessment is being done using WHO-UNAIDS modelling	Poor staffing and/or staff shortages mean that many trained staff are working in isolation without support, supervision or mentoring. Skills levels among some PMTCT staff are low and negatively affect quality assurance in PMTCT programmes. Inadequate funds for support and supervision, including mentoring. Capacity at national level to manage the vast database that emanates from 1560 sites is inadequate
13. Inadequate efforts to ensure male engagement	Men not sufficiently involved and informed on PMTCT issues	Male dialogues and sensitisation done in communities to engage men. Impact yet to be seen	Male involvement minimal. Disclosure to males is not easy. Need to improve partner involvement	Male engagement is challenging. There are emerging good practices using traditional leaders in Southern Zambia	Y, But getting a partner tested and consistent condom use with partner is a big challenge
14. Impact of gender inequality and of gender-based violence		Disclosing to partners and family has led to gender violence and eviction	Y	No reliable, validated data currently captured to show extent	Regarded as a major bottleneck for effective performance
15. Lack of capacity to cost plans		Poor	Insufficient capacity	National, costed scale-up plan for PMTCT-paediatric HIV (2007-2010) for minimum 80% coverage. Translated into district- and province-specific plans responsive to needs of each administrative and geographic level.	An ongoing challenge in decentralisation efforts
16. Slow scale-up of PITC	Y	PITC contributed a lot in speeding up PMTCT implementation. All nurses provide PITC in all health facilities.	N, PITC part of comprehensive PMTCT Training and service provision	Uptake steadily increasing from 25% to 61% in past two years for PMTCT, and on-track according to national plan	Y, Need to increase counselling space. PITC must be extended outside ANC, e.g. in family planning and for youths
17. Slow scale-up of early infant diagnosis of HIV	Y, Management systems not based on best practices and resources not adequate to ensure PCR HIV testing is performed at 6 weeks	Y, PCR only at national level	Still slow. Training packages needed. Referral system establishment. Transportation of samples from health facilities to reference lab and back	Scale-up slow as programme matures. Major challenge is courier system for DBS samples to the 3 PCR labs in the country, and the extended turn-around time. Pace has been accelerating	Y, Programme in initial stages. Being implemented in the 4 central referral hospitals. Resources needed to scale-up in phases so service can be accessed countrywide

The analysis is based on IATT 2006/2007 and country 2008 reports

Table 4.1: PMTCT implementation needs in Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar

Country	Angola	Botswana	Democratic Republic of Congo	Lesotho	Madagascar
1. Need to speed up development of policies and guidelines	Existing guidelines recently revised	Reviewing and updating 2006 PMTCT guidelines. 2008 Botswana National HIV/AIDS Treatment Guidelines available	Existing guidelines, not updated	Update IYCF policy. Finalised IYCF curriculum. Finalisation of PMTCT guidelines in progress	Revise 2007 PMTCT protocol
2. Need to improve M&E (PMTCT indicators, registers)	Y	PMTCT programme improving its data quality. Improved tool and reviewed registers pilot-tested in 2009	Y	Y, PNC register piloted	
3. Need to improve C&T (quality)	Y	Y, Botswana PMTCT programme improving quality through support visits, training, refresher courses, etc.	PITC adopted	Y	
4. Appropriate use of lay health workers in the health care setting	Y	Lay counsellors basically provide testing and counselling services at facility level. Also do follow-up of mothers and children	As community relay and social agents		
5. Improve integration of PMTCT into paediatric AIDS treatment and care activities	Y	Y	Y	Y	PMTCT policy addresses integration of PMTCT into paediatric AIDS care. Implementation a big challenge due to staff shortages at clinical and community levels.
6. Effective communication on PMTCT	Y	Y	Y	Y	
7. Scale up cotrimoxazole prophylaxis	Y	Y, CTX prophylaxis routinely given to HIV-positive babies and general population	Y	Y	
8. Improve community support/male involvement	Y	Y, Ongoing	Y, Involve community leaders (cultural, religious, etc.) in raising awareness among population	Y	
9. Strengthen quality assurance for PMTCT services	Y	Y, Ongoing	Y	Y	
10. Roll-out more efficacious regimens in all facilities providing PMTCT services	Y	2008 Botswana National HIV/AIDS Treatment Guidelines used. Pilot on universal access to HAART planned for financial year 2009-10	Y	Y	
11. Roll-out early infant diagnosis	Y	EID using Dried Blood Spot routinely available in all health facilities		Y	Emphasis on scale-up of more efficacious regimen with strong link to ART, as highlighted in 2006-2010 Zimbabwe National HIV/AIDS Strategic Plan
12. Other, Integration of services	Y		Y	Integrated PMTCT into under-5 services, nutrition	Strengthening of linkages with reproductive health, family planning, IMCI

Table 4.2: PMTCT implementation needs in Mauritius, Malawi, Mozambique, Namibia, Seychelles

Country	Mauritius	Malawi	Mozambique	Namibia	Seychelles
1. Need to speed up development of policies and guidelines	Revise 2004 PMTCT protocol. Revised protocol 2008, but no policy	N, "Three Ones", TWGs, umbrella organisations and sub-groups	Review of guidelines & policies	Update some policies & guidelines.WHO guidelines recommend 6 months exclusive breastfeeding, but we recommend 4 months.	Y, Speed up revision of PMTCT guidelines
2. Need to improve M&E (PMTCT indicators, registers)	Finalising National HIV/AIDS M&E Framework Operational Manual. Much being done in PMTCT M&E. Training of service providers ongoing	Harmonising indicators and finalised ANC and maternity registers. Passport: child, mother (adequate HIV info) being produced	Y	Y, PMTCT Annual report p 4	Y, Need to set up an M&E system, and SADC Member States should have some similar indicators for comparison
3. Need to improve C&T (quality)	Greater emphasis on continuous training	Y		Y	Y, Train more people to fill capacity gaps
4. Appropriate use of lay health workers in the health care setting	Y	Y	Y	Y, but uses community counsellors	Y, Need to train more and integrate them into health care settings
5. Improve integration of PMTCT into paediatric AIDS treatment and care	Y	Y	Y	Y	Y, There needs to be trained paediatricians
6. Effective communication on PMTCT	Aggressive campaign to break stigma	Y	Y	Y	Y, Must be strengthened and reinforced
7. Scale up corimoxazole prophylaxis		Y	Y		Covered well
8. Improve community support/male involvement	Y, Is needed to increase male involvement	Y, Expand	Y	Y	Y, More needs to be done
9. Strengthen quality assurance for PMTCT services	Y, To improve treatment compliance	Y	Y	Y	Y, To ensure quality services, effective management and quality control system with continuous M&E
10. Roll-out more efficacious regimen in all facilities providing PMTCT services	Increase in HIV-positive pregnant women. Decentralise PMTCT delivery points at least to regional hospitals	Y		Y	N/A
11. Roll-out early infant diagnosis	Being done	Y	X	Y	Y, PCR needed
12. Other, Integration of services		Integrate PMTCT into Youth Reproductive Health services			

Table 4.3: PMTCT implementation needs in South Africa, Swaziland, Tanzania, Zambia, Zimbabwe

Country	South Africa	Swaziland	Tanzania	Zambia	Zimbabwe
1. Need to speed up development of policies and guidelines	Update IYCF policy FP guidelines for HIV infected women. Need to update protocols (dual therapy, when to begin HAART)	Update IYCF policy	Need to revise PMTCT policy. Disability not addressed in guidelines	National PMTCT guidelines were revised in 2008	Revise national PMTCT guidelines. Need to revise pediatric ART guidelines to include early treatment of HIV infected infants
2. Need to improve M&E (PMTCT indicators, registers)	PNC register piloted and ready. All districts should appraise status of PMTCT. Institute PMTCT barometer to evaluate performance in districts. Standardise data collection tools, strengthen M&E systems and improve quality of District Health Information System data. Introduce Excellence award for best performing district	Y	Y	Done already. New HMIS launched on January 1st 2008, with the desired indicators included.	Need to improve policies on M&E (PMTCT indicators, registers) through introduction of standardised integrated electronic data system for all programmers. Need tracking tools to link PMTCT services with ART services. Computers needed for the sites. Email communication would assist in movement of data.
3. Need to improve C&T (quality)		Y	Y	Y	Y
4. Appropriate use of lay health workers in health care setting	Y	Y, Advocacy in accommodating task shifting in health system	Policy not yet clear – still in discussion.	Y	Lay counsellor recognised, but remuneration very poor, leads to attrition. Resources needed for training and retention
5. Improve integration of PMTCT into paediatric AIDS treatment and care activities	Y	Planning and scaling-up to lowest level ongoing	Y	Y	Well-integrated at policy level. Train more health workers (doctors and other clinicians) to initiate paediatric ART
6. Effective communication on PMTCT	Community mobilisation, door-to-door campaigns, other district campaigns	Y	Health sector HIV communication strategy needs to address PMTCT issues	Y	Y
7. Scale-up cotrimoxazole prophylaxis		Y	Gradually growing	Y	Y
8. Improve community support/male involvement	Y	Y, Evaluation needed to support improving this activity	Y	Roll-out couple counselling services	Y
9. Strengthen quality assurance for PMTCT services		Y, Great need. Lab has quality assurance	Y	Y	Strong M&E system. Internal and external for rapid HIV Testing Counselling QA: client and provider surveys
10. Roll-out more efficacious regimen in all facilities providing PMTCT services		Y, 3TC tail is only available in hospitals. Dual regimen being quickly scaled-up	Y	Y	Y
11. Roll-out early infant diagnosis		Y, Need to cover lowest level clinics to do DBS	Y	Y, Need to improve courier system	Programme being scaled-up following successful piloting in 6 sites. Need resources to assist movement of commodities to implementing sites countrywide.
12. Other, Integration of services	Y	Integration of PMTCT services with IMCI, nutrition, EPI, growth monitoring			

Table 5: PMTCT SWOT analysis by country

Country	Strengths	Weaknesses	Opportunities	Threats
Angola	· PMTCT protocol (2006) · PMTCT guidelines review (2008)			
Botswana	· Government commitment and leadership: Political commitment is supported with resources · Policy compliance with global minimum standards, and adjusted to suit Botswana case. · Training and use of lay counsellors with quality control checks once a month · Peer men / peer women counselling · Standardisation of programme through development of national guidelines, training manuals, procedures, etc. · Full integration of PMTCT and SRH services from inception of the programme (one-stop shop) · Availability of national ARV programme · Implementation of routine HIV testing using on-site rapid HIV test · Long-course ARV prophylaxis · Counselling supervision training programme. · Good information, education and communication strategy · Improved turn-around time for infant test results (DNA PCR) · Implementation of WHO AFASS criteria in infant and young child feeding	· Inadequate monitoring of infant formula, mixed feeding · Inadequate logistics management at clinic level · Lengthy procurement strategies resulting in interrupted supply of infant formula. · Limited male involvement –4-11 % · Unfriendly set-up of health facilities for males, adolescents and PLWHA involvement · Weak ARV-PMTCT link · Sub-optimal post-test counselling	· Review of policies to fully integrate PMTCT into SRH · Review and harmonise policies/guidelines (e.g. national HIV/AIDS policy and family planning guidelines that define the age of consent to testing) · Strengthening HIV/AIDS prevention and family planning limbs of the SRH · Ongoing infant and young child feeding counselling according to AFASS criteria for HIV-positive mothers · UNICEF seconded procurement officer to MOH in February 2009 · Intensify post-test and supportive counselling to ANC clients · Scale-up peer mothers programme · Integration of HIV/AIDS into famiy planning guidelines	· Limited financial resources. · Inadequate communication between NGOs and MOH · Poor definition of male involvement

Democratic Republic of Congo	· PMTCT protocol published in 2007 · PMTCT implementation plan	· Non-integration into other programmes concerned by PMTCT, e.g. National Reproductive Health Programme · Stigma and discrimination · Poor infrastructure · Poor male involvement · Motivation of service provider – poor remuneration · Inconsistent supply of test kits and medication	· Integration of PMTCT into national reproductive health and other programmes · Scale-up training of more service providers · New strategies for male involvement · Updating existing guideline · Scale-up involvement of PLWHA · Scale-up involvement of entire family unit for care and support · Improve monitoring and evaluation. · Training of more service providers · Scale-up acess to ART and ARV prophylaxis	· Poor overall health system: due to lack of human and financial resources, poor infrastructure
Lesotho	· Government commitment and leadership · The PMTCT policy and guidelines are in a final draft (2008) · Consultative policy process · Policies and guidelines readily available · PMTCT up to 97% · Improved turnaround time for CD4 count cell results · Finalised IYCF curriculum · Use of community health workers in PMTCT · Availability of PMTCT scale-up plan	· Operationalisation of draft policy within sites · Majority of programmes emphasise women's issues only · No clear policy for HIV negative pregnant women · Q&A: double counting occurs	· Partners in Health strong on men's issues · Free HIV/AIDS services · Training of HCWs in PMTCT · Task shifting · Partnership with NGOs · Involvement of PLWA	· Weak supply chain (drugs and test kits) · Insufficient HR · Dependency on donors · Stigma and discrimination · Limited funds · Topography of country
Madagascar				

Malawi	· National guidelines for PMTCT and training manuals · 2008-2013 PMTCT costed Implementation plan · Large geographic coverage · Paediatric HTC guidelines · Strong coordinated & sustained partnership · Political Commitment · Formation of programme acceleration committee · Presence of sub-group · Availability of funding	· Poor accessibility to female condoms · Only 2 PCR labs nationally · Limited male involvement and low spouses/ partner testing for HIV in PMTCT settings · Inadequate laboratory equipment, supplies & services	· Scale-up male involvement through IEC, peers educators · Scale-up EID (DNA-PCR) · ARV and ART scale-up · Integrate PMTCT into youth RH services · Full integration of maternal & child health services & other RH services · Development and integration of ANC, maternity registers, Child and mother passport, follow-up registers for mother and child pair · Operational research for evidence based interventions · Scale-up referral/support of women in childbearing and access to FP for HIV positive mothers · Private sector involvement · Integrate PMTCT into all service delivery points (FP, NRU, Under-Five Clinics)	· Infrastructure (Inadequate laboratories · Lack of human resources
Mauritius	· PMTCT protocol (2004) · PMTCT guidelines (2008) · >95% of pregnant women attending state facilities tested · Free HIV and PMTCT services, including ART	· No PMTCT policy · Inadequate PMTCT M&E · Poor male involvement · Guidelines not easily accessible	· Scale-up decentralisation of PMTCT delivery points to regional hospitals · Development PMTCT policy	· Private clinics do not do HIV testing · Concentrated epidemic progressing to generalised epidemic
Mozambique				
Namibia	· Political will (President officiates at conference) · Participatory policy development · National policy on HIV/AIDS (2007) includes PMTCT policy · PMTCT guidelines (2008) · 92% of ANC attendees tested – 72% knew result · Training for adolescent-friendly health services ongoing · Availability of DNA-PCR test from 6 weeks · Training of HCWs in DBS · Pre-service training of staff at University of Namibia	· PMTCT policy not separate · Poor referral systems (from ANC to ARV, and for follow-up) · Poor male involvement · NVP uptake needs improvement · Infant formula not provided · People with disabilities not catered for · Few adolescents attend RHS · Staff shortages and high turnover · M&E system inadequate	· Government commitment, e.g. national HIV testing day · Scale-up NVP uptake · Upscale registration for postnatal care/follow-up for HIV-positive mothers · Scale-up 'one-stop-shop' service delivery model, e.g. co-locating ANC and ART · Integration of MCH services into one policy	• Insufficient funding to fully implement international policy recommendations

Seychelles	· Political commitment: Chair of NAC is President of the Republic · Clear guidelines and protocols that adhere to global minimum standards · Couple counselling for HIV-positive female · Counselling by trained nurses and medical doctors · 99% PMTCT coverage · AZT/Triple therapy · Free HIV, PMTCT service · 7 Seychellois doctors, 6 nurses and midwives specialised in HIV/AIDS management from University of Bordeaux, France · Good follow-up system · Good contact tracing · Technical Advisory Committee for HIV/AIDS & STI	· Stigma and discrimination · Lack of organised, consistent HIV/AIDS/STI surveillance activities · Inadequate M&E · Lack of guidelines and operational plans at district level · Insufficient research, dissemination and use of research in decision-making	· Promote IEC and male involvement · Reviewing policies and guidelines · Integration of legal issues into PMTCT programme, e.g. have mandatory HIV test for all pregnant women considering rights of the unborn · Training of paediatricians and lay counsellors · Strengthen M&E system · Strengthen PCR early infant diagnosis and education of infant feeding	· Limited human & financial resources · Poor perception of risk · Increase in IDUs, MSM, CSW · Hepatitis C increasing · Increase of new HIV infections in 15-49 year age group · Many people reporting in late stages of disease
South Africa	· PMTCT policy drafted in 2001 · New PMTCT guidelines adopted February 2008 · PLWHA and disability sector involved in social mobilisation plan for PMTCT · Wide consultation on policies and plans · Availability of PMTCT accelerated plan	· PMTCT protocol does not (fully) match international best practice norms · Men not sufficiently involved (but 'Men as Partners' programmes addressing this) · Adolescent mothers not included in PMTCT planning · Inadequate human resources · Poor quality counselling · Infant formula supply problems · Weak M&E	· Recent renewed political commitment · Accelerated PMTCT roll-out launch (Mar/Apr 2009) · Change to PITC in ANC and maternity settings · PNC register piloted and ready to be printed · Use of NGOs to assist the programme	· HRH · Health worker attitudes

Swaziland	· Strong political commitment (MOHSW full support) · Swaziland PMTCT implementation plan for 2007 to 2011 with costed plan of action · Integration of PMTCT in MCH · 94% uptake · Integration of monitoring indicators in existing registers and patient cards (ANC, CWC etc.)	· Centralised services, e.g. one M&E unit for all HIV data, including PMTCT · PCR only at national level · Limited male involvement & low disclosure rates · Lack of well-established referral system · Interrupted supplies, e.g. kits · Infant feeding: consensus statement in the guidelines does not tally with SWZ PMTCT guidelines · Limited testing of HIV-exposed infants / pediatric testing · Long turn-around time of DNA PCR test results	· Scale-up of PITC, early Infant Diagnosis (EID), dual regimen, quality assurance, integration of PMTCT and MCH · Develop new strategies to involve men · Review guidelines · Improved integration of PMTCT in sexual and reproductive health programme	· Most funding from partners · Human resources
Tanzania	· Strategic HIV plan in place for 2008-2013 · PMTCT guidelines revised in 2007 · Decentralisation of PMTCT at the district level · Good partner coordination at a regional and district level · Draft five years scale-up plan for PMTCT and paediatric care and treatment · National M&E Framework	· Stigma and discrimination which leads to low PMTCT uptake · Poor linkage between facilities and care · Inadequate male involvement · Lack of competency in paediatric care · Poor follow-up on exposed children within the continuum care · Inadequate test kits at testing sites · Inadequate supply of drugs for HIV-positive mothers · Insufficient local services at lower level	· Scale-up PMTCT which includes PITC · Strategies to address male involvement and PLHW · Training health care workers, expand obstetric and medical care to address the specific needs of women infected with HIV · Full integration of PMTCT into community structures for follow-up and support services · Source of funding, for example GFATM, PEPFAR, UN agencies and CSOs	· Inadequate financial services- donor dependent. · Harmonisation between health care services. · Lack of skilled paediatric specialists · Infrastructure or distribution of health care services across the country

Zambia	· Policies developed in collaborative fashion involving local and international stakeholders. · Policies checked against international standards and based on WHO (2006) guidelines · Revised policies produced December 2008 · Policy documents available to any stakeholders, free of charge · National system of quarterly programme review, data audits, validation and feedback to all the 72 districts, 9 provinces and national level, with focus on improving service delivery coverage and quality · Functional national Technical Work Group for PMTCT, with regular reviews of emerging evidence locally and internationally and review of national progress. · Research agenda incorporated among some of the implementing partners, which generates international standard local evidence	· Understaffing (and under-skilled staff) in public health system constrains programme expansion · Inadequate infrastructure · Disabled clients (blind, deaf) not well-catered for · Inadequate supervision of policy implementation	· Zambia Emory HIV Research Project (ZEHRP) research project on couples counselling offers opportunity to involve men · Traditional leaders in Southern Province helping get men involved · Implementation of smart care, an electronic card system for continued care of a client with capacity for all levels to optimise data use	Unpredictable funding arrangements
Zimbabwe	· Government commitment and leadership; emphasis on national ownership · Standardisation of programme through development of national guidelines, training manuals, procedures etc. · Programme based on context-specific operational research and international guidelines · Strong partnerships built through the PMTCT Partnership Forum (PPF) and its sub-committees · MOHCW ensures collaborating partners follow national polices & guidelines and assists in coordination of activities. Number of partners rose from 10 in 2002 to 25 in 2007 · Regular supervision and training programme to equip health workers with relevant skills · Use of couples who have gone through PMTCT as mobilsers of other couples and to offer counselling · Media campaigns · Use of primary care counsellors · Data collection through courier system; collection tools are integrated	· Limited infant and young child feeding option · Lack of resources for those who want alternative feeding · Limited male involvement · Poor follow-up and testing of HIV exposed infants. · Weak referral systems between PMTCT, ART and family health services. · Slow integration of PMTCT with others services that provide maternal and child health services. · Communication channels at all levels as the economy struggles	· Review of policies to fully integrate PMTCT into SRH · Integrate PMTCT with RH Communication strategy to include information regarding pregnancy, aerobics, labour and post natal care for fathers and mothers (not just HIV-infected) · Linking PMTCT with HTC mobilisation · Review and harmonise policies/guidelines (e.g. national HIV/AIDS policy, age of consent in reproductive health policy, disclosure etc.) with view to creating conducive environment for PMTCT implementation · Development of services for teenage mothers · Universal treatment for all people eligible for ART including infants <12 months	· Limited financial resources. · “Brain drain” of nursing/ medical staff · Unstable economy · High sero-prevalence resulting in heavy burden of disease

Directorate of Social & Human Development & Special Programs SADC Secretariat

Private Bag 0095
Gaborone, Botswana
Tel: (267) 395 1863
Fax: (267) 397 2848
Email: registry@sadc.int
Website: www.sadc.int

ISBN: 978-99968-0-180-8