

Prevention of Mother to Child Transmission of HIV



Full Protocol

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Provincial Administration
of the Western Cape



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Pictures:

Above – From “Mother to Child”, a film documenting the MTCT programme at Chris Hani Hospital, Gauteng, courtesy Steps Initiative

Cover – From the “Beat-it” series (Idol Pictures), Mercy, Pumeza and Baby, Michael Mapongwana clinic, Khayelitsha

Preface

Prevention of mother-to-child transmission of HIV has become the flagship programme in the Western Cape Province and a shining example to the rest of the country and continent.

Already, sixty percent of pregnant women attending public sector maternity services have access to MTCT prevention. By June 2002, this will have increased to ninety percent and universal coverage will be achieved by March 2003.

The MTCT prevention programme will save more than a thousand babies from HIV each year. When new regimens become available this number will be even higher until we reach a point when it will be a rare event for a baby to be born HIV positive in the Western Cape.

The MTCT programme has had wider spin-offs that are as important as its direct effects. It has taken away the secrecy surrounding HIV. As more than 30 000 women have been tested for HIV in this programme over three years the epidemic is no longer buried deep in the labyrinth of private life but talked about openly. The public benefits of this must be substantial.

Another spin-off of the MTCT programme is that it has united us all against the virus. Our decision to implement the programme has brought together government, NGOs, clinicians and the community. A failure to implement this programme would have split us all apart. Through MTCT prevention we have become one winning team.

The main reason for the success of the MTCT prevention programme is that we have a large number of nurses, doctors, counsellors and other staff who have shown such dedication and commitment to implementing this programme that we could not fail. These wonderful individuals work in provincial hospitals and MOUs, local authority clinics and NGOs.

This protocol has been written for these health workers. It will be a guide and a learning tool to help them with the daily work of MTCT prevention throughout the Western Cape. It will also be of use to managers, patients, private health facilities and our colleagues in neighbouring provinces.

Two versions of the protocol have been published. A detailed protocol containing all the elements of the programme and a shorter, punchier version which serves as a quick reference. Make sure you get both!

Many individuals have contributed to the preparation of this protocol and I would like to end by thanking them sincerely.

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Chapter One: Overview

The Mother-to-Child-Transmission (MTCT) programme has the potential to dramatically decrease HIV transmission from mothers to their babies. This document offers guidelines to initiate and sustain the programme to prevent mother-to-child-transmission of HIV. It is written for health care providers in the Western Cape Province of South Africa. It may however be of use to similar programmes in other areas. Features of the MTCT programme include:

- Voluntary counselling and testing (VCT) during antenatal care
- Referral of women for support and care services
- Distribution of nevirapine to HIV-positive pregnant women for self-administration during labour
- Administration of nevirapine syrup to the newborn before discharge from the delivery facility (or to newborns born at home – BBA)
- Offering 6 months of free replacement formula feeds to mothers who elect to forego breast-feeding.
- Follow-up care for the infant at community paediatric clinics, which includes: assessment for HIV-related symptoms and administration of co-trimoxazole to prevent pneumonia (from 6 weeks of life until one year).
- HIV testing of the baby at nine months and if needed at eighteen months.

a) Epidemiology of HIV

- In 2000, 24% of South African women attending antenatal clinics were HIV-positive. The regional rates varied from 36% in Kwa-Zulu Natal to 8.7% in the Western Cape Province. However, the prevalence of HIV infection increased faster in the Western Cape than in any other province, increasing by 37% between 1998 and 1999. In the Western Cape the HIV infection rate varies dramatically from less than 1% in the Central district to close to 20% in Cape Town's Khayelitsha district.

b) How do newborn babies get infected?

- Two-thirds of *HIV infected* newborns get infected during the delivery process as they pass through the birth canal and are exposed to their mother's blood and vaginal secretions, which contain HIV.
- Nevirapine will not prevent infection in babies already infected in utero.
- HIV in mother's milk may infect an additional 14-29% of breast-fed babies. This route of infection is prevented if the mother chooses formula feeding instead of breast-feeding. It may also be reduced for babies that are exclusively breast-fed (defined as nothing given to the baby other than breast milk during the period of breast-feeding) and rapidly weaned.

c) Mother to Child Transmission (MTCT) Interventions

- Without treatment, between 25-40% of babies born to HIV infected mothers will contract HIV infection during pregnancy and through breast-feeding. Treatment programmes in Africa have successfully reduced mother-to-child transmission to

approximately 12%. In the future, new treatment regimes may be able to reduce transmission even further.

- In developed countries with counselling, testing, anti-retroviral therapy linked with comprehensive antenatal and intrapartum care and effective promotion of formula feeding, MTCT programmes have reduced transmission rates to below 5%.
- In the Western Cape, two treatment protocols have been successfully implemented to reduce mother to child transmission. These programmes were initiated in six districts with the highest prevalence of HIV infection.
 - In January 1999, an MTCT programme was initiated in Khayelitsha. A short-regimen of oral zidovudine (AZT) is taken twice a day by the mother during late pregnancy (from 34 weeks gestation). With the onset of labour AZT is taken three hourly until delivery. Babies are not treated with anti-retroviral agents. Mothers are offered replacement feeds (Pelargon®) for nine months.
 - In January 2001, a second MTCT protocol was initiated with an ultra-short treatment regimen. This protocol involves a single dose of nevirapine (200mg) to the mother during labour and a single dose of 2mg/kg nevirapine to the infant shortly after birth. Mothers are offered replacement feeds (Pelargon) for six months. Programmes were launched in Guguletu, Paarl, George, Worcester and Langa/Bontheiweel.
- Nevirapine is relatively simple to administer, requiring only a single dose for the mother while she is in labour and a single dose for the baby within 72 hours of being born. The baby is given another dose of nevirapine before discharge, which reduces the HIV that may be present in the baby's blood, decreasing the chance that the baby will become infected with HIV.
- Independent studies have demonstrated similar results from the zidovudine/AZT and nevirapine regimens. They both result in transmission rates of approximately 10-12% at 6 weeks post-delivery. The two programmes differ in cost; in 2001 AZT therapy for MTCT was available at more than ten times the cost of nevirapine therapy.



Chapter Two: Voluntary Counselling and Testing

The first step in the MTCT programme is to encourage pregnant women to know their HIV status. All pregnant women are offered voluntary HIV counselling and testing (VCT) and those testing HIV-positive are offered enrolment in the MTCT programme.

a) HIV Counselling

Counselling should be performed by people who have been trained in:

- HIV counselling
- Values clarification
- Components of the MTCT Programme

Lay counsellors do most of the pre-test, post-test, and ongoing counselling but in the absence of trained lay counsellors, VCT (including counselling) may be performed by nurses or doctors who have been trained in counselling and testing.

At the booking visit (or subsequent visit) all pregnant women will receive prenatal care and health information on: voluntary counselling and testing and information on mother to child transmission of HIV via both a group information session and individual counselling.

(1) **Group information session:** The session includes the following key components:

- (A) Information about HIV transmission and how to prevent it;
- (B) Information about mother to child transmission of HIV and programme measures to reduce this: nevirapine and formula feeding.
- (C) Information about the HIV testing process and the fact that an HIV test is a prerequisite for enrolment on the programme;
- (D) Explanation on confidentiality and discussion of shared confidentiality;
- (E) The implication of a negative result and the meaning of the “window period”
- (F) The implication of a positive result, for both mother and child
- (G) Recap of the MTCT programme

(2) **Individual pre-test counselling:** After the group information session, each woman is further counselled individually and in private. The counsellor in the individual pre-test counselling session:

- (A) Assesses if the information provided in the group session has been absorbed;
- (B) Answers any remaining questions;

- (C) Discusses the four options for enrolment in the MTCT intervention:
1. To be counselled and tested and receive the results on that day
 2. To be counselled and tested but receive the results at a later visit;
 3. To be counselled at a subsequent visit if she so decides; or
 4. To not take part in the interventions (no further counselling and testing)
- (D) Counsels according to pre-test counselling format provided during counsellor training
- (E) Records the pre-test counselling session in the **Counselling Register** (page 40). If the woman refuses testing after individual pre-test counselling, this is recorded in the *comments* section of the Counselling Register.

b) HIV Testing

- (1) If a woman consents to HIV testing, she gives consent to have blood taken and signs a consent form (page 28).
- (2) After she has signed consent for HIV testing, she is directed to the blood room, where her blood is taken for a rapid HIV screening test by a trained licensed practitioner (midwife). In the absence of a nurse, a laboratory assistant may conduct the tests. However, the results need to be verified by a trained professional nurse.
- (3) If the first test is negative, the woman is considered HIV-negative.
- (4) If the first rapid test is positive, a second rapid test is done on a second sample using a different rapid test.
 - If both tests are positive, the woman is HIV-positive
 - If the first test is positive and the second test is negative the woman is HIV indeterminate.
- (5) If HIV status is indeterminate, a blood sample must be sent to the laboratory (SAIMR/NHLS) for re-testing by the ELISA technique
- (6) After the test has been performed, the midwife or laboratory assistant enters the results (checked and countersigned by a registered professional nurse) in the **MOU Blood Test Register** (page 44). The register is kept confidential and always remains on site. Test results are given to the lay counsellor or nurse concerned for post-test counselling.

c) HIV Post-Test Counselling

- (1) All women, regardless of their HIV status receive post-test counselling according to the post-test counselling format provided during counsellor training.
- (2) If a woman tests HIV-negative, she receives post-test counselling focused on how to maintain her HIV-negative status, with a focus on her health, safer sexual practices, and the high risk of transmission to her baby should she become infected during pregnancy or breast-feeding. The window period should be explained once more and she should receive routine antenatal care.
- (3) If a woman tests HIV-positive, she is provided with immediate support, informed about MTCT and offered an opportunity to participate in the programme. Follow-up visits are arranged, including the 30 week visit in order to receive the nevirapine that is required to be taken at the onset of labour. Over the next visits, the newly diagnosed HIV-positive woman is also provided with:
 - Ongoing counselling which includes: emotional containment, assessment of coping, information about existing support groups, appropriate referrals for support and information around positive living
 - Information about HIV disease, potential health problems and the importance of clinical care for HIV disease
 - Information about the MTCT programme and medicines that are offered (including potential side-effects)
 - Counselling about feeding options including the health benefits and risks of formula feeding and breast-feeding.
 - Counselling about partner identification and disclosure, stigma and discrimination.
 - Information about safer sex during pregnancy and the long term
 - Information about partner testing.
- (4) HIV results and the post counselling session are recorded in the **Counselling Register** (page 40).

d) Documentation and Monitoring

- (1) The sticker below is placed on the antenatal card and folder of all women undergoing counselling and testing in the MTCT programme. It identifies those women who are on the MTCT programme.

Retroscreen:	Yes	No
AZT	NVP	None N/A
Feeding:	Formula	Breast
Booking Facility: _____		

- (2) If, after counselling, the patient elects to test for HIV, *Yes* is circled. If she declines testing, or would like to reconsider at a later stage, *No* is circled. If the patient returns for VCT after the initial refusal, a new sticker is placed on top of the existing one, and *Yes* is circled.
- (3) NVP is circled if the patient is in a programme dispensing nevirapine. AZT is circled if the patient is in a programme dispensing AZT/Zidovudine. None is circled in the rare case of an HIV-positive mother who has chosen not to take any medications. *N/A* is circled if the mother is HIV-negative.
- (4) The mother's choice on how she would like to feed her child (after adequate counselling on feeding options) is indicated by circling either Formula or Breast.
- (5) The name of the facility where this first antenatal assessment is taking place is written on the sticker in the space provided.
- (6) The sticker, on both the antenatal card and folder is to be filled out by either the counsellor or the midwife.



Chapter Three: Antenatal and Obstetric Care

Please note the guidelines for the management of HIV-positive women are to be used in conjunction with the obstetric management policies for the MOU.

As emergency situations arise, i.e. massive bleeding, elevated blood pressure, premature labour etc.; the immediate safety of the mother and baby takes priority.

Staff may need additional training on the antenatal or obstetrical management of HIV-positive pregnant women.

a) Antenatal Care

- (1) The midwife who palpates the pregnant woman in the antenatal clinic will ensure she returns at a gestational age of 30 weeks in order for nevirapine to be dispensed. This (the anticipated visit) must be recorded in the **Antenatal Nevirapine Register** (page 42).
- (2) A card with written instructions is given with the dose of nevirapine at 30 weeks gestation. The dispensing of nevirapine will be documented in the **Antenatal Nevirapine Register**.
- (3) The **Antenatal Nevirapine Register** includes the following information:
 - Name,
 - Address,
 - Hospital or clinic folder number,
 - Gestational age at booking,
 - The date to return for nevirapine,
 - The date that nevirapine is dispensed antenatally (at 30 weeks)
- (4) Near term the patient is re-educated regarding the taking of the nevirapine with the onset of labour or rupture of membranes.

The midwife also checks that the patient:

- has not lost her dose of nevirapine.
- knows when to take nevirapine.
- knows to present in early labour or immediately after rupture of membranes.
- has made an informed decision about how to feed her baby – electing replacement feeds or exclusive breast-feeding.

The midwife ensures that all the information is recorded on the antenatal card and in the patient's folder.

- (5) During antenatal care the pregnant woman is counselled about breast milk transmission and about options to prevent transmission through replacement feeding or to minimise transmission through exclusive breast-feeding. The patient is assisted in making an informed decision on how to feed the baby prior to going into labour.

- (6) All women are informed of support groups within their area, or of a support group within the clinic and are also referred to a local clinic for HIV care.

Maternal Nevirapine (NVP) Regimen

Week 30:

- dispense one tablet of NVP (200mg)

At onset of labour or rupture of membranes:

- mother to take dose of NVP

b) Management of Patients During Labour and Delivery

Midwifery and obstetrical practices are modified for the HIV-positive woman to reduce the risk of HIV transmission to the infant. Although elective caesarean section (prior to labour) is of value, it is not feasible to be routinely offered in this setting.

Other practices are modified including:

- Avoiding routine episiotomy
- Avoiding routine rupture of membranes
- Avoiding unnecessary suctioning of the neonate as well as other invasive procedures such as intrauterine scalp monitoring

- (1) Upon admission, the midwife inquires if the woman took nevirapine at home.
- (2) If the patient is found to be in labour or to have ruptured membranes and did **not** take the nevirapine at home, she takes her dose immediately.
- (3) If the patient does not have the nevirapine tablet distributed previously in the clinic, she is given a dose of nevirapine from the facility's supply.
- (4) If nevirapine is redispensed, this is documented in the **Labour Nevirapine Register** (page 48). The reason for re-dispensing is documented e.g. forgot, lost, false labour etc.
- (5) In the case of false labour or mistaken rupture of membranes: If the patient is evaluated before she has taken her nevirapine and is found to not be in true labour and not to have ruptured membranes, she is sent out to await more active labour. She is instructed to take her nevirapine with the onset of stronger and more regular contractions or with rupture of membranes. If she is evaluated after she has taken her nevirapine and is found not to be in true labour and not to have ruptured membranes, she is given another nevirapine tablet and sent home to await more active labour, and instructed to take this dose if active labour or rupture of membranes occur more than 24 hours after the initial dose. If a second dose is dispensed to the mother, this must also be recorded in the **Labour Nevirapine Register**. If the patient returns on a second occasion after taking a second nevirapine tablet and is still not in active labour, she is referred to a district hospital for management.
- (6) In the case of an elective caesarean section, the nevirapine is given at least 4 hours before surgery.

- (7) In the case of emergency caesarean section, nevirapine should have already been administered during labour.
- (8) Women can be given nevirapine in all stages of labour. It is only too late to give nevirapine if the baby is delivering imminently (the head is crowning). If the baby delivers less than two hours after the mother takes nevirapine, the baby receives one dose of nevirapine immediately after delivery, and a second dose 48-72 hours after delivery.
- (9) If a mother knows she is HIV-positive at delivery but is not in the MTCT programme, she may be offered nevirapine for her and her baby **as long as she is also counselled about the MTCT programme**, including feeding practices and the importance of care, follow-up and HIV testing for her baby.
- (10) When the mother has not received nevirapine during labour, the baby receives two doses of nevirapine (section a) 5, page 10)
- (11) Artificial rupture of membranes should not be undertaken if progress of labour is adequate. Prolonged rupture of membranes should be avoided.

FALSE LABOUR

*Nevirapine can be taken again
24 hours after the first dose if the
patient remains in labour and
is undelivered.*



Chapter Four: Neonatal Care at Obstetric Facilities

There are three essential components for neonatal care:

1. Administration of anti-retroviral therapy (for mother and baby)
2. Initiating feeding practices
3. Arranging follow-up for the mother and her baby.

Please note that in the case of premature births, appropriate adjustments to feeding and supplementation regimens will need to be made according to local guidelines for premature neonates and infants

a) Anti-retroviral therapy for newborns

- (1) If nevirapine is given to the mother in labour and the baby after birth, HIV transmission can be reduced from 25% to 12%.
- (2) Nevirapine syrup dose:
 - If a baby weighs 2 kg or more (>2000g):
 - Give 0,6ml (6 mg)
 - If a baby weighs less than 2 kg, dose nevirapine by baby's weight:
 - Give 0,2 ml/kg (2 mg/kg)
- (3) Nevirapine is given to the baby between 4 and 72 hours after delivery. It is given at least one hour prior to discharge in order to observe the baby for this period.
- (4) If the baby vomits within one hour of nevirapine, a second dose of nevirapine is given and the baby is observed for another hour. *A third dose of nevirapine should not be given.*
- (5) If the mother did not take nevirapine or took her dose of nevirapine less than two hours prior to delivery, the baby gets two doses of nevirapine, the first dose within one hour of life and a second dose one hour prior to discharge (and at least four hours after the first dose). If the baby will be in the MOU or nursery for longer, it is preferable to give the second dose of nevirapine later, up to 48-72 hours of life.
- (6) This information (details of nevirapine given to the neonate) is recorded in the **Labour Nevirapine Register** (page 48) or in hospitals, in the **Hospital Baby Nevirapine Register** (page 52).
- (7) Babies should receive their routine immunisations (OPV and BCG) in their first hours of life.
- (8) If a mother knows she is HIV-positive at delivery but is not in the MTCT programme, she may be offered nevirapine for her and her baby **as long as she is also counselled about the MTCT programme**, including feeding practices and the importance of care, follow-up and HIV testing for her baby.

- (9) If the baby is born outside of the MOU or hospital and presents to the clinic within 72 hours of delivery (when the mother is known to be HIV-positive and is in the MTCT programme or gives her consent), nevirapine may be given to the baby as above. This should be noted in the **Labour Nevirapine Register** (pages 48 & 50) as 'BBA'.

b) Feeding practices

- (1) Counselling of the mother regarding the relative risks and benefits of formula and breast-feeding begins antenatally. The role of the staff at the MOU or referral hospital is to ensure that mothers understand the risks and benefits of different types of feeding and to help mothers determine their choices regarding feeding.
- (2) Breast-feeding in the first two years of life can contribute to an additional 14%-29% HIV transmission to babies. Exclusive formula feeding can eliminate this risk of exposure and is promoted in the MTCT programme. Exclusive breast-feeding with rapid weaning may also have a lower rate of HIV transmission than mixed feeding.
- (3) The mother's choice regarding feeding practices should be known prior to delivery so that proper care can be given to the baby. Mothers opting to formula feed should **NOT** have their babies latched after delivery.
- (4) Free formula is offered for babies in their first six months of life through the baby clinics. For mothers choosing formula feeding, they should be taught how to mix the formula and sterilise the bottles or cups and be given an initial supply of formula (1 kg - two 500g tins) from the MOU.
- (5) Mothers choosing formula feeding should be asked to bring bottles or cups to their delivery. Cups are easier to keep clean/sterile than bottles. (The MOU should have sample bottles and cups available to demonstrate proper mixing of formula. They should also have disposable cups and spoons available for mothers who have not brought their own cup or bottle)
- (6) Mothers choosing to breast-feed should be advised to practice exclusive breast-feeding (no supplemental water, tea, juice or milk) and encouraged to rapidly wean from breast-feeding at age 4 to 6 months in order to decrease HIV transmission.
- (7) At follow-up, the mother's feeding practices or problems should be discussed.
- (8) In breast-feeding infants, mastitis and cracked and bleeding nipples greatly increase the risk of HIV transmission. Mothers are instructed to come to clinic if they experience signs of mastitis or nipple problems. Mothers are instructed **NOT** to breast-feed the baby from the breast with mastitis or nipple problems. Milk from the affected breast should be manually expressed and thrown away. Breast-feeding can continue in the unaffected breast.
- (9) In breast-feeding infants, oral lesions on the baby increase the risk of HIV transmission. In this case, replacement feeds are used until all oral lesions heal.
- (10) The importance of clinical follow-up for the baby should be reinforced, and referral to a local health unit that can provide appropriate follow-up is arranged.

c) Administrative considerations and follow-up

- (1) Managers should ensure that staff are aware of the paediatric components of the MTCT programme.
- (2) The mother's decision regarding her feeding practices is determined before delivery so that mothers who have chosen formula feeds **do not** have their babies latched after delivery.
- (3) Feeding decisions are reinforced post-natally. Mothers are instructed in formula preparation and provided with 1kg of formula and followed up at initial post-natal visits.
- (4) Referrals are provided to the most convenient and competent paediatric programme. Paediatric follow-up programmes should be skilled in HIV-targeted clinical assessments, able to provide appropriate HIV medicines and HIV testing for babies, as well as provide formula. Each paediatric clinic may have special days on which clinicians are available if needed for sicker patients - referral lists can be checked for this information. Ideally, paediatric programmes should be co-located with clinical services for the mother.
- (5) Documentation: Care information and HIV exposure are noted on the baby's Road to Health Card with the sticker (page 35) and in a referral form or letter to the health clinic for the mother and child (page 33). Delivery data about the mother and baby are entered in appropriate registers.



Chapter Five: Paediatric HIV Care in Baby Clinics

All babies who are born to HIV-positive mothers are *HIV-exposed*. For those babies whose mothers did not take an anti-retroviral medication or chose to breast-feed, up to 25-40% will become infected. However, if the mother has taken nevirapine and formula fed her baby, the rate of HIV infection in the babies will be greatly decreased (12% of these babies will be HIV-infected).

The majority of the paediatric components of the MTCT programme are implemented in the baby clinics during the first 18 months of the baby's life as part of routine care. The MTCT components include:

- Administration of the paediatric MTCT service
- Support for formula feeding and distribution of free formula
- Dispensing of co-trimoxazole to prevent PCP
- Frequent clinical visits to monitor for clinical signs of HIV infection and provide routine paediatric care including immunisations
- HIV testing of the infant at nine months and retesting of HIV-positive babies at eighteen months

a) Administrative issues and follow-up

- (1) All HIV-exposed babies in the MTCT programme should arrive from the MOU or hospital with a referral letter and sticker on the Road to Health Card with HIV care needs further noted by the presence of a co-trimoxazole dosage and the need for formula.
- (2) HIV-exposed infants should be seen by the professional nurse at the general baby/paediatric clinic within one to two weeks of birth to establish a follow-up routine, monitor clinical status and provide formula (page 37).
- (3) Clinical skills at paediatric clinics should be assessed, as staff may require additional training in clinical assessment.
- (4) Clinics may choose to provide comprehensive HIV services for sicker patients at designated times of the week, when the doctor or clinical nurse practitioner is available. Referral mechanisms and procedures for babies needing additional clinical care or hospitalisation should be determined.
- (5) Clinics should attempt to coordinate maternal and paediatric clinical care to reduce the number of visits for the mother.
- (6) Staff members should be assigned responsibility for components of the programme such as maintenance of formula and medication supplies, maintenance of registers and tracing and follow-up for mothers who default.
- (7) An expanded role for lay counsellors might be considered: ongoing counselling for mothers about formula and medications; follow-up for defaulters; and mobilisation of community awareness about the importance of HIV testing.
- (8) Appropriate patient education materials should be provided to mothers.

- (9) HIV testing for the brothers and sisters of HIV-exposed infants as well as children presenting with clinical signs of HIV infection through the voluntary counselling and testing programme (VCT) may be considered. Partners or husbands of HIV-positive women should also be offered HIV testing.

b) Formula and nutrition

- (1) Breast-feeding by HIV-positive Mothers contributes an additional 14 to 29% HIV transmission over 18 months. Formula feeding can eliminate this additional risk. Distribution of free formula is a major component of the MTCT programme (comprising 60% of the MTCT budget) and requires extensive logistical and clinical attention.
- (2) Logistics: staff are assigned for ordering, storage, distribution and stock control of formula supplies and maintaining the **Baby Register** (Page 60).
- (3) Mothers need sufficient formula and efficient access to ensure regular and sole use of formula. Clinics should consider ways to fast-track the distribution of formula and for each baby in the programme provide 2kg of formula (four 500g tins) every fortnight (4 kg's per month). This is documented in the **Baby Register**.
- (4) In the MTCT programme, Pelargon formula is given free of charge for six months at which point the baby is introduced to food and the family is responsible for buying the formula. For those families who are unable to afford formula, referral is considered to an NGO or the provincial Protein-Energy-Malnutrition (PEM) scheme.
- (5) After formula is discontinued at 6 months, or after weaning for those babies being exclusively breast-fed, the babies should be assessed within two to four weeks to see if there is evidence of growth faltering or if the baby otherwise meets the PEM criteria for ongoing formula or maize meal supplements.
- (6) Multivitamins (containing Vitamin A) are given to HIV exposed infants for nutritional support until HIV infection is excluded. If multivitamins are not available, Vitamin A supplements should be given according to the schedule below every 6 months and documented on the RTHC.

a.	If baby is	< 6 months,	give Vitamin A 50 000 iu x 1
b.	If baby is	6 –12 months,	give Vitamin A 100 000 iu x 1
c.	If baby is	> 12 months,	give Vitamin A 200 000 iu x 1
- (7) Mothers choosing to breast-feed should be advised to practice exclusive breast-feeding (no supplemental water, tea, juice or milk) and encouraged to stop breast-feeding at age four to six months to decrease HIV transmission. It is suggested that women in urban areas be encouraged to abruptly stop breast-feeding at four months and switch to formula, while women in rural areas without access to clean water may wish to continue exclusive breast-feeding until six months. However, if the breast-fed baby seems to require supplemental feeds, the mother should be encouraged to stop breast-feeding and change to formula and solids so as not to use mixed feeds.

c) PCP prophylaxis with co-trimoxazole

- (1) PCP (Pneumocystis carinii pneumonia) is the leading killer of HIV infected babies. PCP is virtually preventable with co-trimoxazole.
- (2) Co-trimoxazole is given to the baby starting at six weeks of life and continues until at least 12 months if the baby still tests HIV-positive. Nurses may need to get a standing order allowing them to administer co-trimoxazole.
- (3) Co-trimoxazole can be stopped *whenever* the baby tests HIV-negative.
- (4) Co-trimoxazole can be stopped if the baby is HIV-positive but has no symptoms and is doing well at 12 months.
- (5) Co-trimoxazole is continued beyond 12 months if the baby is HIV-positive and has symptoms of HIV such as: growth faltering, recurrent bacterial infections, pneumonia, thrush, severe nappy rash or has ever had PCP.
- (6) Co-trimoxazole is dosed by weight and can be given *once a day, three times a week* – Monday, Wednesday and Friday. The following is the once a day dosage. If given twice a day (bd) the dose should be divided in half.

Weight	Daily Dose	(50ml) Bottles needed per month
<5kg	5 ml	1 (give 2 bottles at first visit)
5-9.9kg	7.5 ml	2
10-14.9kg	10 ml	3
15-19.9kg	15 ml (1.5 tabs)	4
>20kg	20 ml (2 tabs)	5

- (7) **Allergic reactions** are rare but can present as generalised body rashes. If a mild rash occurs refer the same day to an experienced HIV clinician for evaluation and possible switching to Dapsone (2 mg/kg daily).
- (8) A **blistering rash** involving skin, mouth, red eyes (if scabies or impetigo are ruled out) is a medical emergency. Co-trimoxazole is stopped and the baby is immediately referred to a tertiary hospital. Switching to Dapsone will be required.
- (9) Medicine is kept in a cool place and refrigerated if possible. Mothers are asked to bring the baby's medicine bottle to each clinic visit so compliance can be assessed.
- (10) Dispensing of co-trimoxazole to mothers should be made as easy as possible. Consideration should be given to: fast-tracking the distribution; coordinating the distribution with routine immunisation visits starting at six weeks. Co-trimoxazole administration is documented in the **Baby Register**.

d) Clinical Evaluation

- (1) Follow-up should be more frequent for HIV exposed babies. Screening and secondary prophylaxis can be life saving and prevent serious complications.
- (2) Professional nurses see babies at two and six weeks and then every four to six weeks coordinated with the immunisation schedule. The suggested visit schedule for the first year of life is: Weeks: 6,10,14 and 18 and Months: 6,9,12,15, and 18. This can be increased if needed.
- (3) Follow-up occurs at weeks 26 and 28 (seven months) to see if babies can sustain their weight after the formula has been discontinued at six months.
- (4) At monitoring visits the professional nurse should assess for the following clinical conditions. If they are present, the baby is referred to a clinical nurse practitioner or doctor. The nurse:
 - (A) checks weight for growth faltering;
 - (B) checks for oral thrush or sores and nappy rash;
 - (C) checks for fevers, if the baby is floppy or irritable;
 - (D) asks about inter-current illnesses;
 - (E) asks about diarrhoea and cough; and
 - (F) asks about TB contacts.
- (5) The professional nurse should also routinely assess:
 - (A) The mother's coping and general health. She encourages clinic visits for the mother and participation in support groups
 - (B) Feeding practices and problems
 - (C) Adherence with co-trimoxazole
 - (D) Adherence with immunisations as per paediatric schedules.
 - (E) The need for anti-worm treatment. This should be considered every six months starting at one year of age using Mebendazole (5 ml bd for 3 days) or Albendazole (200mg).

e) HIV testing of babies

- (1) All babies should be tested at 9 months using rapid HIV tests as for adults. Blood can be obtained via heel sticks. The 9-month visit can be coordinated with the immunisation visit.
- (2) At nine months or at any age, an HIV-negative test means the baby is uninfected (unless the baby is being breast-fed). An HIV-negative baby can be "graduated" from the MTCT programme.
- (3) For babies with a positive HIV test at nine months, parents should be told that this may be a "false positive" result because some babies are slow in clearing their maternal antibodies. They will need to be re-tested at eighteen months.

Rationale: Although "false positive" tests at 9 months are of concern, the 9 month test is readily incorporated into the immunisation schedule and the majority of babies will test HIV-negative, providing earlier reassurance to the parents and allowing many babies to be discharged or "graduated" from the MTCT program.

- (4) Babies testing positive at 9 months are entered into the **Baby Clinic Post 9-Month Follow-up Register** (Page 58) to facilitate further follow-up.
- (5) At 18 months, all remaining HIV-positive babies should be retested. By 18 months, all *uninfected babies will test HIV-negative* and *HIV-infected babies will test HIV-positive*. An HIV-positive test for a baby who is 18 months or older confirms HIV infection.
- (6) Breast-fed babies can contract the infection from breast milk. All breast-fed babies, even if testing negative at 9 or 18 months, should be retested 3 months after weaning from breast milk in those cases where breast-feeding has continued for longer than suggested in this protocol.
- (7) All test results are documented in the **Baby Clinic Blood Test Register** (page 56).
- (8) Advanced testing: A PCR test detects the virus itself and can confirm or rule out “true infection” by 2 months of age and is available at tertiary hospitals if needed. Tests such as this may be used as part of the testing strategy in the future.

Nine month test		Eighteen month test	
Baby HIV-	Uninfected, no further testing*	Baby HIV-	Uninfected, no further testing needed*
Baby HIV+	May be infected, retest at 18/12	Baby HIV+	Baby is infected, continue clinical follow-up

* unless breast-feeding is ongoing or was stopped in the last three months



Chapter Six: Monitoring

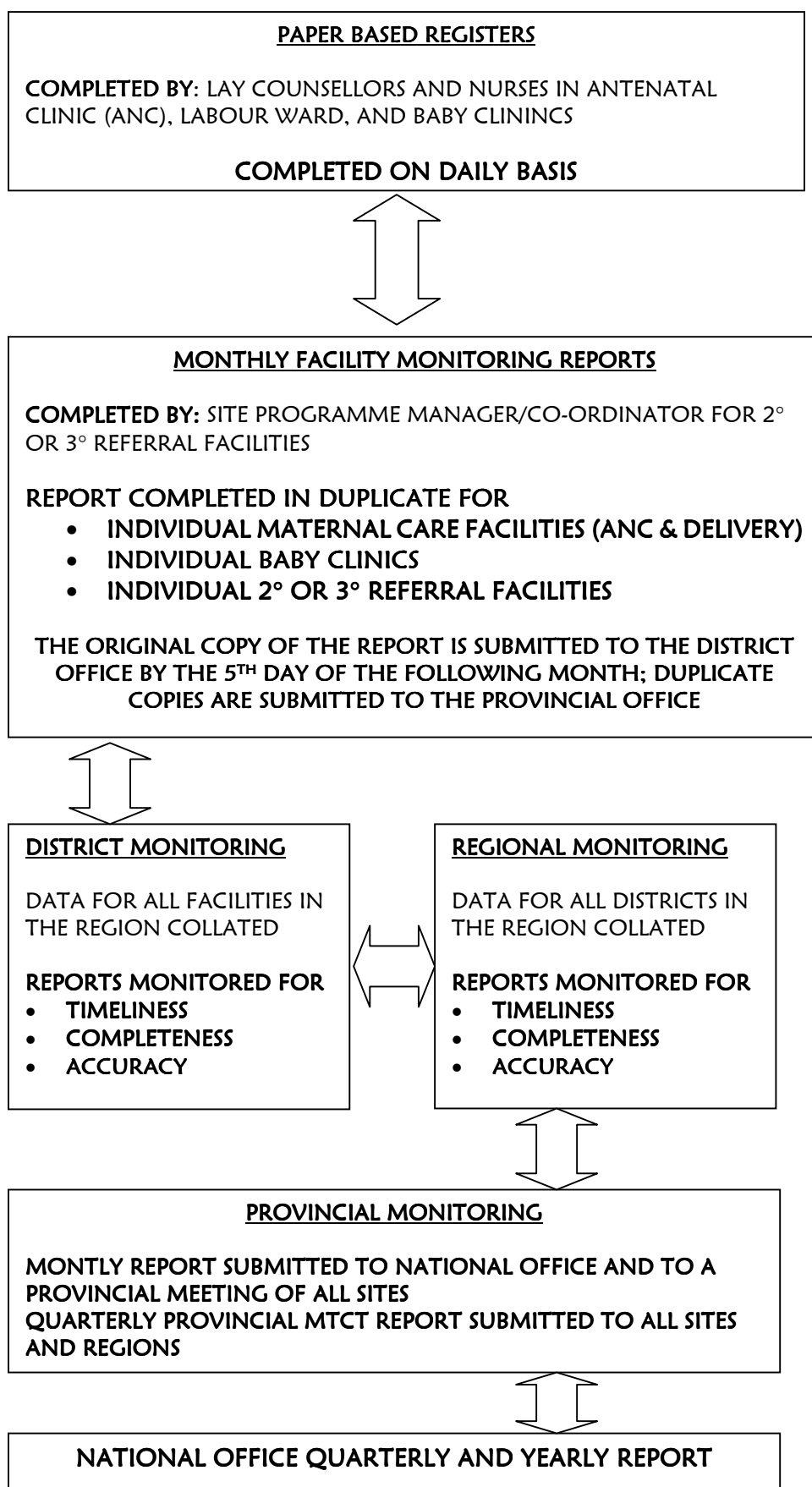
The objectives of the monitoring system are:

- (1) To monitor the process of the screening, enrolment, delivery, care and follow-up of all women and babies of HIV-positive women who are receiving care at all sites offering the programme to Prevent Maternal to Child Transmission of HIV.
- (2) To have a health information system which can effectively and efficiently identify programme successes and failures.

a) Administrative Issues

- All sites offering the MTCT programme are expected to prepare a monthly monitoring report for maternal care and baby follow-up. This report is included in the annexures (page 62) and summarises the key elements for the successful implementation of the MTCT programme. Preparation of the monthly reports allows clinic managers and staff to identify successes and challenges in the implementation of the MTCT programme.
- While several sites have found the attached “paper-based” registers to be the most useful and efficient way to collect the information for the monthly reports, local sites can adapt these registers as long as the information required by programme managers can be collected for the monthly reports.
- The lay counsellors and the sisters at the antenatal clinic, labour ward, postnatal ward and baby clinics complete the registers on a daily basis. At the end of each month, the programme manager or other designated person collates the data from the maternal and baby facilities and completes the monthly report for each facility. From this data, a monthly report is compiled for the overall programme.
- The programme manager or designated person aggregate the data in the reports to assess the success of the programme and identify programme failures.
- Information from the monitoring system is used to provide feedback to the staff at all facilities and to the district, regional, provincial and national levels for the purpose of strategic planning within the programme.

CHART OF HEALTH INFORMATION FLOW IN MTCT



Completing the monthly report and monitoring registers

(Note annexures for the monthly reports and monitoring registers – page 39)

- (1) Counsellor's Register
 - (A) Record the date of pre-test counselling
 - (B) Record HIV result
 - (C) Record the date of post-test counselling
 - (D) Record date to return for ELISA results if applicable
- (2) Blood Register
 - (A) Sister performing rapid tests records HIV results
 - (B) Record the number of rapid test kits used and those remaining in stock
- (3) Antenatal Nevirapine Register
 - (A) Record gestational age at booking
 - (B) Record date to return for nevirapine when 30 weeks
 - (C) Record date when nevirapine actually dispensed
 - (D) Record date of referral to secondary or tertiary institution
- (4) Labour Nevirapine Register.
 - (A) Record date and time of the mother self administering nevirapine before delivery
 - (B) Record date and time of labour onset
 - (C) Record date and time of delivery
 - (D) Record date and time of referral to secondary or tertiary institution during labour
 - (E) Record the outcome of the delivery and the number of live births
 - (F) Record date and time of administering nevirapine to the baby
 - (G) Record if baby or mother are given a second dose together with the reason
 - (H) Record the nevirapine stock used and the remaining stock
 - (I) Record the number of tins of milk given to the mother on discharge
 - (J) Record the milk tins remaining in stock
 - (K) Record choice of feeding practice
 - (L) Record stillbirths, drug reactions if applicable
- (5) Place baby identification sticker on the Road to Health Card (RTHC)
 - (A) Record the site where mother **joined** the MTCT programme (i.e. the mother's booking site)
- (6) Complete the MOU to Baby Clinic Referral Letter
- (7) In the Baby Register at the Baby Clinic, record the arrival date of the baby, the mother's booking site, and the amount of formula and co-trimoxazole that is dispensed together with the date. Not in the register if the baby is being exclusively breast-fed.
- (8) In the Baby Register, record the date that the baby is expected to return for the nine and eighteen month HIV test.
- (9) Record the results of the nine month test in the Baby Blood Book. If the baby is HIV-positive at nine months, enter the baby into the Baby Clinic Post 9-month Followup Register, noting regularly the dispensing of co-trimoxazole, and the eventual result of the second blood test.

- (10) If the baby tests HIV-negative at nine or eighteen months, the sticker may be removed or blacked out on the RTHC. If the baby is receiving breast milk, this should not be done until three months after the baby has been weaned from breast milk and an HIV test is repeated.

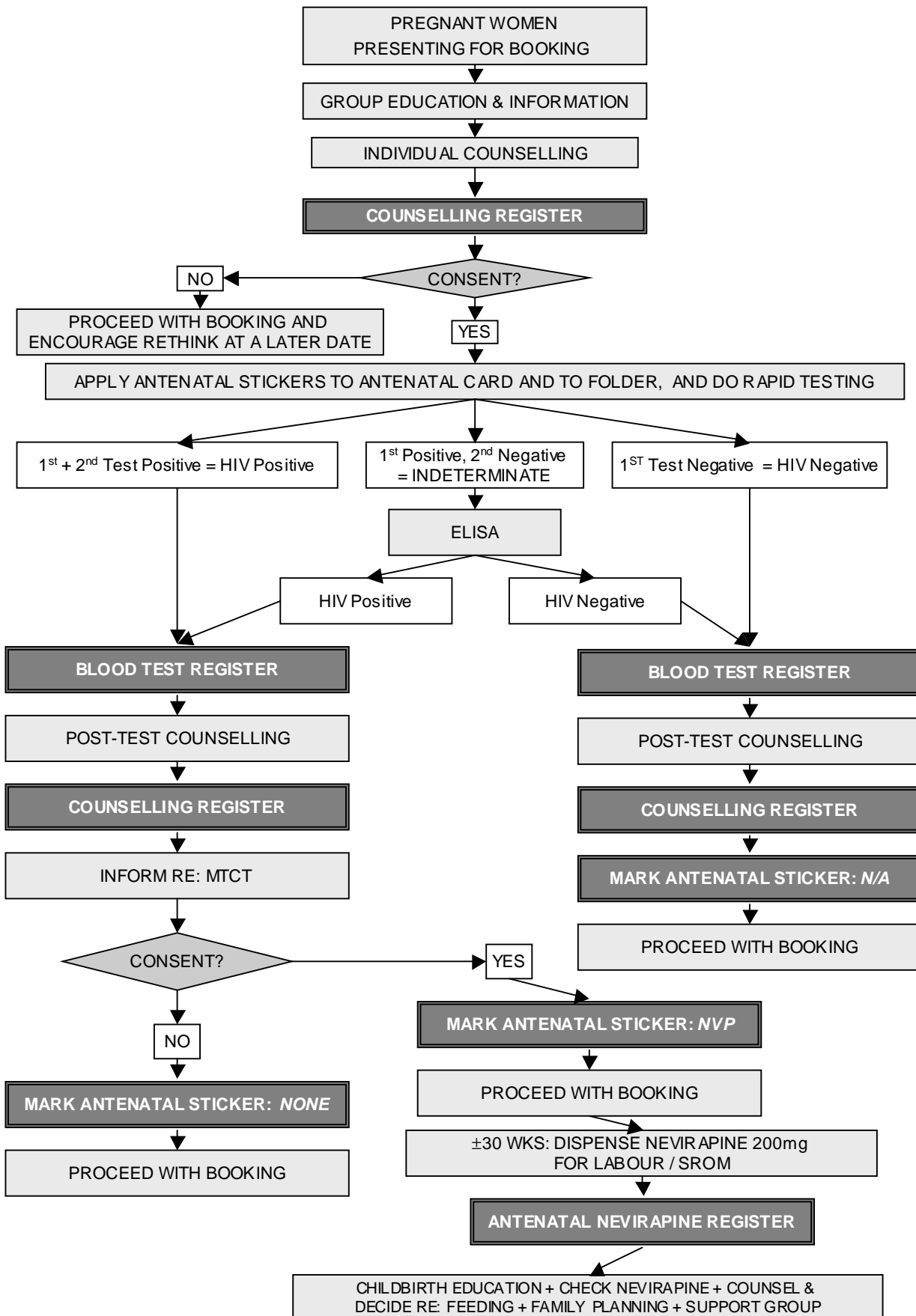


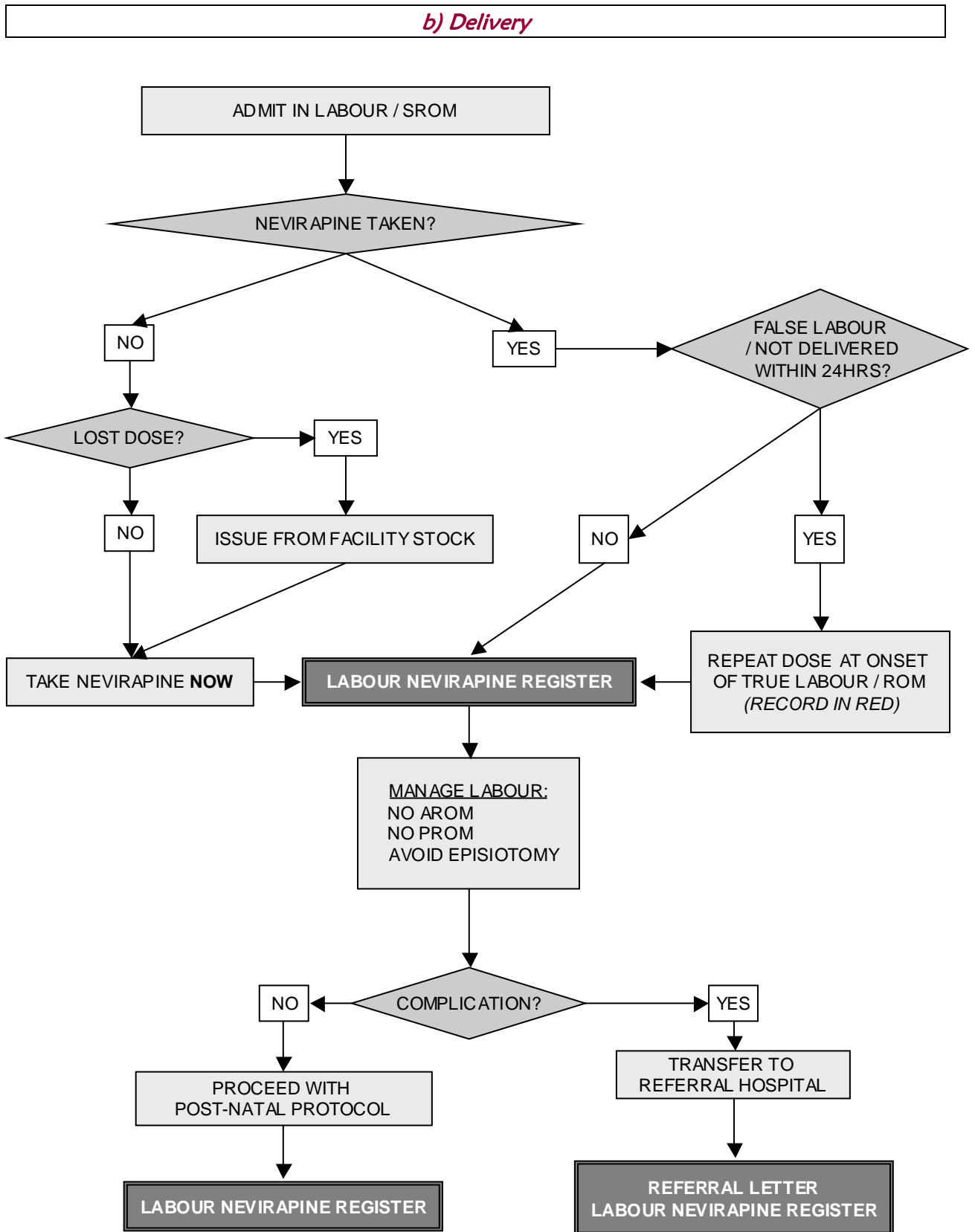
Note: The following annexures include tools which may be of use at an operational level, or which may provide a guide to the development of local tools. They do not conform exactly with the range of materials already in use in the province.

Annexure A: Flowcharts

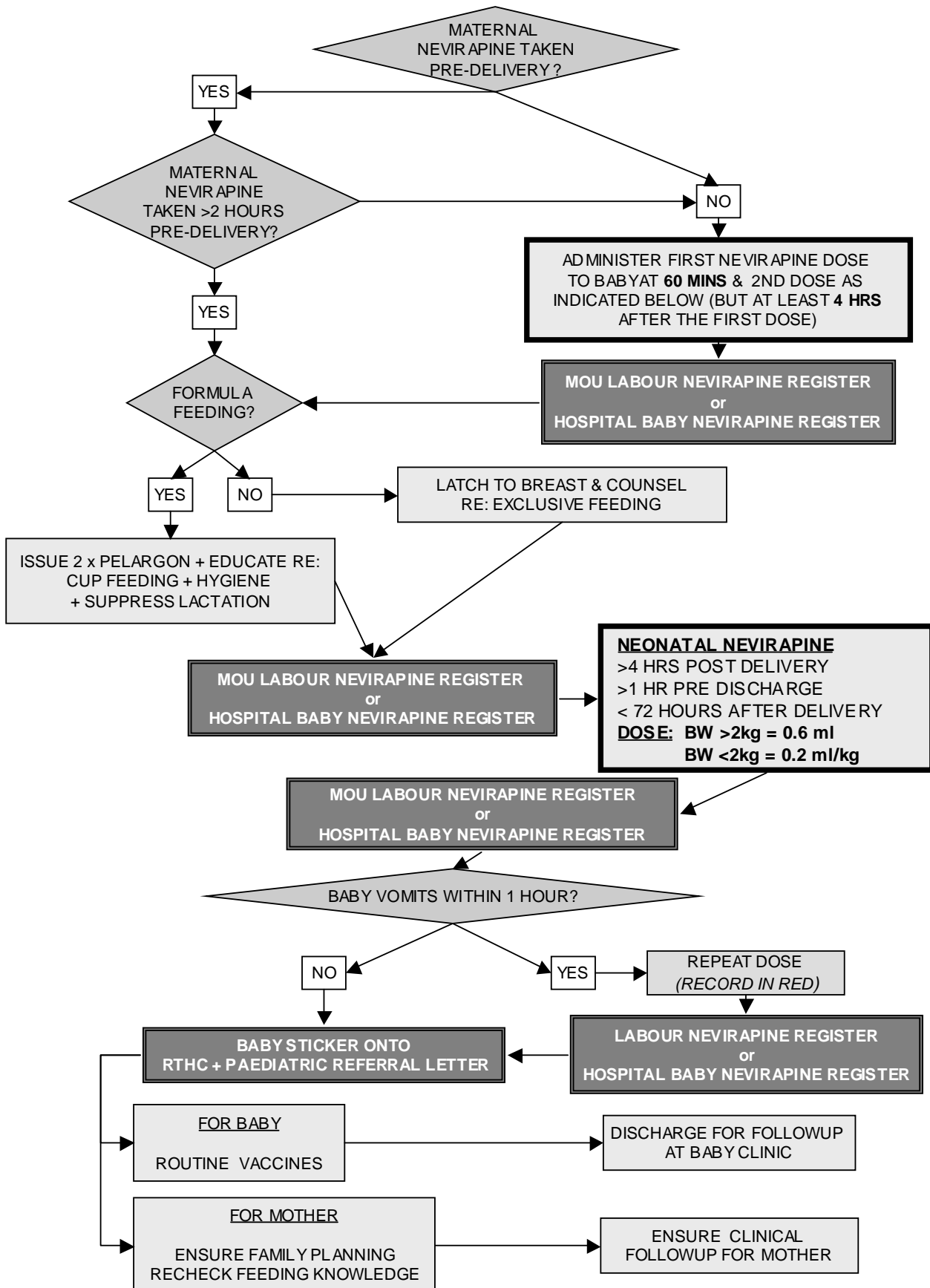
The following five charts diagrammatically reflect the sequence of activities in the MTCT programme.

a) MTCT Antenatal Care Flow Chart

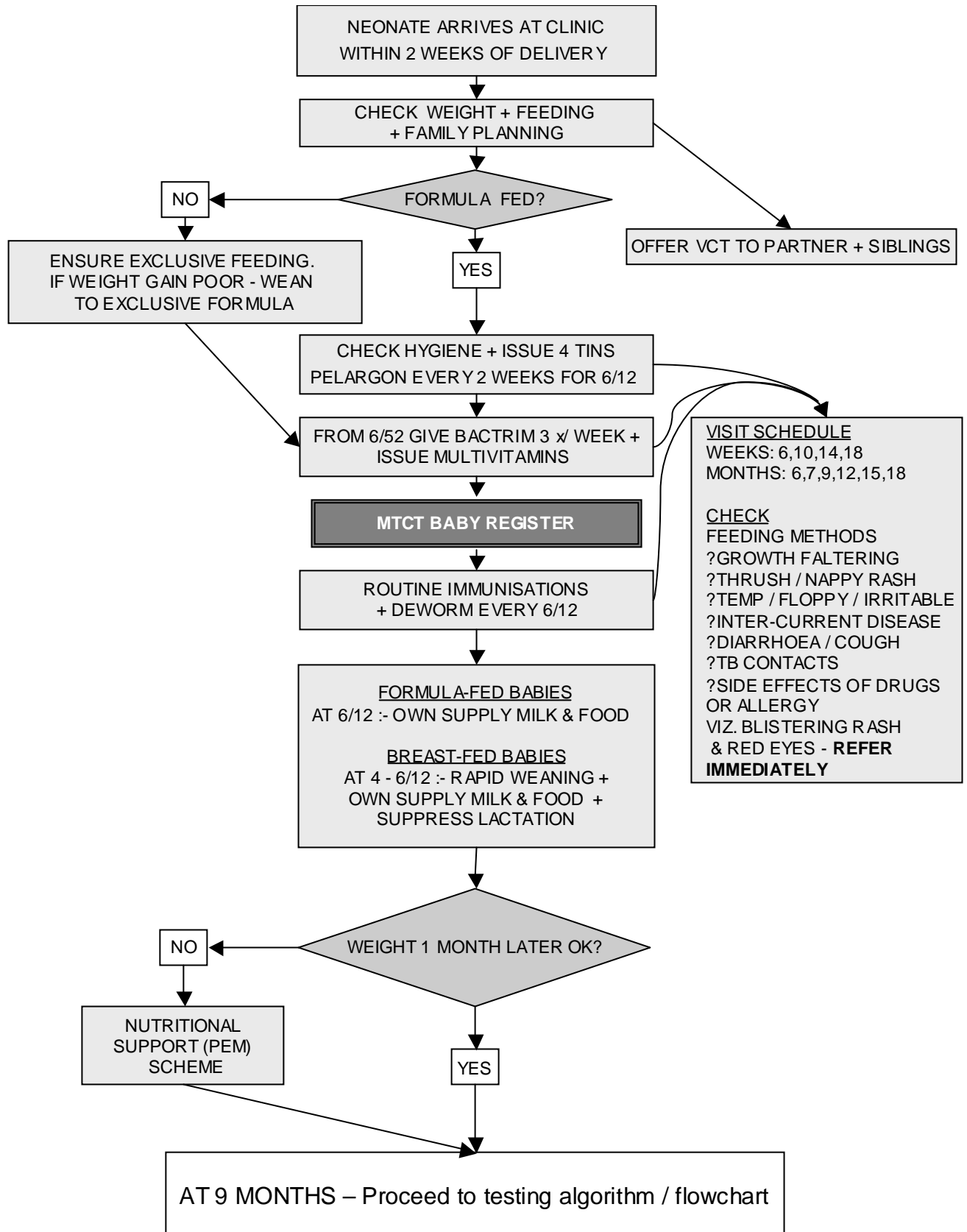




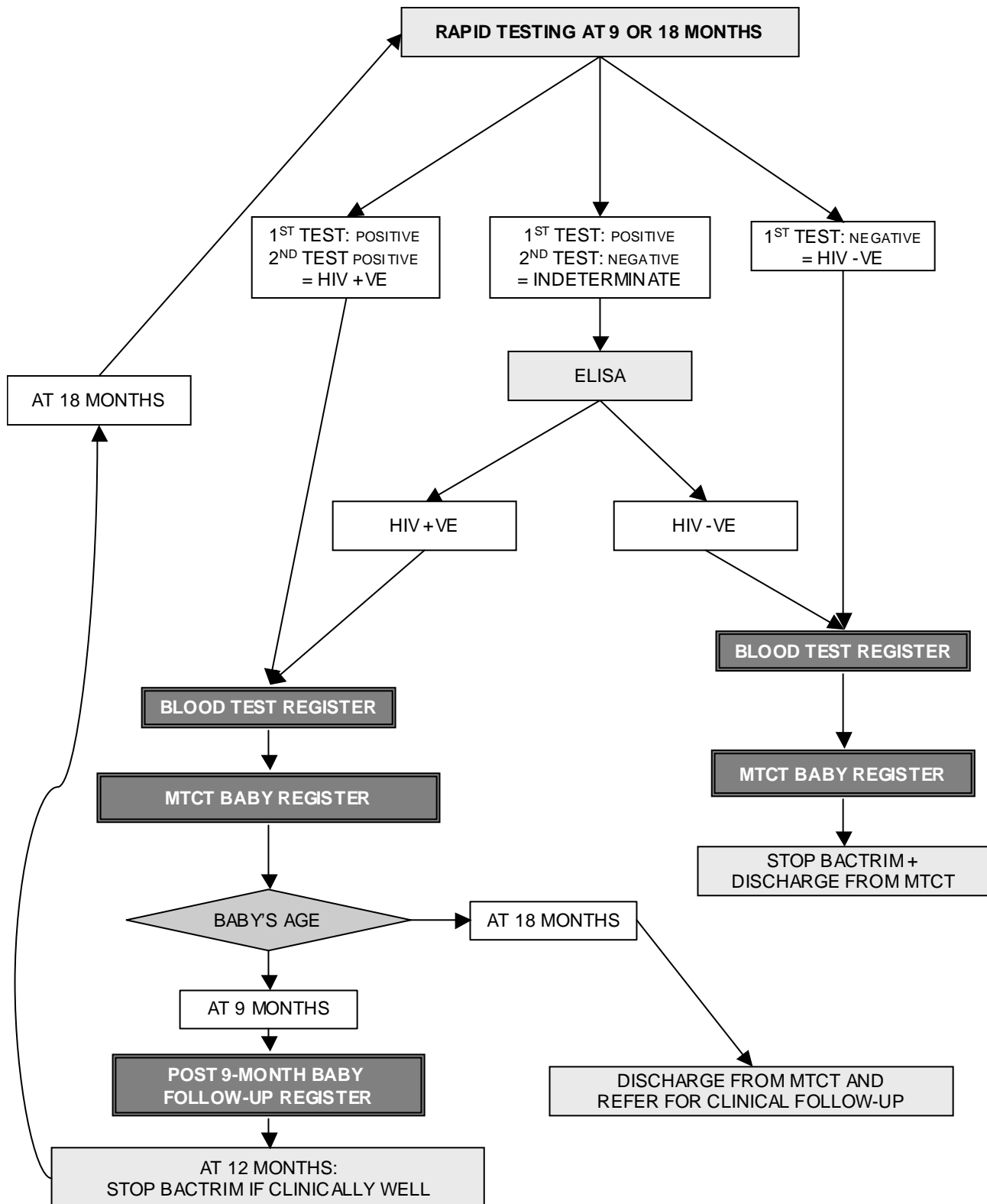
c) Postnatal



d) Baby Follow-up



e) Baby Testing



Annexure B: Counselling

a) Client Information Form

CLIENT INTERVIEW FORM

CONFIDENTIAL

CLIENT:
NAME:

Client Information

Date of Birth: Male/Female:

Clients Tel No: Postal Code:

Geographical area or residence:

Previous STDs:

Family planning referral:

Previous reactions to good/bad news:

.....
Social and financial Profile:

Number of Sexual partners in previous 5 years:

Condoms used: Always/sometimes/never:

Present sexual relationship (s):

Willingness to inform partner (s):

Willingness to practice safer sex:

Who will client tell if she/he tests HIV-positive:

Potential support if HIV-positive from:

Number of children/dependants: Children ages:

Employed/unemployed/student:

Financial resources in the event of being HIV-positive:

Counsellor's notes on client's decision regarding testing:

.....

.....

Results	Negative	Yes	No
	Positive	Yes	No
	Indeterminate	Yes	No

Counsellor Name: Signature: Date:

b) Consent Form

MTCT Consent Form

I, the undersigned consent to having a specimen blood taken to be tested for HIV

SIGNATURE

OF CLIENT----- DATE:-----

WITNESS NO. 1

PRINT NAME

DATE

SIGNATURE

WITNESS NO. 2

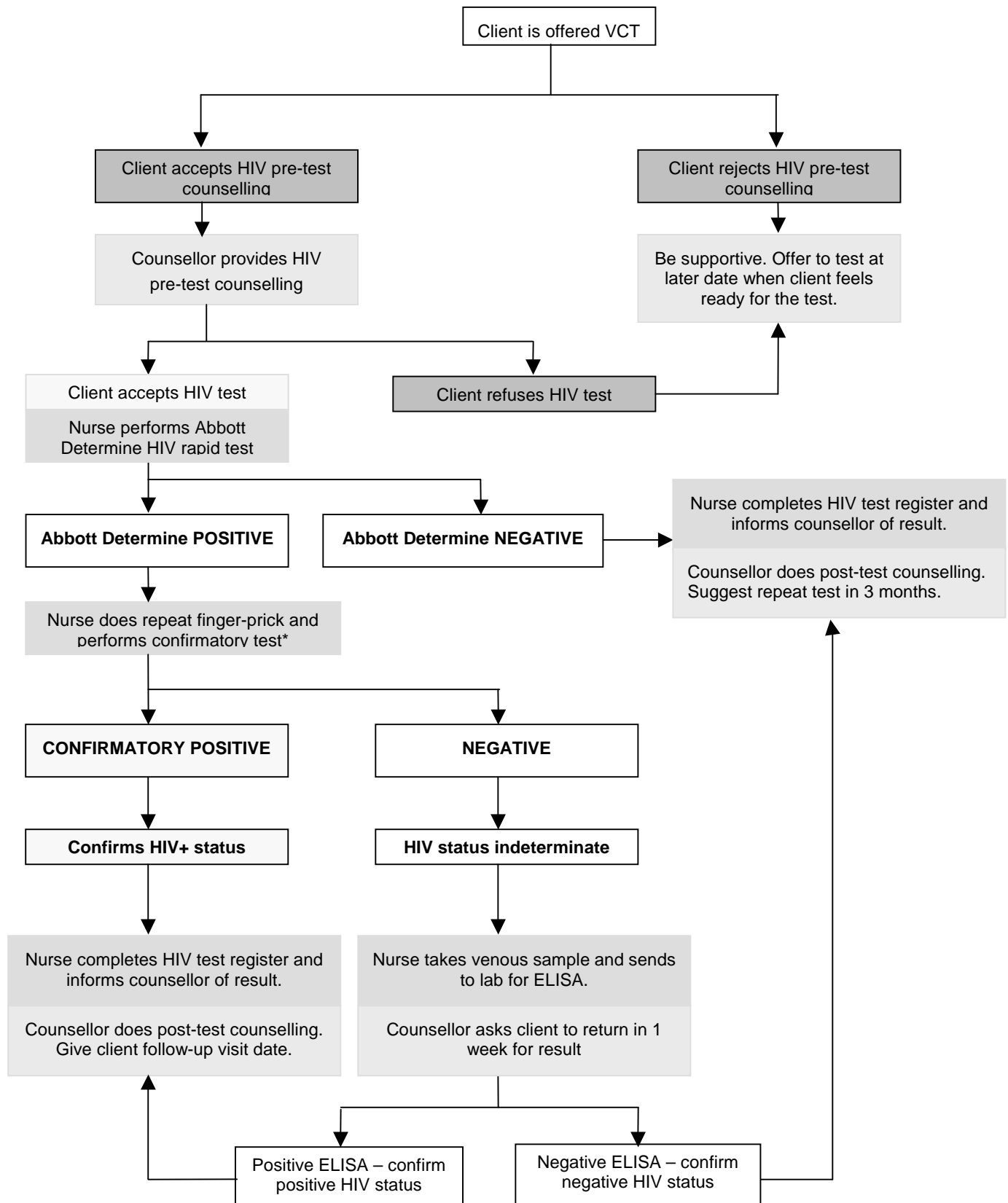
PRINT NAME

DATE

SIGNATURE

Annexure C: Rapid Test Instructions

a) VCT Algorithm



b) Abbott Determine Instructions

The Abbott Determine™ Rapid Test

Detects antibodies to HIV-1 & HIV-2 from serum, plasma or whole blood

- When the sample is placed on the sample pad, it migrates through the pad.
- If the sample contains HIV antibodies these mix with the antigen conjugated within the pad; when this occurs a chromatographic reaction takes place producing a red line in the patient window.
- A line in the control window ensures validity of the tests
- The Abbott Determine is a very sensitive test and it is therefore used as the screening test

Precautions

Universal precautions apply (including the use of gloves)

- Beware of sharp injuries (eg. glass capillary tubes)
- Do NOT pipette by mouth
- Decontaminate spills
- Ensure appropriate disposal of sharps and blood products

Storage

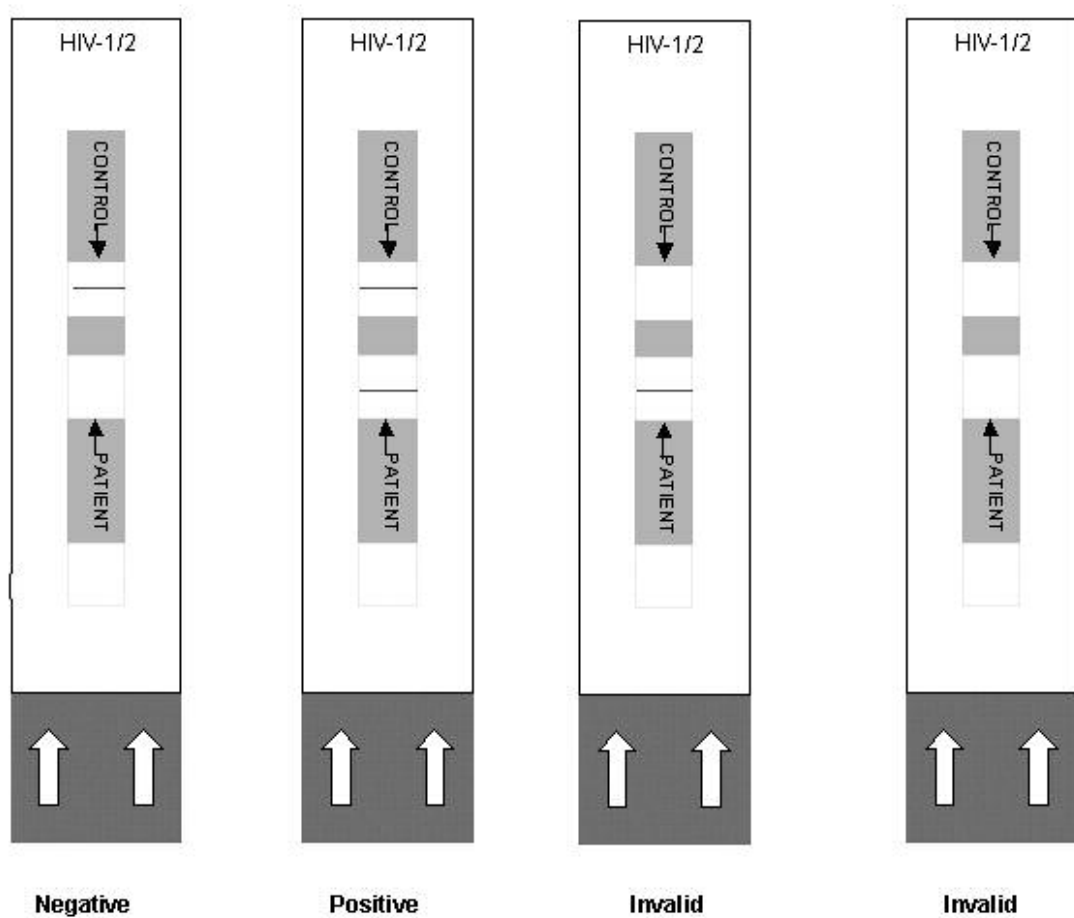
Kits and buffer can be stored at 2-30°C and must be used prior to the expiry date on each pack.

Method

Remove an individual test strip from the pack

- Remove the protective foil cover from the test strip and attach the strip to a surface with a sticker
- Label the sticker with the client's code / folder number
- Clean client's fingertip with alcohol swab and allow to air-dry
- Prick fingertip with Softclix lancet; dispose of lancet
- Collect 50 micro-litres of blood in the glass capillary tube: the black lines on the tube measure 50 micro-litres from each end; ensure that blood is collected to between the two black lines
- Apply the end of the capillary tube to the sample pad above the arrows
- Wait until the whole sample is drawn into the pad (the last drop is difficult to get out; ensure that this has been compensated for when drawing blood into the capillary tube)
- Apply one drop of chase buffer to the sample pad and note the time on the sticker
- Read the results after 15 minutes. If the kit has been left for more than 2 hours before reading, the test needs to be repeated.
- Ensure that the control bar is positive to confirm the validity of the test
- Dispose of test once the results have been recorded

Results



Additional Points for Consideration

- No test is 100% accurate
- Always confirm positive results with another test (eg GAIFAR Instantscreen)
- Remember the “window period” – this reflects the time taken for the individual to start producing antibodies and the ability of the test to detect these antibodies in the blood. For practical purposes this is taken as 12 weeks
- Remember that antibody and not virus is being detected (relevant if babies are being tested)
- The intensity of the bar does not correlate with antibody titre; even a feint bar in the patient window indicates a positive test

c) Stock Control Forms

Clinic Stock Control Register (with example entries)

Type of test	Date received DD/MM/YY	Quantity	Batch Numbers	Sign for receipt of tests	Reconciliation		Notes: Please note invalid tests / other problems
					Check usage	Signature	

Control Abbott Determine Usage

Abbott Determine Usage					
No.	Date	Initial	No.	Date	Initial
100			50		
99			49		
98			48		
72			22		
71			21		
70			20		
69			19		
68			18		
67			17		
58			8		
57			7		
56			6		
55			5		
54			4		
53			3		
52			2		
51			1		

Initial use of tests from 100 downwards.
Please re-order when 20 tests remain.

Control Confirmatory Test Usage

GAIFAR Instant Screen		
No.	Date	Initial
20		
19		
18		
17		
16		
15		
14		
13		
12		
11		
10		
9		
8		
7		
6		
5		
4		
3		
2		
1		

Initial use of tests from 20
downwards.

Annexure D: Communication

a) Referral Letters

i) Maternal Transfer Letter

MTCT MATERNAL REFERRAL FORM			
REFERRING FACILITY: _____		Date: _____	
PATIENT'S NAME: _____		REFERRED TO: _____	
HOSPITAL #: _____		DOB: _____	
DATE OF DELIVERY (EDD): _____		DELIVERY METHOD: _____	
MEDICAL OR OBSTETRIC PROBLEMS			
MEDICATIONS TO MOTHER			
Medicines		Date of last issue	
AZT		_____	
NVP		_____	
AZT + NVP		_____	
MOTHER'S LABORATORY TEST RESULTS (if available)			
Test	Results	Date of last issue	
CD4	_____	_____	
Total Lymphocyte Count	_____	_____	
Other	_____	_____	
FAMILY PLANNING METHOD			

SITE OF PAEDIATRIC CARE			

PAEDIATRIC PROBLEMS			

FEEDING CHOICE	<input type="checkbox"/> Breast - Exclusive	ISSUED Yes/No DATE OF LAST ISSUE	
	<input type="checkbox"/> Formula		

MEDICATION TO BABY			
NVP given to baby	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Co-trimoxazole initiated (at 6 weeks)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Other	_____		
For additional information please call: Dr. _____ at _____			
Signed: _____		Date: _____	

ii) Paediatric Referral Letter

MTCT PAEDIATRIC REFERRAL LETTER

DATE _____

REFERRING FACILITY: _____

REFERRED TO: _____

BABY'S NAME: _____

MOTHER'S NAME: _____

BABY'S DOB: _____

ADDRESS: _____

ANTIRETROVIRAL REGIME

☐ NEVIRAPINE

☐ AZT

☐ AZT + NEVIRAPINE (used in women who received <2 weeks AZT)

CHOICE OF FEEDING METHOD

☐ Formula feeding. Baby will need 2 tins per week for _____ months.

DATE OF LAST ISSUE OF FORMULA _____

☐ Exclusive breastfeeding for _____ months followed by abrupt weaning

CO-TRIMOXAZOLE & MULTIVITAMINS

Co-trimoxazole syrup required 3 times per week starting at 6 weeks of age

Co-trimoxazole (Co- T) initiated ☐ YES ☐ NO

Multivitamin syrup containing Vitamin A required daily

Multivitamin (MTV) syrup initiated ☐ YES ☐ NO

DATE OF LAST ISSUE : Co-T _____ MTV _____

NO. OF BOTTLES ISSUED: Co-T _____ MTV _____

STOP IF HIV NEGATIVE AT 9 MONTHS, CONTINUE TO 12 MONTHS IF HIV POSITIVE AND BABY CLINICALLY WELL

b) Stickers

i) Antenatal Stickers

Retroscreen:		Yes	No
AZT	NVP	None	N/A
Feeding:		Formula	Breast
Booking Facility: _____			

Retroscreen:		Yes	No
AZT	NVP	None	N/A
Feeding:		Formula	Breast
Booking Facility: _____			

ii) Baby Stickers

<p>Formula and PCP prophylaxis</p> <p>Formula: 2 [500ml] tins / week Cotrimoxazole: [3x/week] [<5kg-5ml] [5-9.9 kg-7.5ml] [10-14.9kg-10ml] [15-19kg - 15ml(1.5 tabs)] [>20kg - 20ml (2 tabs)]</p> <p>Mother's booking site.....</p>

<p>Formula and PCP prophylaxis</p> <p>Formula: 2 [500ml] tins / week Cotrimoxazole: [3x/week] [<5kg-5ml] [5-9.9 kg-7.5ml] [10-14.9kg-10ml] [15-19kg - 15ml(1.5 tabs)] [>20kg - 20ml (2 tabs)]</p> <p>Mother's booking site.....</p>

c) Nevirapine Card

THIS PILL MAY PROTECT YOUR BABY AGAINST INFECTION

1. PUT IT IN A SAFE BUT EASY TO FIND PLACE
2. ONLY TAKE IT WHEN IN LABOUR
3. LABOUR IS WHEN
 - YOUR PAINS ARE STRONG & REGULAR I.E. PAINS COMING EVERY 5 MINS CONTINUOUSLY FOR AT LEAST 1 HOUR
 - OR IF YOUR WATERS HAVE BROKEN EVEN WITHOUT PAIN

IF YOU HAVE ANY QUESTIONS PLEASE RETURN TO THE CLINIC WITH YOUR PILL

HIERDIE TABLET SAL JOU BABA TEEN BESMETTING/ INFEKSIE BESKERM

1. PLAAS DIT IN 'N VEILIGE MAAR TOEGANGLIKE PLEK.
2. GEBRUIK SLEGS TYDENS BEVALLING.
3. BEVALLING IS
 - WANNEER PYNE INTENS EN GEREELD IS ONDER ANDERE PYNE ELKE 5 MINUTE TEN MINSTE 1 UUR EN AANHOUDEND VOORKOM.
 - OF JY GEEN PYN VERDUUR MAAR JOU WATER GEBREUK HET.

INDIEN ENIGE NAVRAE, NEEM DIE TABLET SAAM MET JOU TERUG NA DIE KLINIEK.

LE PILISI INO KU KHUSELA USANA LWAKHO KWINTSHOLONGWANE

1. NCEDA UYIBEKE KWINDOWO EKHUSELEKILEYO KODWA EFIKELELEKAYO
2. YISELE XA USIVA ULUNYWA:
3. UKULUNYELWA KUXA INTLUNGU ZOKUBELEKA, ZIQINILE,
 - ZINGXAMA ROQO NYEMIZUZU EMIHLANU NGEYURE
 - OKANYE XA AMANZI EGQABHUKILE NOBA AKUKHO ZINTLUNGU ZOKUBELEKA

XA UNGAQINISEKANGA, UNOMBUZO, THABATHA IPILISI UPHINDELE E CLINIC.

Annexure E: Clinical Forms

a) Lactation Suppression Guidelines

LACTATION SUPPRESSION

- Bromocriptine will not be supplied for routine suppression of lactation. It is very expensive, and has potentially serious side-effects.
- There will be NO DRUG REPLACEMENT for Bromocriptine.
- Mothers who will not be breastfeeding (e.g. after stillbirths, after decision not to breastfeed for any reason e.g. MTCT programme) will need particular support and advice with respect to suppression of lactation. The following information is provided as a guide and help in these situations.

ADVISE MOTHER TO WEAR A FIRM BRA

This should be one size larger than normal.

EXPRESS A SMALL AMOUNT OF MILK - if breast very full.

The breast should not be emptied, even a very small amount to relieve the pressure is helpful, and will not make more milk. This can be repeated a few times a day.

RAW CABBAGE LEAVES INSIDE THE BRA

The cabbage leaves should be from the freezer or a fridge, and should be changed every two hours or so.

If problems on the 4th day – EXPRESS BREAST COMPLETELY

Do this in the evening, and only once, best with a pump, can also be done manually, but is painful.

If there are still problems on the 5th day -- then REFER.

If there is any sign of INFECTION, MASTITIS - REFER IMMEDIATELY

This may be on any day.

DO NOT BIND THE BREASTS - this can block ducts and cause mastitis and further discomfort.

DO NOT RESTRICT FLUID INTAKE - it makes no difference, it may however help to reduce salt intake.

b) Screening tool for mothers

Patient Name: _____

Folder Number: _____

Date: _____

SCREENING FOR COMPLICATIONS OF RVD INFECTION**Screening questions:****HISTORY**

Significant weight loss	Yes	No
Fever/Chills/Sweats > 4 weeks	Yes	No
Tongue coating	Yes	No
Oral ulcers	Yes	No
Enlarged lymph nodes	Yes	No
Painful swallowing	Yes	No
Cough > 2 weeks	Yes	No
Diarrhoea > 4 weeks	Yes	No
Genital ulcers	Yes	No
Rash/Skin Lesions	Yes	No
Treatment for TB in last year	Yes	No
Severe Headache	Yes	No
Confusion, Change in Mental Status	Yes	No

EXAM

Abnormally Thin	Yes	No
Unusual skin lesions (not itchy)	Yes	No
Lymph Nodes > 2cm	Yes	No
Oral Thrush	Yes	No
Mouth ulcers or dark spots	Yes	No

LABORATORY

Hgb < 8.0gm/dl	Yes	No
----------------	-----	----

Nursing/Midwife Assessment

Routine Care in MOU

☐ Referral for Consultation with Doctor**Report by Doctor**

Antenatal Care	Delivery Care
MOU	<input type="checkbox"/> MOU
Secondary level Care	<input type="checkbox"/> Secondary level Care
Tertiary level Care	<input type="checkbox"/> Tertiary level Care

Annexure F: Monitoring

a) Registers

The following registers have emerged from constant dialogue between the services who are using them, and service managers at all levels, and are made available for use or adaptation as appropriate.

The registers included are:

For use at facilities providing antenatal care

1. Counselling Register (pg. 40)
2. Antenatal Nevirapine Register (pg. 42)
3. MOU Blood Test Register (pg. 44)
4. Combined Counselling and Testing Register (replaces 1 & 3 in some clinics - pg. 46)

For use at non-hospital obstetric units

5. MOU Labour Nevirapine Register (pg. 48)

For use in hospital obstetric and neonatal wards

6. Hospital Labour Ward Nevirapine Register (pg. 50)
7. Hospital Baby Nevirapine Register (pg. 52)

For use in clinics where babies are followed up

8. Milk Register (pg. 54)
9. Baby Clinic Blood Test Register (pg. 56)
10. Baby Clinic Post 9-Month Follow-up Register (pg. 58)
11. Baby Register (pg. 60)

Counselling Register

NAME OF COUNSELLOR: _____

This register is to be completed by the individual counsellor

(Start on a new page each week)

Month and Year Current month and year

Date Date of HIV counselling

Name, age and folder number
Name, age and folder number of the mother

Pre-test Fill in date and sign when pre-test counselling done

Test 1: Result HIV test result

Test 2: Result HIV test result

Post-test Fill in date & sign when post-test counselling done

ELISA: Result HIV ELISA result

Post-test Fill in date when post-test counselling done after ELISA result

Reason for testing Tick the appropriate column

VCT	Med	Voluntary testing suggested by a health practitioner to a patient for medical reasons
	Self	Patient requests testing in order to learn his/her HIV status
MTCT		Referred by the MTCT programme
TB		Referred because of TB diagnosis
STI		Referred because of STI diagnosis

Antenatal Nevirapine Register

Month and Year Use the sheet that contains the month in which mother is due to be 30 weeks. If the mother is 29 weeks or more at booking, use the sheet with the month of the booking visit.

No. of NVP Tablets In Stock No. of NVP tablets in stock in antenatal ward when this page of the register is started

Name Name of the mother

Folder number Folder number of the mother

Antenatal period

Gest age Gestational age of the mother at booking

Date to return for NVP The date when the mother is due to be 30 weeks

Date NVP dispensed The date when nevirapine dispensed

**Referral Dates
To 2°/3°** Date of referral to secondary / tertiary hospital

Additional Information Comment on NVP balance in hand, and any other comment if applicable

MOU BLOOD TEST REGISTER

START ON A NEW PAGE EACH WEEK
THIS REGISTER TO BE COMPLETED BY THE PERSON DOING THE TESTING

Month and Year	Current Month and Year
Date	Date of HIV testing
Name	Name of mother
Folder number	Folder number of the mother
Rapid test 1	
Test 1 result	Result of first rapid test (write pos or neg)
Test 1 balance in hand	Record balance in hand of Rapid test 1
Rapid test 2	
Test 2 result	Result of second confirmatory rapid screen (write pos or neg)
Test 2 balance in hand	Record balance in hand of Rapid test 2
ELISA Results	ELISA results for indeterminate results

MOU BLOOD TEST REGISTER

Year _____ Month _____ Rapid Test 1 in stock _____ Rapid test 2 in stock _____

[illegible]

Totals: Total number of women tested for HIV: _____
 Total number of women HIV positive (both rapid tests positive or ELISA positive): _____
 Total no. indeterminate results: _____

Combined Counselling and Testing Register

Many clinics where VCT is not limited to the MTCT programme, have elected to use a combined register for recording results. This register may need to be enlarged before use

The VCT register contains confidential information and is to be kept in a locked cupboard when not in use.

VCT Client Record (Below):

This is the section in which individual client information is entered.

1. Please start each new month on a new page.
2. Label the first page for the month as Page 1, the next as Page 2 etc.
3. All clients who undergo individual pre-test counselling must be entered in the register, irrespective of whether they are tested or not.
4. Complete the date (DD/MM/YY), client code (or folder number) and age.
5. For the remainder of the columns mark the appropriate column with a cross as follows:

a. Sex:

- i. M = male, F = female

b. Referral:

- i. **Med = Medically referred.** This implies that the client has been assessed by a health worker and referred for an HIV test for a specific indication:
 1. Client has an STD
 2. Client has TB
 3. Client has signs of immunosuppression eg. shingles / oral thrush etc
 4. Antenatal client to access MTCT etc.

The time between referral and testing is not relevant.

- ii. **Self = Self-referred.** This implies that the client has on his or her own decided to have an HIV test. There could be several reasons for this, including:
 1. The client is ill
 2. A partner or baby is ill or has died
 3. The client is concerned about his or her risk activities or those of a partner
 4. The client has become aware of the service through the media or health education talks etc

c. Service attended

- i. **"MTCT"** refers to any women *currently* attending the antenatal service that is being tested with a view to accessing anti-retrovirals to prevent mother to child transmission of HIV. Partners or babies who test are entered in the "Other" category.
- ii. **"TB"** refers to any current TB patient who has an HIV test
- iii. **"Other"** refers to all other clients utilising VCT services (self-referred to VCT, STI, oral thrush, MTCT baby, partner from MTCT etc)

- d. **Accept Test**– for clients accessing testing at this facility, indicate whether the client accepted the test ("Yes") or refused the test ("No").
- e. **Referred in Positive** - If a client has been tested elsewhere and referred to your clinic for on-going care, indicate with a cross in this column.
- f. Indicate the test result only for those tested at the facility.
- g. In the **"Positive Result Category":**
 - i. Mark as MTCT positive if a women currently attending antenatal services tests positive.
 - ii. Mark as TB positive if a client on current TB treatment tests positive.
 - iii. Mark as "Other" all other clients who test positive.
6. When the page has been filled, total each of the columns and record as TOTAL.
7. Proceed to the next page of the register.

Monthly clinic report (Page 65)

1. Transcribe the TOTAL from each page in the VCT Client Record section to a new line of the "Monthly Clinic Report". When all the pages for the month have been recorded, calculate a total for each category.
2. This total represents the total HIV counselling and testing for the facility for the month. Transcribe the TOTALS onto the appropriate line (by month) in the **Annual Clinic Record** sheet if this is available.
3. The loose "Monthly Clinic Report" must be submitted to the health information officer in your district who will collate the district information.
4. "Monthly Clinic Reports" for the month must be submitted by the 5th day of the following month.

Quality Control of Information – Internal Checks

For each page of the register

- A. Column 1 (M) + Column 2 (F) = 20
- B. Column 3 (Med) + Column 4 (Self) = 20
- C. Column 5 (MTCT) + Column 6 (TB) + Column 7 (Other) = 20
- D. Column 8 (Yes) + Column 9 (No) + Column 10 (Referred in positive) = 20
- E. Column 11 (Pos) + Column 12 (Neg) = Column 8
- F. Column 17 (MTCT positive) + Column 18 (TB positive) + Column 19 (Other positive) = Column 11

Combined Counselling and Testing Register

NB: Commence each new month on a new page										Tick appropriate box										HIV Test Results (for those tested at this facility)						Positive Result Category (tested at facility)			Counsellor's signature Notes (results not given; ELISA sent etc)
Month: _____		Page Number: _____		Sex		Referral		Service Attended		Tested		Referred in Positive		Screening Test		Confirmatory Test		ELISA		MTCT positive			TB positive		Other positive				
Date	Code	Name	Surname	Age	M	F	Med	Self	MTCT	TB	Other	Yes	No	R	Pos	Neg	Pos	Neg	Pos	Neg	+	+	+	+					
1																													
2																													
3																													
4																													
5																													
6																													
7																													
8																													
9																													
10																													
11																													
12																													
13																													
14																													
15																													
16																													
17																													
18																													
19																													
20																													
TOTAL					1	2	3	4	5	7	9	10	11	12	13	14	15	16	17	18	19	20	21						
					M	F	Med	Self	MTCT	TB	Other	Yes	No	R	Pos	Neg	Pos	Neg	Pos	Neg	MTCT +	TB +	Other +						

MOU Labour Nevirapine Register (can be used in a primary level care setting)

Month and Year	Month and year
No. of NVP Tablets in Stock	No. of NVP tablets in stock in labour ward when this page in the register is started
No. of tins of milk in stock	No. of milk tins in stock in labour ward when this page in the register is started
Name	Name of the mother
Folder number	Folder number of the mother
Labour NVP S/A D/T	<p>Nevirapine S/A = Self administered NVP D/T = date and time Indicate the date and time when HIV +ve women self administered NVP</p>
Labour ward/2nd NVP dose D/T	Indicate date and time when <u>and</u> if NVP is dispensed in the labour ward. Also indicate “2nd dose” and the date and time if a patient received a second NVP dose. 2nd dose only given per protocol instructions
Labour onset D/T	Indicate date and time of labour onset
Delivery D/T	Date and time of delivery
Referral D/T	Date and time of referral in labour (if referred)
Postnatal	
NVP to baby D/T	Date and time of dispensing NVP to baby
Milk	Number of formula tins dispensed. Please specify if 2 (500g) or 1 (1kg) tin given or exclusive breastfeeding
Comments	Indicate live or still birth, multiple births, BBA's, remaining stock of NVP tablets and milk tins, and the reason for a 2nd dose NVP if given, e.g. false labour

Hospital Labour Nevirapine Register

Month and Year	Month and year
No. of NVP Tablets In Stock	No. of NVP tablets in stock in labour ward
Date, Name	Delivery date and the name of the mother
Folder number mother	Folder number of the mother
Referral Site	Site where mother is referred from or indicate “own” for patient booked and delivering in your hospital
NVP S/A or MOU D/T	Date and Time (D/T) of Nevirapine being self administered (S/A) by patient or administered at MOU. Record SA & date and time for self admin, record MOU & date and time for admin at MOU
NVP labour/ 2nd dose NVP D/T	Date and Time of Nevirapine being administered in labour ward (only if not self administered by patient or if patient receives second dose due to vomiting or false labour –see protocol)
Labour onset	Fill in the date and time of the onset of labour
Delivery	Fill in the date and time of delivery
Comments	Indicate live or still birth, multiple births, BBA no. NVP tablets balance in hand, reason for 2 nd dose NVP e.g false labour

Hospital Baby Nevirapine Register

Month and Year	Month and year
No. of milk tins in stock	No. of milk tins in stock in labour ward when this page in the register is started
Date, Name	Date of first NVP dose to the baby, and the name of the mother
Folder Number mother	Folder number of the mother
Folder Number baby	Folder number of the baby
Postnatal NVP	Nevirapine given to baby – date and time administered; must be given within 72 hrs, best within 12 – 72 hrs. if > 2kg give 0.6 ml if < 2 kg give 0.2 ml /kg
NVP second dose	Only give second dose if mother had received NVP < 2 hours before delivery or baby vomits (see protocol).
Milk or Exclusive Breastfeeding	Indicate Milk given e.g. 2 x 500g tins or exclusive breastfeeding
Comments	Indicate reason for 2 nd dose of NVP , milk tins balance in hand, date when co-trimoxazole is initiated.
Signature	Signature of the person completing this entry in the register

Milk Register

Month &Year

Month and year

No. of Milk tins In Stock

Indicate no. of milk tins in stock in postnatal ward

Date

Date of dispensing Pelargon

Name & folder number

Name & folder number of mother or baby

Pelargon

Indicate no. of milk tins and quantity dispensed e.g. 2x 500g

Milk tins balance in hand

Indicate the milk tins balance in hand

Siganture

Signature of nursing sister

MILK REGISTER

Year _____

Month _____

No. of tins in stock _____

Date	Name & folder number of mother OR baby	Pelargon – No. of tins and quantity e.g. 2x 500g	Milk tins Balance in stock	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

TOTALS:

Total no. of babies dispensed formula _____

BABY CLINIC BLOOD TEST REGISTER

START ON A NEW PAGE EACH WEEK
THIS REGISTER TO BE COMPLETED BY THE PERSON DOING THE TESTING

Date	Date of HIV testing
Month and Year	Current month and year
Name and folder number of the baby	Name of baby, and baby's folder number
Name and folder number of the mother	Name of the mother, and mother's folder number
Age of Baby (months)	Age in months of baby being tested
Rapid test 1	
Test 1 result	Result of first rapid test (write pos or neg)
Test 1 balance in hand	Record balance in hand of Rapid test 1
Rapid test 2	
Test 2 result	Result of second confirmatory rapid screen (write pos or neg)
Test 2 balance in hand	Record balance in hand of Rapid test 2
ELISA Results	ELISA results for indeterminate results

**NB: POSITIVE BABIES AT ANY AGE BELOW 18 MONTHS
MUST BE RETESTED AT 18 MONTHS**

BABY CLINIC POST 9-MONTH FOLLOW-UP REGISTER

This is for babies who are positive at 9 months.

Month & Year	Record month & Year	Baby's Name	Name of the baby	Baby's Folder number	Folder number of the baby	Mother's booking site	Facility where mother booked
9 months or 10 – 17 months test							
Co-trimoxazole							
Month 10 –Month 17							
18 months test							
Date	Tick for every month when co-trimoxazole is dispensed						
Age in month	Record the date when the test is done						
Date Pre test Counsel.	Record the baby's age in months when the test is done						
RapidTest 1 result	Record the date of Pre Test Counselling						
RapidTest 2 result	Result of first rapid test (write pos or neg)						
Date Post test Counsel	Result of second confirmatory rapid screen (write pos or neg)						
Elisa result	Record the date of Post Test Counselling						
	Results of ELISA for indeterminate result at 18 months						

Baby Clinic Post 9-month Follow-up Register

Year _____ Month _____

Baby's Name	Baby's Folder number	Mother's Booking Site	CO-TRIMOXAZOLE								18 MONTHS TEST						
			Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Date	Age in months	Date Pre Test Counsel	Rapid Test 1 Result	Rapid Test 2 Result	Date Post test Counsel	ELISA Result

Totals: Total number of babies actually tested at 18 months _____
Total number of babies HIV+ at 18 months _____

BABY REGISTER

This is illustrative of the full register which has a separate page for each month, and columns for each of the nine months following the month in which the baby is entered into the register

Month & Year	Record month & Year
Name	Name of the baby
Baby folder no.	Folder number (at this facility) of the baby
Mother's folder no.	Folder number (at this facility) of the mother
Address	Address of mother and baby
DOB	Date of birth of the baby
Date of arrival	Date on which the baby first presented at this facility
Mother's booking site	Facility at which mother first presented with this pregnancy. This is not always the same facility at which the mother delivered
Month 1 .. 9	The register has a section like this for the current month and for the following 9 months as well
Wk 1..5	The columns P and C are ticked for the corresponding week each time a mother and baby receive either formula (P - Pelargon) or co-trimoxazole (C)
Additional information	The precise dates on which the blood tests are performed should also be recorded as well as any other relevant information

BABY REGISTER

(Condensed form of the register. Each sheet in the register contains 9 months e.g. February 2001to October 2001)

YEAR _____

MONTH _____

Name	Baby folder no.	Mother's folder no.	Address	DOB	Date of arrival	Mother's booking site	Month1 ... 10										Additional information		
							Wk 1		Wk 2		Wk 3		Wk 4		Wk 5		9 month test date	18 month test date	Comments
							P	C	P	C	P	C	P	C	P	C			
1.																			
2.																			
3.																			
4.																			
5.																			
6.																			
7.																			
8.																			
9.																			
10.																			

b) Facility Monthly Report Forms***MTCT monthly monitoring report for MOU's*****Period:** .../.../..... to .../.../.....**Facility:**.....**Person recording data:**.....

	DATA		INDICATOR PROPORTION X 100 = %	Source
1.Total number women booked for first ANC visit			N/A	Booking register
2. Total number women booked for follow-up ANC visit also requesting testing			N/A	Booking register
3.Total number of women individually pre test counselling			=#3/(#1+#2)	Counsellor's register
4.Total number mothers accepting HIV testing			=#4/(#1+#2)	Blood register
5.Test results for the month.	HIV +	HIV -	Positivity Rate = HIV+/ #4	Blood register
6.Total number of HIV +ve & HIV -ve women individually post test counselled			=#6/ #4	Counsellor's register
7.Total no. HIV +ve women on MTCT who delivered in this facility			N/A	Labour NVP register
8.Total number of women on MTCT who self-administered nevirapine out of those who delivered at your site. (Excluding patients referred during labour)			=#8 /#7	Labour NVP register
9.Total number of women on MTCT who received nevirapine in labour ward in this facility			N/A	Labour NVP register
10.Total number of births in women on MTCT at this facility (including BBA's & stillbirths)	No. Live births		N/A	Labour NVP register
	No. BBA's			
	No. Stillbirths (SB)			
	Total Live Births (excl SB)			
11.Total number of babies who received nevirapine at this facility			#11/live births	Labour NVP register
12.Total number of babies of women on MTCT who were dispensed formula after delivery			#12/#live births	Labour NVP register
13.Total number of babies of women on MTCT being exclusively breastfed			#13/#live births	Labour NVP register

Date of form: 03/2002

MTCT monthly monitoring report for Baby Clinics**Period:** .../.../..... to .../.../.....**Facility:**.....**Person recording data:**.....

DATA	MTCT baby register		
1. Total no. new arrivals for the month	New arrivals =		
	Transfers in =		
	Total =		
2. Total no. on programme			
	Actual	Expected	
3. Total no. received formula			
4. Total no. with good formula compliance		(N/A)	
5. Total no. exclusively breastfed		(N/A)	
6. Total no. received PCP prophylaxis (Bactrim)			HIV positive
7. Total no. tested at 9 months			
8. Total no. not tested at 9 months but tested between 10 and 17 months		(N/A)	
9. Total no. tested at 18 months			
10. Total no. not followed up	Loss to follow-up (absence for more than 3 consecutive months) =		
	Transfer out =		
	Total =		
11. Total no. known to have died			

Total number in programme = babies born to HIV +ve mothers on the MTCT programme who registered at the clinic. Take this number minus

- e) lost to follow-up (absence for more than 3 consecutive months)
- f) deaths
- g) HIV negative before 18 months
- h) All tested at 18 months (HIV –ve & HIV +ve)

Good formula compliance = having a supply of 2 tins / week for the month

SITE OF ORIGIN OF NEW ARRIVALS OR TRANSFER INS	TOTAL NUMBER
1.	
2.	
3.	
4.	
5.	
6.	
TOTAL	

Date of form: 03/2002

MTCT monitoring report for Hospitals

Period: .../.../..... to .../.../.....

Facility:.....

Person recording data:.....

	DATA		INDICATOR PROPORTION X 100 = %	Source
1.Total number women booked for first ANC visit (where applicable)			N/A	Booking register
2. Total number women booked for follow-up ANC visit also requesting testing (where applicable)			N/A	Booking register
3.Total number of women accepting pre test counselling (where applicable)			= #3/(#1+#2)	Counsellor's register
4.Total number mothers accepting HIV testing (where applicable)			= #4/(#1+#2)	Blood register
5.Test results for the month.	HIV +	HIV -	Positivity Rate = HIV+ / #4	Blood register
6.Total number of HIV +ve & HIV -ve women post test counselled (where applicable)			= #6/#4	Counsellor's register
7.Total no. HIV +ve women on MTCT who delivered in this facility	AZT	NVP	N/A	Labour register
	Total			
8.Total number of women on MTCT who self-administered antiretrovirals	AZT	NVP	#8 Total/# 7 Total	Labour register
	Total			
9.Total number of women on MTCT who received antiretrovirals in labour ward in this facility or at the MOU's	AZT	NVP	N/A	Labour register
	Total			
10. Total no. of women on AZT regime who received <2 weeks AZT and given NVP in labour				Labour register
11.Total number of births in women on MTCT (AZT & NVP) at this facility	Live births	AZT NVP		Labour register
	BBA's			
	Stillbirths (SB)			
	Total Live Births (excl SB) =			
12.Total number of babies of mothers on NVP who received nevirapine at this facility				Labour register
13.Total number of babies of women on MTCT who were dispensed formula after delivery				Postnatal register
14.Total number of babies of women on MTCT being exclusively breastfed				Postnatal register

Date of form: 03/2002

Combined Counselling and HIV Testing - Monthly Report (see pgs. 39 & 46)

Name of Facility: _____

Month: _____ Compiled by: _____

		Sex		Referral		Service Attended			Tested / Referred in positive			Screening Test		Confirmatory Test		ELISA		MTCT +	TB+	Other+
		M	F	Med	Self	MTCT	TB	Other	Yes	No	R	Pos	Neg	Pos	Neg	Pos	Neg			
column		1	2	3	4	5	7	9	10	11	12	13	14	15	16	17	18	19	20	21
Page:	1																			
	2																			
	3																			
	4																			
	5																			
	6																			
	7																			
	8																			
	9																			
	10																			
	11																			
	12																			
	13																			
	14																			
	15																			
	16																			
	17																			
	18																			
	19																			
	20																			
TOTAL																				

c) District Monthly Report Forms
MTCT monthly monitoring report for Districts – MOU Data
Period: .../.../..... to .../.../.....

District:.....

Person recording data:.....

	DATA		INDICATOR PROPORTION N X 100 = %	Source
1.Total number women booked for first ANC visit			N/A	Booking register
2. Total number women booked for follow-up ANC visit also requesting testing			N/A	Booking register
3.Total number of women individually pre test counselling			=#3/(#1+#2)	Counsellor's register
4.Total number mothers accepting HIV testing			=#4/(#1+#2)	Blood register
5.Test results for the month.	HIV +	HIV -	Positivity Rate = HIV+/ #4	Blood register
6.Total number of HIV +ve & HIV -ve women individually post test counselled			=#6/ #4	Counsellor's register
7.Total no. HIV +ve women on MTCT who delivered in this facility			N/A	Labour NVP register
8.Total number of women on MTCT who self-administered nevirapine out of those who delivered at your site. (Excluding patients referred during labour)			=#8 /#7	Labour NVP register
9.Total number of women on MTCT who received nevirapine in labour ward in this facility			N/A	Labour NVP register
10.Total number of births in women on MTCT at this facility (including BBA's & stillbirths)	No. Live births		N/A	Labour NVP register
	No. BBA's			
	No. Stillbirths (SB)			
	Total Live Births (excl SB)			
11.Total number of babies who received nevirapine at this facility			#11/live births	Labour NVP register
12.Total number of babies of women on MTCT who were dispensed formula after delivery			#12/#live births	Labour NVP register
13.Total number of babies of women on MTCT being exclusively breastfed			#13/#live births	Labour NVP register

Date of form: 03/2002

MTCT monthly monitoring report for Districts – Baby Clinic Data**Period:** .../.../..... to .../.../.....**District:**.....**Person recording data:**.....

DATA	MTCT baby register		
1. Total no. new arrivals for the month	New arrivals =		
	Transfers in =		
	Total =		
2. Total no. on programme			
	Actual	Expected	
3. Total no. received formula			
4. Total no. with good formula compliance		(N/A)	
5. Total no. exclusively breastfed		(N/A)	
6. Total no. received PCP prophylaxis (Bactrim)			HIV positive
7. Total no. tested at 9 months			
8. Total no. not tested at 9 months but tested between 10 and 17 months		(N/A)	
9. Total no. tested at 18 months			
10. Total no. not followed up	Loss to follow-up (absence for more than 3 consecutive months) =		
	Transfer out =		
	Total =		
11. Total no. known to have died			

Total number in programme = babies born to HIV +ve mothers on the MTCT programme who registered at the clinic. Take this number minus

- lost to follow-up (absence for more than 3 consecutive months)
- deaths
- HIV negative before 18 months
- All tested at 18 months (HIV –ve & HIV +ve)

Good formula compliance = having a supply of 2 tins / week for the month

SITE OF ORIGIN OF NEW ARRIVALS OR TRANSFER INS	TOTAL NUMBER
1.	
2.	
3.	
4.	
5.	
6.	
TOTAL	

Date of form: 03/2002

Combined Counselling and HIV Testing - Monthly Report

Name of District: _____

Month: _____

Compiled by: _____

[illegible]

Acknowledgements

We would like to acknowledge the contribution of so many people from provincial level down to clinicians and staff in health facilities and NGO's, who have taken the time to prepare sections for this document, or to review and comment on the contents. Many of the contributors have made their contribution in spite of the huge challenges of comprehensively rolling out this programme. In particular we acknowledge the MTCT sites in Khayelitsha where the programme started, and through which the initial protocol was developed, and the Department of Public Health, University of Cape Town for the initial monitoring system.