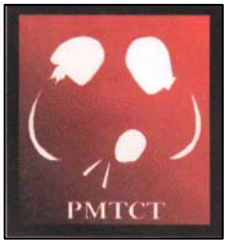
Republic of Zambia
Ministry of Health



INTEGRATED PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV/AIDS

PROTOCOL GUIDELINES

April 2003

Ministry of Health

TABLE OF CONTENTS

ABBREVIATIONS

ANC	Antenatal care
ARV	Antiretroviral drugs
AZT	Zidovudine
BD	Bi-daily
CBOH	Central Board of Health
DHS	Demographic and Health Survey
ELISA	Enzyme-Linked Immunosorbent Assay
HAART	Highly Active Antiretroviral Therapy
HB	Haemoglobin
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IGA	Income generating activities
INH	Isoniazide
IU	International Unit
MCH	Maternal and Child Health
MTCT	Mother to Child Transmission of HIV/AIDS
NVP	Nevirapine
NGO	Non Governmental Organisation
PLWHAs	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
RPR	Rapid Plasma Reagin - Syphilis test kit
STI	Sexually Transmitted Infections
TB	Tuberculosis
TT	Tetanos toxoid
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ZBSS	Zambia Sexual Behaviour Survey

INTRODUCTION

The Government of the Republic of Zambia is committed to providing the country with equitable access to cost effective and quality health care, that is as close to the family as possible. It is within this context that the Central Board of Health is working to increase access to the prevention of mother to child transmission of HIV services (PMTCT) for all pregnant women and their families. This will be achieved through the integration of these services in MCH and the establishment of linkages to other support programmes within the framework of a continuum of care for HIV positive people.

PMTCT interventions must be introduced alongside with the improvement of overall MCH services to ensure a reduction in maternal and childhood morbidity/mortality.

The PMTCT Working Group in collaboration with the Central Board of Health, co-operating partners and NGOs, have drawn up these national guidelines to standardise the implementation of PMTCT services in Zambia. This document has been mainly written for the use of health care providers. It was finalised in April 2003 and it will be updated on a regular basis.

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CHAPTER ONE: CARE FOR THE MOTHERS

a) Antenatal Care

Antenatal care aims at making pregnancy and delivery a safe experience for the mother.

The care package includes:

- Clinical screening and examination :monitoring of blood pressure, urinalysis and weight measurement at every visit – compulsory
- Active detection and effective treatment of STIs (RPR and Benzathine Penicillin). If RPR is done and found negative in the first trimester, repeat at 34 weeks gestation.
- Tuberculosis (TB) clinical screening in HIV infected mothers with sputum smear. If negative give INH as per policy, if diagnosed refer for appropriate TB care.
- Prevention, detection and treatment of anaemia should be strengthened in line with the Safe Motherhood Program. This should include determination of HB at baseline and subsequent HBs if need be and systematic de-worming.
- Malaria prophylactic with sulphadoxine-pyrethamine.
- Multivitamin supplementation for the prevention of low birth weight to all antenatal attendees including 50,000 IU of Vitamin A to be given once during pregnancy.
- Provision of confidential mandatory counselling and voluntary HIV testing as part of the routine service. This needs to be done at each contact point. Husband /partner should be encouraged to come for counselling and testing. Women should be encouraged and support to disclose their status to their partners.
- Psychosocial support for HIV positive mothers and HIV prevention education for negative mothers.
- Referral of positive mothers to peer support groups.
- Promotion and provision of condom for all couples to use at all times during pregnancy.
- HIV positive women who accept to receive ARVs for the purpose of reducing the risk of transmission of HIV to their babies should receive as minimum either:
    - AZT 300 mg tablets BD from 34 weeks of pregnancy and 300 mg three hourly during delivery

- NVP 200 mg for the mother at onset of labour and a single dose 2m/kg syrup for the baby within 72 hours of birth

b) Intra-partum care

Intra-partum care refers to the care that is provided during labour and delivery.

In addition to the labour wards routine activities the following should be observed:-

First stage:

1. Emphasis on keeping the membranes intact for as long as possible unless medically indicated
2. Use of aseptic techniques in conducting deliveries

Second stage:

1. Avoidance of invasive procedures i.e. episiotomies and instrumental deliveries unless absolutely necessary.

c) Immediate Postnatal Care:

Refers to the package of services provided to the mother and the infant before they leave the facility (6 to 48 hours).

- Nevirapine dosis for the baby;
- High dose of Vitamin A (200.000 IU) supplementation for the mother;
- Promotion and provision of condom for use by all women irrespective of the HIV status;
- Counselling on family planning for HIV positive mothers particularly, including use of condoms, and risk of pregnancy in non-breastfeeding mothers
- Nutrition counselling and support especially for HIV positive mothers
- Exclusive breastfeeding counselling and support to enhance good lactation practices for all HIV negative mothers, those of unknown status and positive mothers opting to breastfeed;
- HIV positive mothers should be given enough information about advantages and disadvantages of the available options for them to be able to make an informed choice about what might be best for them. HIV positive mothers, who choose to use replacement feeding i.e. infant formula, should be carefully trained in its preparation. Cup feeding should be demonstrated and started at the hospital/clinic/health centre, and bottle-feeding discouraged.

d) Postnatal check-up:

The purpose of this visit (at 1 week and 6 weeks) is to ascertain the health status of the mother and the baby. It is an opportunity to initiate family planning, to continue with immunisation, to provide nutrition counselling (both for mother and child) and to monitor the baby's growth.

The following activities should enhanced at the implementation sites:

- Promotion and provision of condom for use by all couples irrespective of HIV status (negative mothers should be protected during the lactation period).
- Growth monitoring for all infants and nutrition counselling for all mothers.
- Family planning counselling, including provision of condoms for all women.
- Promotion and support of exclusive breastfeeding, including support to mothers for optimal breastfeeding practices.
- Monitoring of adverse ARV drug reaction both in mothers and babies.
- Care of the breast.

e) Follow up

Adequate as well as frequent growth and development monitoring is important for all infants, but is even more important for children born to sero-positive mothers. HIV positive mothers should be monitored at all baby contacts (eg immunisation, clinic visits etc).

- Monitoring adherence to chosen infant feeding and provision of necessary support. Exclusive breastfeeding should continue to be promoted with safe transition to replacement feeding and complementary feeding at 6 months.
- For HIV positive mothers opting to breastfeed should be supported during safe transition.
- Breast conditions should be identified early and treated.

f) Long Term Support to Mothers after Delivery Period

As much as possible a comprehensive package of care and support should be provided to HIV positive women and their families.

This support should include:

- TB prophylaxis with INH and Pneumocistis Carinii Pneumonia prophylaxis with Cotrimoxazole as per national guidelines;
- Prompt screening, treatment and management of opportunistic infections;
- Good referral networks for mothers to access all care available to HIV infected people including HAART if applicable through the ARV programme.

- Psycho-social support for to mothers and their families: Referrals should be made to community-based groups such as PLWHAs peer support groups, post-test clubs, legal services, churches and faith-based organisations and legal counsellors. Income Generating Activities (IGAs) have the potential to promote sustainability of the programme. This is an area that should be continually advocated for and promoted.
- Continued education and counselling of the mothers and their partners on vital aspects of PMTCT. Issues to address should include the risks of HIV positive women getting pregnant, medical care, good nutrition, infant feeding and prevention of STIs as well as promotion of safer sex practices.

CHAPTER TWO: CARE FOR THE BABIES

Care for the Babies

Health workers and caretakers should be educated on the following:

- BCG vaccination and OPV for all new-born infants and thereafter standard vaccination schedule;
- Adherence to growth monitoring and promotion and early referral for any growth faltering children born to HIV infected women. Growth faltering is one of the earliest signs of HIV/AIDS infection or tuberculosis.
- Primary prophylactic against Pneumocystis Carinii should be provided through the use of Trimethoprim/Sulphamethoxazole oral suspension for first year of life, in line with The Zambian National Guidelines on the Clinical Management of HIV/AIDS.
- Prompt screening and seeking treatment and management of opportunistic infections.
- Adequate basic hygiene, both personal and environmental.
- Nutritional education for caretakers and communities.
- Parents and community education for prompt treatment of illness as per IMCI guidelines (if HWs are not trained it should become paramount to facilitate this training).
- Community education for early childhood care, that also addresses harmful cultural practices.
- Promotion of the use of ITNs for children.

CHAPTER THREE: CARE FOR HEALTH WORKERS

Care for health workers

- Health workers should have access to Post-Exposure Prophylaxis (PEP) kits as per national guidelines.

- Weekly counsellor meeting.
- Supportive counselling for health workers should be available.

CHAPTER FOUR: MONITORING AND EVALUATION

Monitoring and evaluation

- The standard PMTCT indicators will be integrated into the work of the National HIV/AIDS Secretariat Monitoring and Evaluation Working Group.

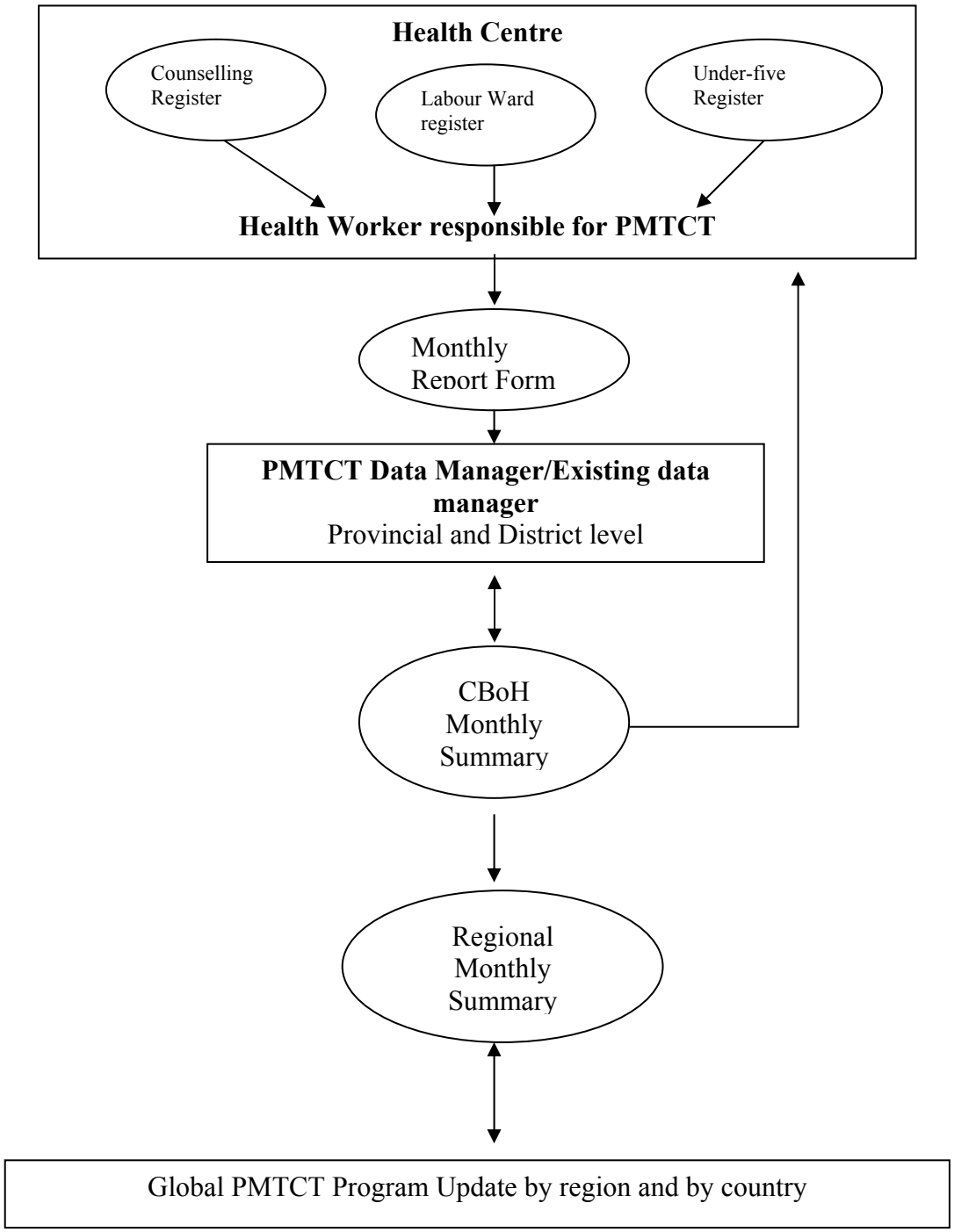
- Sites offering PMTCT services will report to DHMTs, DHMTs to report to Provincial Offices and Provincial Offices to report quarterly to the Central Board of Health (monthly reports to start with). Sites should expect supervisory visits by provincial and district officers (see annexe 2 for report form).

- PMTCT information will be entered in MTCT/HMIS register. These registers have already been developed by the PMTCT Working Group and will be made available to the implementing districts and sites by Central Board of Health.

The minimum standard indicators to be monitored on a monthly basis are as follows:
(Revision could be made as the NACS M&E Working Group develops national indicators)

- Number of first ANC attendants
- Number of deliveries
- Number (%) of women/couples pretest counseled
- Number (%) of women/couples HIV/AIDS tested
- Number (%) of women/couples testing positive
- Number (%) of women/couples post test counseled
- Number of women who received ARV for PMTCT (disaggregate between use of AZT and NVP)
- Number of women who choose to exclusively breastfeed up to 6 months
- Number of women who choose to exclusively use replacement feeding

Reporting System Flow Chart:



Additional Indicators:

The following indicators have been included to guide programme activities.
They have been classified according to the four prongs of PMTCT and should be integrated into other existing data collection and information systems.

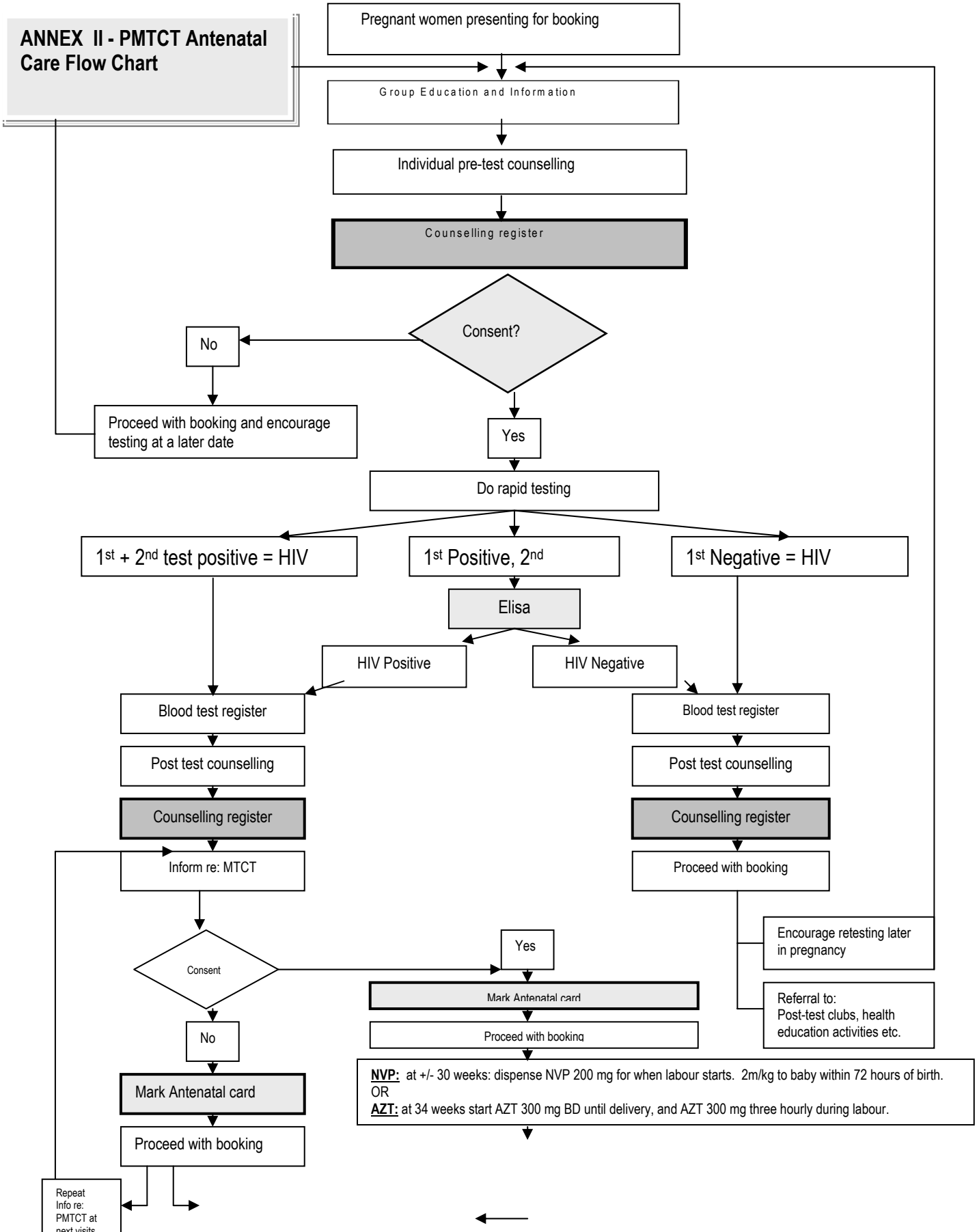
No	Indicators	Means of verification
First Prong Indicators - Prevention of HIV in women		
1	HIV prevalence among ANC attendees	HIV sentinel surveillance system
2	Condom use and condom availability	ZBSS
3	Median age at onset of sexual activities	ZBSS/DHS
4	Prevalence of STIs and percentage of treatment	HMIS
Second Prong Indicators - Prevention of unintended pregnancies		
1	Use of family planning method (?) (DHS?)	DHS
Third Prong Indicators - Prevention of MTCT		
1	Proportion of women attending ANC at least four times (1 in 1st trimester, 1 in 2nd trimester and 2 in 3rd trimester)	HMIS
2	Proportion of pregnant women who receive malaria prophylaxis during at least one ANC visit.	Survey
3	Proportion of pregnant women who received TT2+ dosis.	Survey
4	Proportion of delivery attended by skilled health worker	HMIS
5	Proportion of delivery using safe delivery kits	Survey
6	Number and proportion of infants who are exclusively breastfed up to 3 months	Survey
7	Number and proportion of infants who are exclusively breastfed up to 6 months	Survey
Fourth Prong Indicators - Care and Support		
1	Proportion of women who have received family planning counselling including prevention of HIV transmission and condom use by six weeks postnatal period.	PMTCT registers/Health facility data
2	Proportion of HIV positive mothers with OIs, referred for treatment	PMTCT registers/Health facility data
3	Proportion of HIV positive mothers referred to social networks for follow up support services.	PMTCT registers/Health facility data
4	Proportion of mothers and partners screened for TB	Health facility data

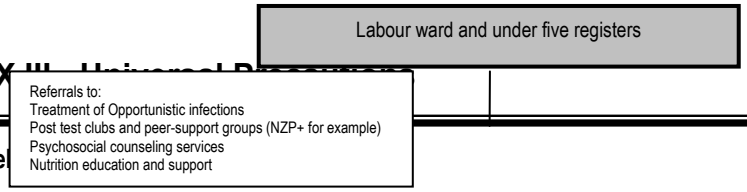
Annex I - List of Back-up Supplies used at PMTCT Sites, provided for information.

ANTENATAL CARE
Disposable sterile surg. gloves latex Size 8
Gloves, examination, non ster., medium (5/c)
Cotton wool 500 grm
Disp. sanitary pads 8'5
Chlorexidine 5 %
JIK or bleach 1 liter
Syringes, disp., ster. 5 ml
Needles, disp. 21 G, 1.5", ster.
Mebendazole 500 mg(1/courses 2)
Sulphadoxine + pyramethamine 525 mg (6/w)
Ferrous salts + folic acid 60 mg + 0.4 mg tablet - OD (270 /c)
Vitamin A 50,000 IU
Micronutrient, film coated OD(90/c)
Urine dipstick (3/c)
Urine containers 30 ml
Lancet (3/c)
Hemoglobin scale and filter paper sheets (3/c)
RPR Kits
Benzathine Penicilline pwder for inj. 2.4 MU
Disp. Syr. 10 ml
Needles, ster, disp. 21 G,1.5"
Glass tube without coagulant, blood red top 10 ml (x2)

These supplies are part of the regular antenatal care supplies. They have been provided as back-up supplies to strengthen ANC services in an effort to reduce MTCT of HIV/AIDS at the PMTCT sites during the pilot phase. PMTCT programme implementers should ensure that ANC services do not run out of these essential supplies

ANNEX II - PMTCT Antenatal Care Flow Chart





ANNEX III: Universal Precautions

(WHO wel

What it is

Universal precautions are simple infection control measures that reduce the risk of transmission of bloodborne pathogens through exposure to blood or body fluids among patients and health care workers. Under the "universal precaution" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or supposed status of the person. Improving the safety of injections is an important component of universal precautions.

Why it is Important

- Any percutaneous or permucosal exposure to blood or body fluids represent a potential source of HIV infection. These include skin-piercing procedures with contaminated objects and exposures of broken skin, open wounds, cuts and mucosal membranes (mouth or eyes) to the blood or body fluid of an infected person.
- Although they account for a minority of HIV infections, health care procedures represent a highly preventable source of HIV infection. Among health care associated sources of infection, unsafe injections are of particular concern, acounting for an estimated 3.9% to 7.0% of new infections worldwide. In addition, unsafe practices in hemodialysis and plasmapheresis centres have been associated with HIV transmission.
- Health care worker protection is an essential component of any strategy to prevent discrimination against HIV infected patients by health care workers.
- If health care workers feel they can protect themselves from HIV infection, they can provide better care. How it is Done

1. *Ensure Universal Precautions*
   - Use of new, single-use disposable injection equipment for all injections is highly recommended. Sterilizable injection should only be considered if single use equipment is not available and if the sterility can be documented with Time, Steam and Temperature indicators.
   - Discard contaminated sharps immediately and without recapping in puncture and liquid proof containers that are closed, sealed and destroyed before completely full.
   - Document the quality of the sterilization for all medical equipment used for percutaneous procedures.
   - Wash hands with soap and water before and after procedures; use of protective barriers such as gloves, gowns aprons, masks, goggles for direct contact with blood and other body fluids.
   - Disinfect instruments and other contaminated equipment.
   - Handle properly soiled linen. (Soiled linen should be handled as little as possible. Gloves and leakproof bags should be used if necessary. Cleaning should occur outside patient areas, using detergent and hot water.)

2. *Ensure Adherence to Universal Precautions*

- **Staff understanding of universal precautions**
  Health care workers should be educated about occupational risks and should understand the need to use universal precautions with all patients, at all times, regardless of diagnosis. Regular in-service training should be provided for all medical and non-medical personnel in health care settings. In addition, pre-service training for all health care workers should address universal precautions.

- **Reduce unnecessary procedures**
  Reduce the supply of unnecessary procedures: Health care workers need to be trained to avoid unnecessary blood transfusions (e.g., using volume replacement solutions), injections (e.g., prescribing oral equivalents), suturing (e.g. episiotomies) and other invasive procedures. Standard treatment guidelines should include the use of oral medications whenever possible. Injectable medications should be removed from the national Essential Drug List where there is an appropriate oral alternative.
  Reduce the demand for unnecessary procedures: Create consumer demand for new, disposable, single-use injection equipment as well as increased demand for oral medications.

- **Make adequate supplies available**
  Adequate supplies should be made available to comply with basic infection control standards, even in resource constrained settings. Provision of single use, disposable injection equipment matching deliveries of injectable substances, disinfectants and “sharps” containers should be the norm in all health care settings. Attention should also be paid to protective equipment and water supplies. (While running water may not be universally available, access to sufficient water supplies should be ensured.)

- **Adopt locally appropriate policies and guidelines**
  Use of sterilizable injection equipment should be discouraged, as evidence shows that the adequacy of the sterilization is difficult to ensure. National health care waste management plans should be developed. The proper use of supplies, staff education and supervision needs should be outlined clearly in institutional policies and guidelines. Regular supervision in health care settings can help to deter or reduce risk of occupational hazards in the workplace. If injury or contamination result in exposure to HIV infected material, post exposure counselling, treatment, follow-up and care should be provided.

ANNEX IV - PMTCT Registers

Counselling Register Page 1/2

SM Register Number	Visits			Origin Code	Age	Grav. no.	Para no.	Duration of pregnancy (in weeks)	COUNSELLING SERVICES									
	Number	Date	Name and Address						Pre-test	Post-test	Supportive	Infant Feeding	Safer Sex	ARV	With Partner	Couple	Baby Care	F. Planning
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)
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Counselling Register Page 2/2

SM Register Number	LABORATORY SERVICES				TREATMENT							
	Blood Taken?	HB	RPR	Serology	B - Penincillin	Iron	Folate	MV	Fansidar1	Fansidar2	AZT/ NVP	REMARKS
(a)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)	(ab)	(ac)	(ad)	(ae)

Instructions for Counselling register:

1. General Information

Column (a) Every woman who attends Antenatal for the first time, is allocated this number. If a woman is recruited into this register, just transfer the number here.

(b) & (c) It is anticipated that a woman shall make up to 6 visits (b) and each visit she makes, a date (c) of the visit will be recorded

(4) Enter name and address. This is useful if you need to conduct home visits. It is important therefore to enter information that will not give you problems afterwards to track your clients.

(e) thru (i) Same as in the Safe Motherhood Register

2. Services

Column (j) thru (t) Tick (✓) against the services provided on this visit. This must be aligned with visit and date in (b) and (c).

(u) Enter the actual reading or "NT" if not taken

(v) thru (w) Enter "A" for Active and "N" for Non-reactive or "NT" if not taken

(x) thru (ad) Enter the dosage or quantity

(ae) Record anything peculiar about the visit.

Labour Ward Register - Page 1/2

Delivery Register Number	Date of Admission	Time of Admission	SM Register Number	Name Address	Origin Code	Age	Grav. no.	Para no.	Duration of pregnancy (in weeks)	Reason for at Risk Pregnancy	Labor Stage	**PROCEDURES PERFORMED**						
												Vaginal Wash					Membrane	Episiotomy
												1	2	3	4	5	(Intact (Y/N))	(+/ -)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)

Labour ward register Page 2/2

Delivery Register Number	DELIVERY			BIRTH					TREATMENT								Under-Five	
									AZT					Niverapine		Feeding Type		Register Number
	Instrumental	Ceaserian	Suction	Date of Delivery	Time of Delivery	SEX	Weight	Height	1	2	3	4	5	Mother	Child			REMARKS
(a)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)	(ab)	(ac)	(ad)	(ae)	(af)	(ag)	(ah)	(ai)	(aj)	(ak)
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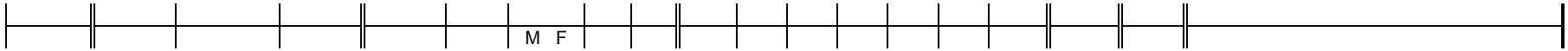

INSTRUCTIONS FOR LABOUR WARD REGISTER

Column (a) thru (l) Same as in the (HMIS) Delivery Register

(m) thru (q) Every time a vaginal wash is done, tick against the number. For example, if you have done the first wash, you should tick against "1". The next wash should be ticked against "2" and appropriately for the subsequent washes.

(r) Enter "Y" for Yes and "N" for a No. Yes means the membrane is intact and the opposite is true.

(s) Record "+" if Episiotomy is done and "-" if not done.

(t) thru (v) Tick if procedure is done

(w) and (x) Record the date and time of delivery

(y) Circle what applies

(z) Enter the weight at birth in *grams*

(aa) Enter the height in *cms*

(ab) thru (af) Every time a dose of AZT is given, tick against the number. For example, if you have given the first dose, you should tick against "1". The next dose should be ticked against "2" and appropriately for the subsequent doses.

(ag) thru (ah) If Niverapine is given, tick against either the mother or the child, depending on who it gas been given to.

(ai) Enter the following codes

FD	=	Formula Feed
EB6	=	Exclusive Breast Feeding for Six Months
BF3	=	Three months' Breast Feeding with Infant Formula thereafter.
MFF	=	Mixed Feeding with formula
MFB	=	Mixed Feeding with Breast Milk

(aj) This is the same number you are going to use in the Under-Five Register. Never leave this blank because it will be difficult to link the two registers.

Under Five Register Page 1/3

						Under one services										
						Immunisations										
Under 5 Register Number	Date of First Atten-dance	Name/Address	Origin Code	Date of Birth	Sex	BCG	BCG scar	DPT1	DPT2	DPT3	OPV0	OPV1	OPV2	OPV3	Measles	Fully immunised
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
					M F											
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Under Five Register Page 2/3

			Feeding Options						Body weight								Body weight				
Birth Weight	Birth Height	Arm Circumference	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	0-1	1M	2M	3M	4M	5M	6M	Vitamin A	7M	8M	9M	10M	11M	Vitamin A
(r)	(s)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)	(ab)	(ac)	(ad)	(ae)	(af)	(ag)	(ah)	(ai)	(aj)	(ak)	(al)	(am)

Under Five Register 3/3

one to four year old services																										
Immunisations			Body weight growth code by age of child and vitamin A																							
DPT booster	OPV booster	Measles booster	between 1-2 years						between 2-3 years						between 3-4 years				between 4-5 years						
			12-14 mths	15-17 mths	Vitamin A	18-20 mths	21-23 mths	Vitamin A	24-26 mths	27-29 mths	Vitamin A	30-32 mths	33-35 mths	Vitamin A	36-41 mths	Vitamin A	42-47 mths	Vitamin A	48-53 mths	Vitamin A	54-59 mths	Vitamin A	Home - Based No.	Date of Death (if applicable)	Remarks
(an)	(ao)	(ap)	(aq)	(ar)	(as)	(at)	(au)	(av)	(aw)	(ax)	(ay)	(az)	(ba)	(bb)	(bc)	(bd)	(be)	(bf)	(bg)	(bh)	(bi)	(bj)	(bk)	(bl)	(bm)

Instructions for completing the Under-five Register

A new entry should be made in the register when the child receives the first immunisation or is weighed for the first time. Subsequent preventive services (immunisations and growth monitoring data) should be entered on the same line in the register. The register should be used for children who are receiving on-going services; a child who comes for a single vaccination or weighing but who normally receives services in another catchment area should not be entered in the register. However, the services provided to the child, such as vaccinations and weighing, should be tallied.

(a) This number should match the number on the child's health passport, children's clinic card or file number in the institution's medical records system, or any other reference number the institution finds useful for keeping track of the child.

(b) The date on which the child first came for a children's clinic visit.

(c) Child's name and address. Enter the name on the top line and the address on the bottom line. The address should include the name of the community or area and the house number if one has been assigned.

(d) Location of client's residence in relation to the Institution:
1 = from within 12 KM, within catchment area;
2 = from more than 12 KM, within catchment area;
3 = from within district, but outside catchment area;
4 = from outside district;
5 = from outside Zambia;
6 = unknown.

This column is optional, depending on the instructions from the District.

(e) Enter the child's date of birth.

(f) Circle M for male; circle F for female.

(g-p) Enter the date when the child receives the immunisation. For BCG scar, enter X when the scar is observed. Measles refers to a dose of measles vaccine given at 9 months or later.

(q) Enter X on the day when the child completes the standard Under 1 series of immunisations in the first year of life. The standard series of immunisations is BCG, DPT 1-3, OPV 0-3, and Measles. Do not enter an X if the child has passed the first birthday when the series is completed.

(r) Enter the child's birth weight in grams, if it is known. If the birth weight is not known, leave the cell blank.

(s) Enter the child's birth height in centimeters, if it is known. If the birth height is not known, leave the cell blank. *(Check the delivery register)*

(t) Enter the child's arm circumference at birth in centimeters. If not known, leave the cell blank.

(u-y) Record the Feeding options for each visit.

(z-af) Body weight growth 0-6 months. Enter code for growth status during the first month of life; leave blank if child not weighed. If useful, enter the exact weight of the child also.

AG = above the lower line growing
AS = above the lower line static
AL = above the lower line losing
BG = below the lower line growing
BS = below the lower line static
BL = below the lower line losing

note: When a child comes for the first time, you do not know the previous reference weight and you cannot know whether the child is growing, static or losing weight. Do not use the codes AG/AS/AL or BG/BS/BL, but write the actual weight and the code "A--" or "B--". This means Above Line or Below Line without the growth specified. The same notation may be used when the previous weight was recorded so long ago that the growing, static, or losing cannot be determined.

(ag) Enter X if the child received a dose of 50,000 IU Vitamin A between 0-6 months of age.

(ah-al) Body weight growth 7-11 months. Use the same codes as listed above for columns (z) through (af).

(am) Enter X if the child received a dose of 100,000 IU Vitamin A between 6 to 12 months of age.

(an-ap) Enter the date when the child receives booster doses of the antigens indicated.

(aq-bj) Enter code for growth status recorded every 3 months; leave blank if child not weighed. Note that some children are weighed more frequently than quarterly in between ages 12 and 56 months. Hence, use the top line for the first weighing and the bottom line for any subsequent weighing. Use the codes listed above for columns (z) through (af). Respectively enter X for each dosis of 200,000 IU Vitamin A provided at the appropriate 6 month intervals between 12 to 15 months.

(bk) Enter the number the child has been assigned in the institution's home based care register or notebook.

Note: Any child whose growth is faltering for three months or more, is losing weight, or has experienced low weight for age with growth faltering should be considered for a home visit or community outreach available in your institution's catchment area.

(bl) Date of Death (if applicable) If the child dies, enter the date of death. Leave empty while the child lives.

(bm) Enter observations on the child's health and factors that might affect it like:

-one or both parents died
-twins
-no longer breastfeeding and under age 1
-prolonged illness
-TB in the household

In addition, enter these risk factors on the children's clinic card. Indicate any action taken in relation to the child's growth status.

ANNEX V

Monthly PMTCT monitoring form from Maternity units

Month: _____ Year: _____

Facility: _____ District: _____

No.	Variables	Number	No.	Variables	Number
1	Antenatal care visits		9	Still Birth	
2	First antenatal care visits		10	Babies received Nevirapine syrup	
3	Women who received pre-test counselling		11	Women opting exclusive alternative feeding from birth	
4	Women HIV tested		12	Women opting exclusively breastfeeding up to 3 months	
5	Women with HIV positive results		13	Women opting exclusively breastfeeding up to 6 months	
			STOCK MANAGEMENT		
6	Women who started AZT		14	AZT dosis dispensed	
7	Women received Niverapine		15	NVP tablets dosis dispensed	
8	Live Birth		16	NVP syrup dosis dispenses	

Any remarks or comments: _____

_____