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WHO Technical guidance note: Strengthening inclusion of reproductive health and maternal, newborn and child health in proposals to the Global Fund and other Partners

This document, the *WHO RH-MNCH Technical Guidance Note* offers support to country teams and stakeholders that are developing proposals to the Global Fund and other Partners. It is specifically focused on information that supports inclusion of maternal, newborn and child health (MNCH) and reproductive health (RH) within disease-specific and/or cross-cutting health systems and community systems strengthening proposals.

The aim is to assist countries in accelerating progress towards achieving the health-related Millennium Development Goals for women, children and people affected by HIV/AIDS, TB, malaria and other major diseases, by maximizing synergies and linking interventions to achieve the maximum possible impact on health outcomes within the context of each country.

The WHO RH-MNCH Guidance Note provides access to the normative technical guidance and other documents and resources on specific aspects of MNCH, health systems and community systems strengthening, HIV, TB and malaria. This provides the necessary technical back ground to support practical guidance documents from other organisations on these topics.

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Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ACT	artemisinin-based combination therapy
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (drug)
CSS	community systems strengthening
DOT	directly observed treatment
DOTS	the internationally agreed strategy for TB control
EPI	Expanded Programme on Immunization
GAVI	Global Alliance for Vaccines and Immunization (also known as the GAVI Alliance)
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIVS	Global Immunization and Vaccines Strategy
HIV	human immunodeficiency virus
HSS	health systems strengthening
IMCI	integrated management of childhood illness
Hb	haemoglobin
IPTp	intermittent preventive treatment of malaria in pregnancy
ITN	insecticide-treated mosquito nets
IPT	isoniazid preventive therapy
IYCF	Global Strategy for Infant and Young Child Feeding
LLIN	long-lasting insecticidal nets
MCH	maternal (or mother) and child health
MDG	Millennium Development Goal
MiP	malaria in pregnancy
MMR	maternal mortality rate
MNCH	maternal, newborn and child health
NTCP	national tuberculosis control program
PEPFAR	President's Emergency Plan For AIDS Relief

MTCT	mother to child transmission
PITC	provider initiated testing and counselling
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
PNMR	perinatal Mortality Rate
ORS	oral rehydration salts
RBM	Roll Back Malaria
RBT	rapid diagnostic test
RH	reproductive health
SP	sulfadoxine-pyrimethamine
SDA	service delivery area
RTI	reproductive tract infection
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WB	World Bank
WHO	World Health Organization

1. Introduction and background

1.1. WHO guidance on maternal, newborn and child health

The World Health Organization (WHO) is the lead agency for the development of normative guidance within the health sector in collaboration with key UN agencies including UNFPA, UNICEF and UNAIDS,¹ with the World Bank (WB), the Stop TB Partnership, Roll Back Malaria (RBM), the Partnership for Maternal Newborn and Child Health (PMNCH), the Global Fund (GF) and civil society organizations. WHO is strongly committed to the Global MNCH Strategy and therefore aims to assist more rapid and effective progress towards MDGs 4, 5 and 6 through supporting programming and interventions that are technically sound and evidence-based.

In this document, WHO provides access to key MNCH technical information and normative guidance for country teams and other stakeholders, focused on the integration of proven priority SRH and MNCH interventions into programming for HIV, TB, malaria and other major health challenges according to each country's context and priorities. The document offers guidance across the full range of RH and MNCH interventions. Countries and partner agencies will be able to use it to support selection of their own priorities within their particular context.

In line with the emphasis on greater progress towards the MDGs, many decision makers and partners at national, bilateral and multilateral levels are also developing their own policy and practical guidance documents specific to their context and priorities.

The Partnership for Maternal, Newborn and Child Health (PMNCH) Knowledge Portal provides access to an extensive and developing knowledge base on many aspects of MNCH policy, practice and experience, sourced from members of the PMNCH.²

The Global Fund (GF) and a number of other organisations have developed a range of guidance documents related to MNCH and RH. The Global Fund document focuses on inclusion of MNCH within funding proposals, and contains links to the other guidance documents.³

1.2. Background - The Millennium Development Goals and integration of health interventions for women and children

The three health-related Millennium Development Goals (MDGs) - reducing child mortality (Goal 4), improving maternal health (Goal 5) and combating HIV/AIDS, malaria and other

¹ UN: United Nations; UNFPA: United Nations Population Fund; UNAIDS Joint United Nations Programme on HIV and AIDS; UNICEF: United Nations Children's Fund; Global Fund: the Global Fund to Fight AIDS, Tuberculosis and Malaria

² http://www.who.int/pmnch/topics/continuum/essential_mnch_knowledge/en/index.html

³ <http://www.theglobalfund.org/en/application/infonotes/> and <http://www.theglobalfund.org/en/application/otherguidance/>

diseases (Goal 6) - are strongly inter-connected. Child and maternal mortality remain persistently high in many countries. Much progress has been made against infectious diseases such as HIV, tuberculosis (TB) and malaria, but there are still significant burdens of disease and deaths that affect women and children disproportionately, particularly around the time of birth. The majority of the burden borne by women, adolescent girls, newborns and children occurs among the poorest and most vulnerable individuals, especially in sub-Saharan Africa and South Asia.

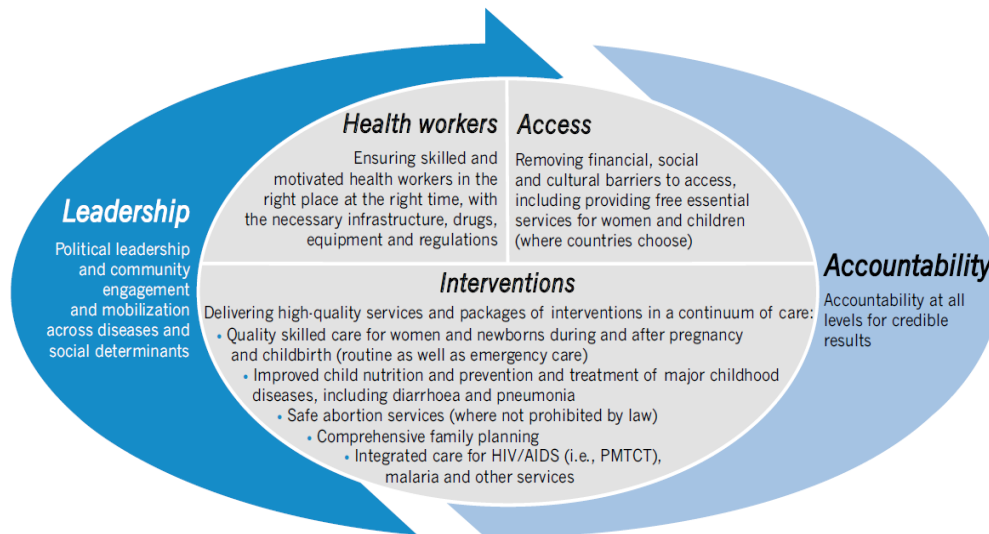
The UN Global Strategy for Women's and Children's Health, launched in September 2010 clearly outlines the key areas where action is urgently required towards the health-related MDGs, including:

- **Country-led health plans:** Partners must support existing, costed national health plans to improve access to services, including human resources, financing, and delivery and monitoring of an integrated package of interventions.
- **A comprehensive, integrated package of essential interventions and services:** women and children have access to a universal package of guaranteed services to support maternal, newborn and child health (MNCH) that include:
 - family planning information and services,
 - antenatal, newborn and postnatal care, including emergency care, skilled care during childbirth at appropriate facilities, safe abortion services (where abortion is not prohibited by law), and
 - prevention of HIV and other sexually transmitted infections.
- **Integrated care** that improves health promotion and helps prevent and treat communicable and non-communicable diseases. Stronger links must be built between disease-specific programs - such as for HIV/AIDS, malaria and TB - and services targeting women and children - such as the Expanded Programme on Immunization (EPI), sexual and reproductive health (SRH), infant feeding support and Integrated Management of Childhood Illness (IMCI). Partners should coordinate efforts with those addressing issues that impact on health, such as sanitation, safe drinking water, nutrition, gender equality and women's empowerment.
- **Health systems strengthening (HSS)** for delivery of integrated, high-quality services and care. They should extend the reach of services, especially at community level and to the underserved, and manage scarce resources more effectively. More health facilities should be provided to ensure that vulnerable people have access to quality medical expertise, medicines and other health goods.
- **Health workforce capacity building:** partners must work together to address critical shortages of health workers at all levels. They must provide coordinated and coherent support to help countries develop and implement national health plans that include innovative strategies to better train, retain and deploy health workers, and to expand the role of existing health workers such as training FP and ANC providers on HIV counselling and testing and TB screening and referrals.
- **Coordinated research and innovation:** partners must find innovative ways to provide high-quality care and to expand research programs that develop new interventions, such as vaccines, medicines and diagnostic devices, and also implementation research to overcome common service delivery challenges at scale. They must develop, fund and implement a prioritized and coordinated global

research agenda for women’s and children’s health, and strengthen research institutions and systems in low- and middle-income countries.

Figure 1 highlights the importance of leadership and accountability within the enabling environment for reaching these goals.

Figure 1. The Global Consensus for Maternal, Newborn and Child Health



Accountability and leadership are crucial at every stage if the MDGs are to be achieved. Three key areas need to be addressed: skilled and well-equipped health workers, priority high quality interventions, and removal of barriers to equitable access for all women and children. Innovative approaches and targeted funding are essential to enable all of these to be achieved. However, integrated planning and interventions are challenging, not only on a technical level but also on the level of cooperation between services, collaboration between service providers, communities and individuals, and decisions on the use of available funds.

Key resources

- (1) Cotton M et al. *Guidance for national tuberculosis and HIV programmes on the management of tuberculosis in HIV-infected children: Recommendations for a public health approach*. Paris, World Health Organization and International Union Against Tuberculosis and Lung Disease, 2010 (<http://www.theunion.org/index.php/en/resources/scientific-publications/item/759-guidance-for-national-tuberculosis-and-hiv-programmes-on-the-management-of-tuberculosis-in-hiv-infected-children-recommendations-for-a-public-health-approach>)
- (2) *Countdown to 2015 Maternal, Newborn and Child Survival 2010 Report*. Geneva, World Health Organization and UNICEF, 2010 (<http://www.countdown2015mnch.org/reports-publications/2010-report/2010-report-downloads>)
- (3) *Guidance on Global Scale Up of the Prevention of Mother-to-Child Transmission of HIV*. Geneva, World Health Organization and UNICEF, 2007 (http://www.unicef.org/aids/files/PMTCT_enWEBNov26.pdf)
- (4) *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva, World Health Organization, 2007 (<http://www.who.int/hiv/topics/vct/PITCguidelines.pdf>)
- (5) *Guidelines for the treatment of malaria, 2nd ed.* Geneva, World Health Organization, 2010 (<http://www.who.int/malaria/publications/atoz/9789241547925/en/index.html>)
- (6) *Guidelines on HIV and infant feeding*. Geneva, World Health Organization, 2010 (http://www.who.int/child_adolescent_health/documents/9789241599535/en/index.html).
- (7) *Integrated management of childhood illness*. Geneva, World Health Organization, 2011 (http://www.who.int/child_adolescent_health/documents/imci/en/index.html)
- (8) *Integrating gender into HIV/AIDS programmes in the health sector: Tool to improve responsiveness to women's needs*. Geneva, World Health Organization, 2009 (http://www.who.int/gender/documents/gender_hiv/en/index.html)
- (9) *Malaria in Pregnancy: Guidelines for Measuring Key Monitoring and Evaluation Indicators*. Geneva, World Health Organization, 2006 (http://www.who.int/making_pregnancy_safer/publications/MIP_ME_Framework_June_06.pdf)
- (10) *Maternal and perinatal health*. Geneva, World Health Organization, 2011 (http://www.who.int/reproductivehealth/topics/maternal_perinatal/en/index.html)
- (11) MCHIP-Maternal and Child Health Integrated Programme. Tools and Resources. Washington DC, United States Agency for International Development, 2011 (<http://www.mchip.net/resources>)
- (12) *New progress and guidance on HIV diagnosis and treatment for infants and children*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/paediatric/Paediatricfactsheet/en/index.html>)
- (13) *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. Geneva, World Health Organization (Department of Reproductive Health and Research), 2004 (http://www.who.int/reproductivehealth/publications/general/RHR_04_8/en/index.html)
- (14) Roll Back Malaria Partnership. *RB Toolbox*. (<http://www.rbm.who.int/toolbox/index.html>)
- (15) Stop TB Partnership. *Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings*. Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf)
- (16) Stop TB Partnership. *Tuberculosis: Women and TB - Fact Sheet*. Geneva, World Health Organization, 2009 (<http://www.who.int/tb/womenandtb.pdf>)

(17) UNAIDS Inter-Agency Task Team on HIV and Young People. *Global Guidance Briefs: HIV Interventions for Young People*. New York, United Nations Population Fund, 2008 (<http://www.unfpa.org/public/iattyp/>)

(18) Williams K, Warren C, Askew I. *Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services*. New York, Population Council and United Nations Population Fund, 2011 (<http://www.unfpa.org/public/home/publications/pid/7287>)

2. Situation overview: women and children affected by HIV, TB and malaria in the context of health and community systems and human rights

HIV, TB and malaria place heavy burdens on the health of women and children, and contribute directly to 13 percent of global maternal deaths. Each year malaria accounts for around 225 million acute cases and nearly 800,000 deaths, 85 percent of which are in children under five years. In sub-Saharan Africa, HIV causes 46 percent of all deaths among women aged 15-59. Malaria causes 17 percent of deaths among children aged 0 to 4. Around 38 percent of incident TB cases in 2008 were among women, who bear a relatively higher burden of TB where HIV prevalence is high.

2.1. HIV

HIV contributes both directly and indirectly to increased mortality in women and children. Recently released estimates report that HIV accounts for 9 percent of maternal deaths in sub-Saharan Africa.⁴ In some African countries, previously-recorded declines in mortality have been reversed by HIV. HIV-infected pregnant women and mothers are at greater risk of death due to severe infection before and after delivery. Stigma and discrimination also limit their access to quality services. Women are more affected at a younger age compared to men and many are also victims of gender-based violence which increases the risk of sexual transmission of HIV.

HIV is estimated to be directly responsible for 12-15 percent of all child mortality, and up to 35 percent of child mortality in southern African high burden countries. In nine countries in southern Africa, at least 1 in 20 young people is living with HIV, and in Botswana, Lesotho and Swaziland, more than 1 in 10 young people are living with HIV⁵. Southern Africa accounts for about 85 percent of all HIV transmissions in both women and children. Africa is home to 21 percent of under-five children while it accounts for about 47 percent of all deaths of children under the age of five years.

HIV infection also affects a mother's ability to care for her family, increasing her children's risk of death, especially if they are HIV-infected. When a mother's CD4 count drops below 200 cells/ml, her children are 3.5 times more likely to die, and when a mother dies her children are 4.2 times more likely to die.⁶ However, recent reports show that child mortality can be significantly reduced when primary health care services coordinate and deliver effective ARV interventions to decrease HIV transmission to infants, and support mothers to breastfeed correctly.⁷

⁴ Inter agency estimates: trends in maternal mortality. 2010

⁵ UNICEF analysis based on estimates of the number of young people aged 15-24 living with HIV in 2008 and age-specific population estimates

⁶ *Mortality of infected and uninfected infants born to HIV infected mothers in Africa: a pooled analysis.* Newell ML, Coovadia HM, Cortina-Borja M, Rollins NC, Gaillard P, Dabis F Lancet 2004;364:1236-43

⁷ *Decline in early life mortality in a high HIV prevalence rural area of South Africa: evidence of HIV prevention or treatment impact?* Ndirangu J, Newell ML, Tanser F, Herbst AJ, Bland R. -AIDS 2010;24(4):593-602

2.2. TB

At least one-third of the estimated 33 million people living with HIV worldwide are infected with TB (latent TB infection - not active disease). Of the 9.4 million new TB cases in 2009, 1.1 million were also people living with HIV of which 80 percent are in sub-Saharan Africa. People with HIV are 20-30 times more likely to develop TB than those without HIV. However, the majority of people living with HIV who are infected with TB do not know their HIV status and are not accessing antiretroviral therapy (ART). Over 60 percent of those living with HIV in Africa are women and adolescent girls who face acute risks of TB/HIV co-infection and subsequent TB disease. Pregnant women with HIV and active TB face far higher risks of maternal mortality than women without HIV.

Despite the importance of early diagnosis and treatment of TB for successful outcomes, few mechanisms are in place to target women of reproductive age with TB services, especially for women living with HIV. Too often, these women face the lethal combination of living with HIV and poor access to health services, making them particularly vulnerable to poorer outcomes linked to undetected or late detected TB disease.

Extra-pulmonary TB and genital tract TB are difficult to identify and manage and consequently receive less attention from healthcare providers, contributing significantly to maternal morbidity and infertility. Women with TB may also experience higher levels of early pregnancy loss and stillbirths. Most of the interventions to prevent these risks should be provided as part of reproductive health services before the woman becomes pregnant.

Non diagnosed TB in pregnancy also puts the newborn at risk for congenital TB. Increasingly, researchers have noted the emergence of perinatal TB with the HIV epidemic. Some studies suggest that TB in pregnant women living with HIV may increase the risk of HIV in-utero transmission. When combined with the high burden of undiagnosed active TB among pregnant women in areas with high HIV prevalence rates, these data indicate a need for routine TB screening in antenatal clinics.

Children are also at risk of TB infection from their main caregivers, almost always women. Children - mainly girls - are often pulled out of school to help care for sick family members or to earn additional income for the family. Children who are infected with HIV are especially vulnerable to TB disease, which increases the risk of child mortality. TB accounts for some 20 percent of all deaths in HIV-infected children.

2.3. Malaria

About 3.3 billion people - half of the world's population - are at risk of malaria. Every year, this leads to about 250 million malaria cases and nearly 800,000 deaths, and 85 percent of deaths are in children under 5 years. People living in the poorest countries are the most vulnerable and, especially in Africa, almost one in every five (18 percent) childhood deaths is due to the effects of malaria disease directly or indirectly. A child under five will have 4-6 febrile episodes a year due to malaria. Where the disease is endemic, it is often responsible for high disease burdens, accounting for as much as 40 percent of out-patient attendances in children and occupying 30 percent of paediatric hospital beds.

Pregnant women are also among the most vulnerable and are at high risk for malaria. The risk is greater for pregnant women with impaired immunity due to HIV or other causes. Malaria in pregnancy increases the risk of: maternal anaemia; stillbirth; spontaneous abortion; low birth weight; neonatal death and preterm labour.

Around 50 million pregnant women are exposed to malaria each year and up to 10,000 mothers and 200,000 infants die due to malaria infection during pregnancy. High morbidity levels due to malaria in pregnancy include: 6-14 percent of low birth weight infants; 8-36 percent of preterm births; 13-70 percent of intrauterine growth retardation; 3-8 percent of infant deaths and 2-15 percent of maternal anaemia. More than 10 percent of maternal deaths are due to acute and severe clinical disease

Women and children combined carry over 60 percent of the malaria burden especially in highly malaria endemic countries. Effective preventive and curative interventions against malaria are available, and considerable gains have been achieved, but poor access, weakened health systems and social and economic inequities continue to contribute to the burden of disease and death.

2.4. Health systems

Health systems strengthening (HSS) is aimed at removing one of the main obstacles to scaling up effective distribution of such life-saving interventions, and therefore also a key barrier to achieving the health-related MDGs. Weak health systems affect access to and the delivery of HIV, TB, malaria, SRH and MNCH services to the most vulnerable groups including women, adolescent girls and children.

The reasons for the relative lack of progress in reducing maternal and child mortality are complex and vary by country, but the following factors often play a role:

- Maternal, newborn and child health and nutrition policies, interventions and implementation approaches are often developed independently of each other and are not adequately included in the overall national health plans;
- RH and MNCH interventions are often planned and delivered in non-integrated ways, through vertical interventions to separate groups, e.g. nutrition supplementation programmes to children, RH advice to women;
- The continuum of care concept is not well understood and does not yet figure prominently in planning RH and MNCH activities. Partners and decision-makers at national level are only now becoming aware of its value-added potential;
- Partners and decision-makers focus on the interventions to be delivered and not on the common social and health system elements or 'critical enablers' that support the effectiveness and efficiency of responses and interventions;
- The actions of global partners in supporting national agencies are often fragmented, each working with their own national partners to provide support to MNCH. They often use independent service-delivery infrastructures, sometimes even in the same geographic locations, without any coordinating input from the national counterpart. This lack of collaboration and coordination tends to decrease efficiency in health systems.

The Countdown team has analyzed interventions that are needed to improve maternal and child mortality in 68 countries, which account for 97 percent of maternal and child deaths worldwide. The analysis shows that multiple opportunities are being missed to provide

comprehensive care. For example, although 80 percent of women receive one or more antenatal visits and 80 percent of children are immunized against measles, coverage is much lower for skilled birth attendance and post-natal visits, and very low for treatment of pneumonia, the major killer of children under five years of age. The contraceptive prevalence rate is 29 percent and the wide disparities in coverage of family planning services across and within countries represent a missed opportunity to improve the health of women and young children. The adolescent birth rate (annual number of births to women ages 15-19 per 1,000 women in that age group) is progress indicator for MDG target 5.B for achieving universal access to reproductive health. High adolescent fertility rates mean that many young women face an elevated risk of maternal death and disability. Newborns and infants of adolescent mothers are also at higher risk of low birth weight and mortality.

Delivery of a package of essential interventions as close as possible to where service users live is therefore of major importance for women and children, given that many live far from facilities that provide skilled care, particularly at the time of birth and early childhood. Strengthening of primary health care services is essential for women of child-bearing age, to ensure timely access to antenatal care, SRH services including family planning, childbirth services, immunization services and support for improved infant and young child feeding. Strengthening of emergency obstetric, neonatal and child care is also needed, including systems for referring urgent cases and ensuring that they are able to access emergency care in a timely and affordable way.

2.5. Community systems and community engagement

The concept of community involvement in improving health outcomes is not new. It is increasingly clear that community support for health and social welfare has unique advantages in its close connection with communities, its ability to communicate through people's own culture and language, to articulate the needs of communities, and to mobilize the many resources that community members can bring to the processes of policy and decision making and to service delivery.

There is now a renewed focus on the role of communities in increasing the reach and impact of health systems, for example in TB, malaria and HIV care and prevention, and in ensuring the continuum of care through pregnancy, childbirth and post-delivery periods.

Community systems - the methods and structures used by communities to organise responses to a community's needs - offer many synergies and linkages with health systems that could be enhanced in order to improve outcomes for MNCH and SRH, HIV, malaria, TB and other health challenges:

- They have unique advantages in advocacy, community mobilization, demand creation, acceptance of interventions and linkage of communities to services.
- They have roles in health promotion and delivery of community health services - for example, community health workers are able to provide some critical RH services such as FP counselling and on-going provision of contraceptives.
- They also have the ability to monitor health systems for equity and quality of services and to engage key affected populations, communities and community organizations in design, delivery, monitoring and evaluation (M&E) of services and activities related to prevention, treatment, care and support.

In addition, a comprehensive approach to improve women and children's health must address greater involvement of men and young boys and ensure they are engaged in supporting the health of women and girls and reducing the risks of transmissible diseases and of maternal and child mortality.

The need to increase funding to community actors has been recognised by WHO, the Global Fund and others since dual-track financing and the concept of community systems strengthening (CSS) were introduced for Round 8 funding proposals. The GF CSS Framework 2010 highlights six core components of community systems, which need to be in place and functioning effectively in order to contribute fully and sustainably to health outcomes. The contributions of community systems to health outcomes include direct service delivery or support for people needing to access or using services, or indirect support for health through activities to develop and improve the enabling social, legal and economic environments for health and wellbeing.

2.6. Human rights and health determinants affecting women and children

Women and children in the poorest families bear the greatest burden of death and ill-health. They are more exposed to health risks and often have less resistance to illness owing to poor nourishment or environmental conditions. Their access to care is also the lowest in developing countries.

Inequality and unfairness also manifest in other ways. Lack of respectful care in health facilities, particularly for poor women, discourages them from using services and may deny them access to accurate and understandable information about available care options and procedures. Women with HIV and TB, especially when pregnant, are often further disadvantaged by stigma and discrimination associated with their medical condition and their status as women living with a transmissible disease. Further, they are often denied the right to make voluntary, informed and responsible choices for their sexual and reproductive health, for example being denied care or forced to accept surgical sterilization as a condition of access to services.

Gender inequalities and lack of equity affect women and children most when:

- they live in rural and remote areas or poorly-resourced urban areas;
- they are members of particular ethnic groups, castes or religions, especially if they are poor, lack education, experience restrictive cultural practices or racial discrimination;
- they are displaced by conflict or live in conflict-affected areas;
- they are subject to sexual violence and consequent risks of unsafe abortion and sexually transmitted infections including HIV.
- they seek care from health workers who deny or lack understanding of women's sexual and reproductive rights, including the right to maintain fertility and determine the number and spacing of their children.

The effects of the lack of equity and denial of rights have many consequences for the health of women and children. This is well illustrated by the statistics quoted in the above discussions on the consequences of HIV, TB and malaria infections. Addressing issues of equity and removal of stigma and discrimination are directly relevant to interventions to

improve the health of women and children and reduce high levels of mortality and morbidity, especially in the context of MNCH and SRH. This should include attention to the needs of adults and young people for services and education on sexuality and health, and to the need to respect the rights of younger children to access the services and support that they need.

Key resources

(19) *Addressing the vulnerability of young women and girls to stop the HIV epidemic in Southern Africa*. Geneva, UNAIDS, 2008 (http://www.unicef.org/aids/files/Vulnerability_young-women-and-girlsSAfrica_2008_UNAIDS.pdf).

(20) *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*. Geneva, UNAIDS, 2010 (http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf).

(21) *Antiretroviral Therapy for HIV Infection in Adults and Adolescents - recommendations for a Public Health Approach - 2010 revision*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/arv/adult2010/en/index.html>).

(22) *Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. Geneva, UNAIDS, 2004 (http://www.unicef.org/aids/files/Framework_English.pdf).

(23) *Global strategy for the prevention and control of sexually transmitted infections: 2006-2015*. Geneva, World Health Organization (http://www.who.int/hiv/pub/toolkits/stis_strategy%5b1%5den.pdf).

(24) IAWG. *SRH & HIV linkages resource pack*. 2010 (<http://www.srhivlinkages.org/en/index.html>).

(25) JHPIEGO. *Malaria in Pregnancy Resource Package*, 2nd ed. 2010 (<http://www.jhpiego.org/en/node/316>).

(26) *Malaria in pregnancy*. Geneva, World Health Organization, 2011 (http://www.who.int/malaria/high_risk_groups/pregnancy/en/index.html).

(27) *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*. Geneva, World Health Organization, 2006, 938.

(28) *Skilled birth attendants - Fact Sheet*. Geneva, World Health Organization, 2008 (http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_sba.pdf).

(29) *Technical guidance note for global fund HIV proposals: Gender responsive HIV and AIDS programming for women and girls*. Geneva, World Health Organization and UNAIDS, 2010 (http://www.who.int/hiv/pub/toolkits/Gender_Technical_Guidance_GlobalFundR10_May2010.pdf).

(30) United Nations Population Fund and World Health Organization. *Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings*. 2006 (<http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf>).

3. Synergies and added value of integrated MNCH, disease-specific and systems-strengthening interventions

There are several global initiatives that highlight and prioritize the health of women and children. At the same time, there are also global initiatives and programs focused on elimination of major infectious diseases, such as HIV, TB and malaria. At implementation level, countries should aim to leverage the impetus generated by these initiatives to strengthen the linkages, integration and outcomes for MNCH and HIV, TB and malaria, and for strengthening the health and community systems that are essential for successful outcomes.

Many opportunities exist for building inclusion and linkages of MNCH interventions within HIV, TB and malaria service settings and vice versa. Entry points include, for example, primary and secondary care, health facility and community settings, including SRH services, antenatal clinics, MCH, well-baby and immunization clinics, post-partum care and family planning services as well as outreach services for prevention, care and support.

In order to optimize the impact of investments for maternal and child health, countries need to have a comprehensive understanding of the specific country contexts of SRH and MNCH and of HIV, TB and malaria. Key national data and other information sources should be used to develop an analysis of programming and funding gaps and development of a strategic plan for selecting and prioritizing key interventions. In order to achieve the maximum benefit from financial and human investments, responses need to be evidence-based, effective, comprehensive yet efficient, sustainable and able to capitalize on existing health delivery mechanisms.

Strengthening MNCH and RH within new proposals for disease-specific and systems-strengthening interventions should aim to supplement - and not replace - existing funding for MNCH. For example, for proposals to the Global Fund, the information provided on the application relating to gap analysis and country context should show how proposed MNCH-related interventions are synergistic with those covering HIV, TB, malaria or HSS.

Deciding which interventions are the ‘best fit’ to maximize outcomes within the country requires knowledge of the national context (and sub-national in some countries). This requires a thorough analysis of the needs and gaps related to MNCH, factors contributing to maternal and child mortality and, for example, how the key entry points in disease-related programs such as HIV, TB and malaria control can be used for enhancing or providing related MNCH interventions. Examples of key entry points for these three diseases are provided in Annex 1.

The main objectives of a gap analysis are to:

- Inform specific programming strategies
- Identify areas of integration or potential linkages
- Map out partners supporting these areas and their contributions
- Identify health system weaknesses and bottlenecks
- Identify policy, programming and funding gaps in the country's context
- Identify overlooked populations or inequalities in service coverage - such as migrants, sex workers, prisoners and difficult to reach communities; also, whether services are equally available to children compared to adults, for example whether

children have the same access as adults to ART or TB interventions including diagnostics,

The situation analysis should provide the following information:

- A summary of the past and current status of the MNCH epidemiological situation, activities currently funded from domestic and international resources and corresponding values, program costs and needs that are currently unfunded, value for money and the national response
- Summary information on the MNCH goals, targets and strategic priorities and objectives of the country with a descriptive section on the current national policies and guidelines.
- A summary of the past and current status of
 - the MNCH epidemiological situation including nutritional status,
 - activities currently funded from national (government, NGO and other partners) and international resources, with corresponding values,
 - program costs and needs that are currently unfunded,
 - value for money and
 - the ongoing national response.

3.1. Choosing appropriate interventions for funding proposals

Each country needs to develop a comprehensive package of interventions that will result in effective inclusion of MNCH within service delivery. MNCH interventions can be included within a proposal for HIV, TB or malaria or, if interventions cover more than one disease component, within a cross-cutting HSS proposal.

Countries are encouraged to include cost-effective and evidence-based RH and MNCH interventions, with a clear potential for synergies. For each disease area, countries should select interventions that are most relevant and suitable for inclusion in a Global Fund proposal based on the following criteria:

- Amenable to improvement in a short- to medium time frame;
- Natural areas of synergy between specific interventions and routine MNCH and SRH services;
- Demonstrated effectiveness that can be assessed and measured;
- Complimentarity (i.e. a modest investment will result in significant gains for both disease-infected populations and the women and children living in the same communities); and
- Address missing links in service delivery that are commonly described in gap analyses.

Section 4 provides guidance on interventions that have most or all of the above features. *Annex 2* provides an illustrative list of interventions for all three disease areas, including benefits, and suggestions for the gap analysis. Some specific interventions will however require other monitoring and evaluation approaches or implementation research methods to estimate their impact. A comprehensive list of interventions that are synergistic with MNCH is being developed by WHO and its partners. However, experience in this area has not been well documented in the past. Implementers and partners are therefore encouraged to share their experiences with WHO to assist in building up the database of interventions.

3.2. Monitoring and evaluation (M&E)

M&E functions are essential to the management and improvement of country program performance. They are also critical for funding partners such as the Global Fund, for assessing the performance, efficiency, effectiveness, equity and impact of its investments. Any proposal will need to include a detailed M&E plan, including validated indicators, which will contribute to improving the quality of interventions, add to the evidence base and meet the requirements of funding partners

Annex 1 is based on the MNCH & SRH continuum of care pathway. It provides suggested lists of MNCH indicators for HIV, TB and malaria components at each level of the continuum. *Annex 2* provides an illustrative list of MNCH interventions linked to HIV, TB and malaria programs, with suggestions for gap analysis, benefits and value for money

Additional indicators may need to be developed in order to fully document the breadth and depth of interventions as well as to monitor outcomes and performance at operational, strategic and policy implementation levels.

Key resources

(31) *Linkages between sexual and reproductive health and HIV/AIDS*. Geneva, World Health Organization, 2011 (<http://www.who.int/reproductivehealth/publications/linkages/en/>).

(32) *Technical Guidance note for Global Fund HIV proposals: Prevention of Mother-To-Child Transmission of HIV (PMTCT)*. Geneva, UNAIDS and World Health Organization, 2010 (http://www.who.int/hiv/pub/toolkits/PMTCT_Technical_guidance_GlobalFundR10_May2010.pdf).

4 Developing MNCH and RH content in HSS funding proposals

4.1 Rationale

Health Systems Strengthening (HSS):

Strong health systems are increasingly considered a prerequisite for effectively improving health outcomes, rather than a ‘spill-over effect’ of disease control efforts. Additionally, evidence indicates that in spite of the availability of effective interventions for many priority health problems, progress towards agreed health goals remains slow, and that one of the primary bottlenecks to achieving the MDG health targets is weak and fragmented health systems. Health systems in many low resource settings are unable to deliver the volume and quality of needed services, or to reach those who most need them, especially the marginalized and the poor.

Countries should aim to strengthen the health system as a whole, bringing each health system component or ‘building block’ up to the standard required for a strong national health system.⁸ Supported by the Global Fund and other partners, HSS programming can then be used as a shared pathway to benefit key priority areas at the same time as improving overall health care delivery. HSS objectives that contribute to better SRH & MNCH outcomes can be achieved through a wide range of health systems interventions. For example, improving laboratory services at first and second level health facilities can benefit diagnosis and facilitate prompt treatment and/or referrals for a range of conditions both for the general population and for vulnerable groups such as pregnant women and children.

It is therefore of key importance to address health system weaknesses for supporting scale-up and increased impact of MNCH interventions, in particular:

- overcoming access barriers of distance, cost and cultural acceptability of MNCH services is essential to increase the numbers of women with access to skilled attendance at the time of delivery, and reduce maternal, newborn and child mortality;
- quality of care issues that affect uptake of MNCH services (affecting women’s choices of where to seek care) and/or delivery of care; these need to conform to evidence based norm, standards and guidelines;
- achieving universal access to quality MNCH services; this requires action on several levels, including:
 - leadership to ensure adequate financing, legal and policy frameworks, and M&E and accountability frameworks;

⁸ The WHO 2007 report - “Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes” - proposed a practical way to organize health systems into 6 operational “building blocks”: service delivery, health workforce, information, medical products and technologies, financing, and leadership and governance. The building blocks approach is a means for locating, describing and classifying health system constraints, for identifying where and why and what kind of support is needed to improve performance.

- service delivery that is available and accessible on a continuous basis, including emergency services, and appropriate to the communities and contexts in which it is provided;
- human resources - for example trained midwives who can deliver skilled childbirth care;
- an adequate and effective supply chain for resources required to support MNCH service delivery - including infrastructure items and commodities such as medicines and other health goods that are appropriate for children and pregnant women;
- health system interactions with women, families and communities, to deliver health education and build capacities to better respond to MNCH needs, and address social, cultural and geographical barriers to uptake and use of services.

Community Systems Strengthening (CSS):

Community systems have an important role in collaboration with health systems. Strengthening of these systems is a way to improve access to and utilization of formal health services. However, it is also aimed at increasing community engagement in health and social care, advocacy, health promotion and health literacy, health monitoring, home-based and community based care and wider responses to ensure an enabling and supportive environment for these activities. To this end, applicants are encouraged to consider including CSS interventions focused on strengthening community structures and organisations and their linkages with health systems and other forms of support for mothers and children.

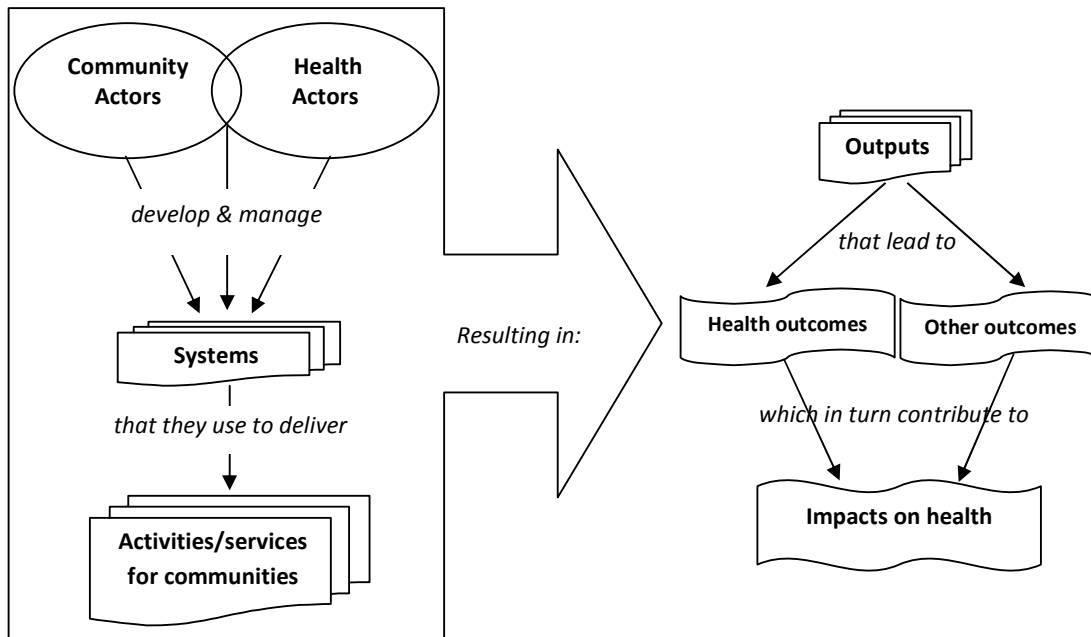


Figure 2: Synergies between community and health actors for achieving health impacts

WHO considers that improvements in health services need to be accompanied by actions at the community level to ensure that women and their newborns have access to the skilled care they need when they need it. Working with individuals, families and communities is therefore a critical link in ensuring the recommended continuum of care for reproductive health and throughout pregnancy, childbirth and the postpartum period. Furthermore, it is recognised that the availability of quality health services will not produce the desired outcomes for women, men, families, and communities if they do not have the possibility to be healthy, make healthy decisions, and be able to act on these healthy decisions.

There is increasing understanding of the need for integrated programming and delivery not just of health services but combinations of health, social, education, legal and economic support. Community based organizations and networks have a vital role to play in the development of such integrated and community-driven approaches.

4.2 A new approach to funding HSS and CSS

The Health System Funding Platform (HSFP) was established in 2009 as a way for development partners to improve how they work together in countries. It has been developed by the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund and the World Bank, and facilitated by WHO, in consultation with countries and other key stakeholders, including civil society. It is based on the principles of the International Health Partnership Plus (IHP+) in line with the Paris Declaration on Aid Effectiveness. The aim of IHP+ is to promote:

- national ownership;
- alignment with national systems;
- harmonization between agencies; managing for results; and
- mutual accountability among partners, donors and countries.

The Platform is part of the broad international effort in strengthening health systems to accelerate progress towards the targets for the health-related MDGs and it will help deliver vaccines and other commodities. The aim is to enable countries to use new and existing funds more effectively for health systems development, and help them access donor funds in a less complicated manner that is more aligned to their own national processes. Funds will still flow from the participating financiers - currently GAVI, the Global Fund and the World Bank. The HSFP is not a global pool of funds.

An HSS common proposal form has been developed for applications to GAVI and GF, independent of the rounds-based GF proposal forms. HSS applications for GAVI funds relating to vaccines and immunisation can be requested direct from GAVI. Countries applying for Global Fund HSS support will be able to use the common proposal form to apply direct to the Global Fund for cross-cutting HSS funding.

For GF submissions, applicants will need to provide convincing justification of how proposed HSS activities will improve health system performance in terms of outcomes related to HIV, TB and malaria and/or MNCH outcomes. The emphasis should be on reducing risk factors for maternal and child mortality through integration of services that improve access, and facilitate case-finding, diagnosis, treatment and follow-up. Proper

attention should be given to diagnosing and addressing underlying causes for poor health system performance, not merely focusing on visible symptoms, including relevant evidence of analytical assessments in the funding applications.

Proposals for HSS interventions should be based on a sound analysis that addresses the economic, political, epidemiological, demographic, and social context of country health systems. They should also describe geographic or other inequalities in service delivery and demonstrate how routine M&E data can be used to inform improvements in health systems. They should demonstrate that proposed HIV, TB, malaria and HSS interventions will address issues of equity, efficiency, sustainability, accountability and quality and will contribute to achievement of health sector goals.

4.3 Defining HSS and/or CSS MNCH interventions

Strategic use of Global Fund and other financing for HSS should aim to foster cohesive programming and appropriate inclusion of SRH & MNCH interventions within HIV, TB and malaria services and vice versa. This specifically includes antenatal, childbirth, post partum, family planning and preventive and curative newborn and child care, aiming to ensure that they are more client-centred and address the needs of women and children in a more holistic, accessible and user-friendly manner.

HSS objectives related to improving MNCH outcomes are specific to the country context and should be based on a robust situational analysis. Based on country circumstances, and depending on national health strategies, HSS interventions may address a wide range of health sector bottlenecks. Funders need to offer flexibility, allowing strengthening of any area of the health system, including but not limited to: service delivery, health human resources, health financing, procurement, supply chain management, health information system, stewardship and governance.

Within HSS funding requests, it is important for applicants to provide convincing justification of how the proposed activities improve the health system's performance in terms of outcomes related to more than one disease (such as HIV, TB, malaria) and related also to SRH & MNCH. Such cross-cutting HSS interventions should be designed to lead to sustainable interventions beyond the life of the funding grant.

The WHO 2007 report “Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes” - outlined a practical way to organize health systems into six operational “building blocks”:

- Health service delivery: a network of health facilities to provide access to primary and secondary care
- Health workers: in the right place at the right time with training, experience and incentives
- Health information systems: to generate quality data and to measure what is being done and achieved
- Logistics and supply systems: so that drugs, equipment and fuel are available
- Health financing: to raise sufficient funds for health and improve financial risk protection
- Leadership and governance: to ensure that strategic policy frameworks exist and there is proper accountability and oversight.

The building blocks approach can be used for locating, describing and classifying health system constraints, for identifying where and why and what kind of support is needed to improve performance. Beyond the six health system building blocks, it is important also to identify effective 'critical enablers' for improved MNCH that are more dynamic, innovative and immediately responsive to local challenges in health systems. This might include Quality Improvement (QI) approaches that use routine local health data for reflecting on, and improving service delivery. These 'critical enablers' should produce not only disease-specific benefits but also improved service delivery across several MNCH interventions, and stronger systems to support this.

For CSS, six essential core components of community systems have been defined for creating functional, effective community systems and enabling community organizations and actors to fulfil their role of contributing to health outcomes:

- Enabling environments and advocacy - including community engagement and advocacy for improving policy, legal and governance environments, and affecting the social determinants of health.
- Community networks, linkages, partnerships and coordination - enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working.
- Resources and capacity building - including *human resources* with appropriate personal, technical & organizational capacities, *financing* (including operational and core funding) and *material resources* (infrastructure, information and essential medical & other commodities & technologies).
- Community activities and service delivery - accessible to all who need them, evidence-informed and based on community assessment of resources and needs.
- Organizational and leadership strengthening including management, accountability and leadership for organizations and for community systems.
- Monitoring & evaluation and planning including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

When all of these community system components are functioning well, they will be able to contribute to:

- improved outcomes for health and wellbeing,
- respect for people's health and other rights,
- social and financial risk protection, and
- improved responsiveness and effectiveness of interventions by communities
- improved responsiveness and effectiveness of interventions by health, social support, education and other services.

Since there are many overlaps between community systems and health systems, the distinction between health system interventions and community systems interventions is not always clear. For purposes of definition, it is probably best to distinguish health system interventions from others based on what the intervention is rather than who is providing it, since community-based health services are delivered by a variety of community actors as well as public and private providers.

4.4 Key activities

Table 4 provides an illustrative list of HSS and CSS interventions and related activities that have the potential to contribute to RH and MNCH outcomes.

Table 4. Synergistic interventions to support HSS/CSS and RH/MNCH integration

Interventions	Importance for MNCH	Benefit for women and children in general population
<p>Governance and policy:</p> <ul style="list-style-type: none"> - Developing, implementing and monitoring health legislation, policies, norms and regulations - Community monitoring and documentation of community and government interventions 	<ul style="list-style-type: none"> - Increased coherence, integration and efficiency in scaling up sustainable MNCH outcomes within national strategies and plans - Increased impact of integrated health, MNCH and HIV, TB and malaria interventions - Improved equity in accessing and utilizing MNCH services and interventions 	<p>Improved MNCH outcomes:</p> <ul style="list-style-type: none"> - Increased % of deliveries in health facilities - Increased % of births assisted by skilled birth attendants - Decreased child mortality rate (neonatal and <5 years) - Decreased maternal mortality - Reduced unmet need for FP <p>plus:</p> <ul style="list-style-type: none"> - Decreased inequities in MNCH outcomes. - Reduced catastrophic expenditures for families and communities (connected with but not limited to MCH)
<p>Human resources for MNCH:</p> <ul style="list-style-type: none"> - Building health workers' capacity - Community skills building for service delivery, advocacy & leadership 	<ul style="list-style-type: none"> - Increased availability and use of quality health workforce able to address HIV, TB, malaria, SRH and MNCH issues. 	Same as above
<p>Service delivery for MNCH:</p> <ul style="list-style-type: none"> - Increasing demand for service utilization, - Developing facility and organizational operating/management systems (increasing supply) - Improving MNCH service delivery infrastructure - Strengthening community organisations & systems for planning, delivery and monitoring of quality services to support MNCH 	<ul style="list-style-type: none"> - Increased knowledge and acceptance of RH and MNCH interventions in communities - Increased availability, access and utilization of quality MCH services and interventions - Improved referral 	Same as above
<p>Strengthening procurement and supply chain management systems.</p>	<ul style="list-style-type: none"> - Increased availability of quality MNCH care and support in facilities and communities - Improved referral and case management 	Same as above
<p>Strengthening health</p>	<ul style="list-style-type: none"> - Notification of maternal deaths and actions taken to 	Same as above, focused mainly on reducing mortality and

Interventions	Importance for MNCH	Benefit for women and children in general population
<p>information and M&E systems</p> <p>Supervision and mentoring to develop capacity to adopt Quality Improvement approaches to use local routine data for improving services</p> <p>Strengthening capacity and systems for community M&E, evidence-building and strategic/operational planning</p>	<p>address bottlenecks in service delivery</p> <ul style="list-style-type: none"> - Registration of all births and all children have a birth certificate - Access to MNCH information - Improved local delivery of services 	<p>morbidity:</p> <ul style="list-style-type: none"> - Increased access to information on MNCH - Improved local services
<p>Developing health system analytical capacity to inform policy</p> <p>Developing community organisations' capacity to inform policy</p>	<ul style="list-style-type: none"> - Documenting good practices, evaluating interventions and developing/strengthening evidence base for MNCH policies - Adapting effective MNCH interventions to country context to maximize benefits 	<p>Same as above, addressing equity in terms of access and improved health outcomes for vulnerable groups</p>
<p>Enhancing capacity of the health financing system</p>	<ul style="list-style-type: none"> - Adequate resources allocated to MNCH as per needs - Efficient use of allocated resources as per plans - Evidence base advocacy for increase in investments for MCH 	<p>Same as above</p>

4.5 Examples

Examples of HSS and CSS MNCH interventions from the current Global Fund portfolio:

- In Malawi the Global Fund's total HSS approved budget is USD 196.8 million. This support contributed to deploying 10,000 community-level Health Surveillance Assistants (by 2009) to provide HIV, TB and malaria services.
- The HSS component of the Sierra Leone Round 9 HIV grant includes the provision of salary incentives to health care workers, which include not only staff providing HIV, TB and malaria services but also maternal and child health care such as aides and nursing aides. In addition, the program includes funding to strengthen ANC facilities to provide PMTCT services, family planning services with HIV testing, and nutritional advice and infant feeding support.

4.6 Monitoring and evaluation for HSS and CSS

Success of HSS interventions will be measured by their impact in improving health of women and children, in addition to improving outcomes for HIV, TB and malaria. Impact and outcome indicators related to the three diseases are already highlighted in all key M&E guidance documents of the Global Fund. *Annexes 1 and 2* provide illustrations of

MNCH activities and indicators that can be included in HIV, TB and malaria components, suggestions for gap analysis and possible benefits and impacts from these activities.

Indicators for monitoring and evaluation of CSS interventions for improving MNCH outcomes in integrated programmes are still being developed. The *Health and Community Systems Strengthening Service Delivery Areas Guide* is provided on the GF website as a starting point. Some CSS interventions may be of a type that contributes directly to one or more of the indicators above. However, other indicators will need to be developed and validated for community SRH/MNCH interventions that are aimed mainly, for example, at providing community support for access to services, community education on SRH/MNCH issues, reduction of stigma and improving the enabling environment.

Key resources

(33) *Scale up of HIV-related prevention, diagnosis, care and treatment for infants and children: a programming framework*. Geneva, World Health Organization, UNICEF, IATT on PMTCT, 2008 (http://www.who.int/hiv/paediatric/Paeds_programming_framework2008.pdf).

(34) United Nations Secretary-General. *The Global Strategy for Women's and Children's Health*. Geneva, World Health Organization (http://www.who.int/pmnch/topics/maternal/201009_globalstrategy_wch/en/index.html).

5. Developing MNCH content in funding proposals for HIV, TB, malaria

5.1. HIV/AIDS and MNCH integration

5.1.1. Rationale

There is unprecedented commitment to improving the health and survival of HIV-infected women and their children and to the elimination of HIV infections in children. The recently launched UN Secretary General's Strategy for Women's and Children's Health consolidates these perspectives and specifically references the importance of preventing HIV infection in these populations.

Gender inequalities are recognized as a key driver of the HIV/AIDS epidemic. This is now reflected in Global Fund initiatives including scaling up interventions for the prevention of mother-to-child transmission (PMTCT), promoting gender equality in responses to HIV, TB and malaria, and addressing the needs of women and girls through the adoption and implementation of the gender equality strategy. It is also reflected in PEPFAR's⁹ focus on women and girls and the UNAIDS strategy which call for addressing gender, human rights and other determinants as its third strategic pillar.

5.1.2. Defining HIV - MNCH interventions

Comprehensive PMTCT interventions provide a major opportunity for improving maternal, newborn and child health and survival since comprehensive PMTCT is not only about the provision of lifelong antiretroviral treatment (ART) or antiretroviral (ARV) prophylaxis. By implementing all 4 prongs of PMTCT as recommended by WHO¹⁰, there is the prospect of addressing HIV prevention, care, treatment and support of both HIV-infected and uninfected women, children, adolescents and families living with, and in communities affected by HIV.

Family planning and contraceptive use have an important role in prevention of unintended pregnancies among women living with HIV. Reduction in unintended pregnancies will decrease the number of complicated pregnancies and unsafe abortions, and reduce numbers potentially infected children, also reducing the need for ARVs as prophylaxis in PMTCT. Another important benefit is the improved quality of life for women and children when pregnancies are planned and spaced according to the family's needs and resources.

Large-scale implementation of provider-initiated HIV and syphilis testing and counselling (PiTC) at ANC clinics not only allows for a large proportion of at-risk women to know their HIV status, but can also facilitate HIV testing and counselling of their male partners and their families. It also allows HIV positive women and men to commence ART at an early stage, which is now known to be effective in reducing HIV transmission to uninfected

⁹ PEPFAR: the (US) President's Emergency Fund for AIDS Relief

¹⁰ The four components of a comprehensive PMTCT approach include : primary prevention of HIV infection among women, especially young women, ,prevention of unintended pregnancies among HIV-infected women,, prevention of HIV transmission from HIV-infected women to their infants and provision of care, support and treatment for HIV-infected mothers, their infants and families.

partners and to children.¹¹ In addition, HIV testing of pregnant women should always be accompanied by testing for syphilis to avert the situation of babies free from HIV infection but dying of congenital syphilis. Furthermore, the identification and treatment of syphilis in a pregnant woman is an HIV prevention intervention because an HIV-positive pregnant woman with syphilis is twice as likely to transmit HIV to her baby compared to a woman infected with HIV alone, and a syphilis diagnosis is an opportunity to engage male partners in both HIV and syphilis prevention and care interventions.

Support for improving infant feeding practices and providing antiretroviral medicines to HIV-infected mothers will not only reduce the risk of HIV transmission to infants but also improve survival of those infants who never become infected. Simplification of infant feeding messages and appropriate support at health facilities has the potential to also improve feeding practices in the entire population and overall child survival. Effective linkages and implementation of PMTCT interventions within MCH and SRH services will strengthen the health system and improve health outcomes in all mothers and children in the community. (see example in section 5.1.4 below)

All four components of comprehensive PMTCT need to take into account and address gender inequalities as a central aspect of PMTCT interventions. If delivered appropriately, these services can also help to address issues of gender equality and human rights. For example, they can support women’s ability to negotiate sex and safer sex, improve access to SRH services and utilization of contraceptive methods, and support women in disclosure of their HIV status. Such services should also include men’s health education and access to SRH services and family planning, and inclusion of men as partners and supporters of women accessing maternal and child health services. This requires an approach that identifies and capitalizes on existing strengths and opportunities in addition to strengthening HIV-specific services.

5.1.3. Key interventions for inclusion of MNCH in HIV proposals

Table 1 provides an illustrative list of HIV interventions and related activities that can be supported by the Global Fund. These interventions would support implementation of the 2010 WHO PMTCT guidelines and the 2010 WHO guidelines on HIV and infant feeding, and contribute to achieving the fullest health benefits for HIV-infected women and their children.

Table 1: Synergistic interventions to support HIV- MNCH integration

Interventions	Importance for HIV prevention and care for HIV-infected women and their children	Benefit for women and children in general population
Programme and Health Services		
Joint HIV, MNCH and nutrition planning and revision of: - evidence-based policies for PMTCT of HIV and	Strengthens and influences planning of programmes at national and decentralized settings;	Strengthens MNCH planning and programming including integrated and quality service delivery in all settings for improved survival for

¹¹ The HPTN 052 Study showed that starting ART for people with CD4 counts of 350 to 500 cells/mm sq reduced the risk of HIV transmission from treated partner to uninfected partner by 96%.

Interventions	Importance for HIV prevention and care for HIV-infected women and their children	Benefit for women and children in general population
syphilis, and - policies for women, adolescents and children related to HIV	Supports scale-up of comprehensive and sustainable HIV prevention, treatment and care for women and children	women, adolescents and children
Community engagement	Improved acceptability and uptake of all HIV interventions Increased involvement of communities and people affected by or living with HIV	Improved care seeking practices including early ANC attendance and postnatal follow-up Reduced stigma and discrimination
Sexual and Reproductive Health services		
Improve access to, and quality of, family planning services for HIV-infected women	Fewer unwanted pregnancies Increased proportion of planned pregnancies including initiation of ART/ARVs pre-conception or early in pregnancy Increased acceptability and use of condoms for dual protection	Fewer unwanted pregnancies Improved capacity to negotiate use of contraceptives Primary prevention of HIV
Improve HIV testing of partners within SRH services Counselling of discordant couples	More men understand the importance of HIV prevention within relationships	Less risk of HIV transmission to women in relationships and consequent reduced risk of MTCT of HIV
Expand SRH services to adolescents	Improved health and prevention of new HIV infection in adolescents	Improved primary prevention of HIV among adolescents
Antenatal care (ANC) services		
Improve access to and quality of ANC	More women and partners know their HIV status and can start earlier on improved ARV regimens for PMTCT and lifelong ART Syphilis, which increases HIV transmission, can be prevented and treated in women and children	Improved coverage and quality of services along the SRH/MNCH lifecycle continuum of care Increased and improved childbirth care in health facilities Improved maternal and neonatal outcomes, including decreases in stillbirth, newborn mortality and congenital syphilis
Childbirth care services		
Strengthen obstetric care in health facilities	Improve ARV adherence during delivery	Reducing obstetric complication Reduced maternal and newborn

Interventions	Importance for HIV prevention and care for HIV-infected women and their children	Benefit for women and children in general population
	Opportunity for HIV counselling and testing/re-testing Reduced MTCT (safer childbirth practices) Early newborn resuscitation and care	complications and deaths
Postnatal care services		
Promote early postnatal visits for mothers and infants	Reduced unintended pregnancies through FP information and services in postpartum period. 6 week immunisation attendance and early infant HIV diagnosis and co-trimoxazole prophylaxis Early assessment and treatment of postpartum maternal sepsis Mothers and infants assessed for ART	Birth spacing and planned pregnancies All infants (including HIV-exposed): improved immunization coverage and growth monitoring until 3 months Reduced maternal sepsis and mortality
Joint support for ARV prophylaxis and infant feeding counselling	Initiation and adherence of ARV prophylaxis to prevent breastfeeding HIV transmission Early initiation of exclusive breastfeeding	Improved early infant feeding practices
Training opportunities		
Pre- and in-service retraining on integrated MCH and HIV care and treatment (including IMCI).	Improved knowledge of all HIV-related interventions for PMTCT and care of HIV-infected women and children	Improved case management of all children
Education of community health workers and community involvement on linkages between MNCH and HIV/PMTCT	Improved knowledge and dissemination of HIV-related information and care	Improved maternal, newborn and child preventive and curative care in the community

5.1.4. Examples

It is important to note that proposals aimed at improving MNCH outcomes will also contribute to HSS and extend across the three diseases and wider health services. A good example of this is shown in improvements in health service delivery in Ethiopia. With

Global Fund support, Ethiopia is accelerating the expansion of its primary health care infrastructure and work force under the country's Health Extension Program. Over 30,000 health extension workers, recruited from the community, have been trained and deployed in the health services between 2004 and 2009. These health extension workers played a critical role in scaling up not only HIV and malaria services, but also reproductive and child health services, especially in rural areas.

Key resources

- (35) *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html>).
- (36) *Antiretroviral therapy for HIV infection in infants and children: Towards universal access*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/paediatric/infants2010/en/index.html>).
- (37) *Condom programming for HIV prevention*. United Nations Population Fund, World Health Organization, PATH, 2008 (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/condom_prog2.pdf).
- (38) *Delivering HIV test results and messages for re-testing and counselling in adults*. Geneva, World Health Organization, 2010 (Accessed 2 February 2010) (http://www.who.int/hiv/pub/vct/hiv_re_testing/en/index.html).
- (39) Hardee K, Gay J, Dunn-Georgiou E. *Practical Guide to Implementing Reproductive Health and HIV/AIDS into Grant Proposals to the Global Fund*. Washington DC, Population Action International, 28 August 2009 (http://www.populationaction.org/Publications/Reports/A_Practical_Guide_to_Integrating_Reproductive_Health_HIV-AIDS/Summary.shtml).
- (40) *Making the case for interventions linking sexual and reproductive health and HIV in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Geneva, World Health Organization, 2009 (http://www.who.int/reproductivehealth/publications/linkages/rhr_10_02/en/index.html).
- (41) *PMTCT strategic vision 2010-2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals*. Geneva, World Health Organization, 2010 (http://www.who.int/child_adolescent_health/documents/9789241599030/en/).
- (42) *Rapid advice: antiretroviral therapy for HIV infection in adults and adolescents*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/arv/rapid_advice_art.pdf).
- (43) *Rapid advice: infant feeding in the context of HIV*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/mtct/rapid_advice_mtct.pdf).
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5.2. Tuberculosis and MNCH integration

5.2.1. Rationale

TB is a disease of poverty that affects vulnerable groups disproportionately. The vast majority of TB deaths are in the developing world. TB is the fourth leading cause of death

among children, girls and young women aged 10-19 in low-income countries. In most HIV prevalent settings (particularly in Africa) over the last decade increasing numbers of women developed TB, especially in young age groups, due to the HIV epidemic. A quarter of HIV deaths are linked to TB. In 2008, 3.6 million women fell ill with TB and 700,000 women died from TB including 200,000 women with HIV. There is a markedly increased risk of TB disease and increased mortality in HIV-infected children compared to HIV-uninfected children.

Women account for an estimated 3.1 million-3.5 million TB cases, equivalent to 35 percent of all cases. TB can impact on maternal and perinatal outcomes for pregnant women living with HIV. The risks can range from death of the mother and the newborn, to prematurity and low birth weight of the newborn. Screening pregnant women living with HIV for active TB within maternal HIV services is important in order to reduce these risks to the mother and the newborn. Between 1995 and 2009, a total of 41 million TB patients were successfully treated in DOTS programs¹², and up to 6 million lives were saved, including 2 million women and children.

5.2.2 Defining TB - MNCH interventions

Comprehensive interventions for prevention and management of TB in women and children are based on a client-centred, non-vertical approaches that are the most appropriate for maximizing the opportunity to improve maternal, new-born and child health and survival. These interventions provide opportunities to address TB prevention, detection and subsequent treatment and support, to improve linkages with SRH, HIV prevention, health education on self-care, for both TB infected and uninfected women, also reaching their infants and families in communities affected by high TB prevalence.

5.2.3 Key interventions for inclusion of MNCH in TB proposals

Table 2 provides an illustrative list of TB interventions and related activities that can be supported by the Global Fund with the potential to contribute to MNCH outcomes.

Table 2. Synergistic interventions to support TB - MNCH integration

Interventions	Importance for prevention of TB or care for TB-infected women and their children	Benefit for women and children in general population
Joint planning and revision of evidence-based policies for TB prevention, diagnosis and care in women and children	Strengthening national , sub-national and service level planning for integrated TB/SRH/MNCH programs, to scale up TB prevention, treatment and care for women and children	Strengthened national and sub-national planning for integrated TB/SRH/MNCH programmes to improve health and survival for women and children
TB case diagnosis and treatment for pregnant women in ANC	More TB cases among women diagnosed, treated and cured.	Effective and efficient care for pregnant women Less HIV transmission if the pregnant women is HIV positive

¹² DOTS is the the internationally agreed five-component strategy for TB control
<http://www.who.int/tb/dots/en/>

Interventions	Importance for prevention of TB or care for TB-infected women and their children	Benefit for women and children in general population
<p>Child health services: assessment for TB disease of any child who had contact with TB positive patients</p> <p>Improved case management of TB in children.</p>	<p>More TB cases in children diagnosed, treated and cured.</p> <p>Better survival for TB children</p>	<p>Effective and efficient care for children</p>
<p>Isoniazid preventive therapy (IPT) for all young children (<5 years) and HIV-infected children of any age who are household contacts of a case with sputum smear-positive TB AND do not have any evidence of TB disease.</p>	<p>IPT greatly reduces the risk of an infant or young child with TB infection from developing disease.</p>	
<p>Community based interventions for TB through MNCH outreach.</p>	<p>More TB cases among women diagnosed, treated and cured.</p>	<p>Improved TB notification and treatment outcome rates for women and children.</p>
<p>Application of the diagnosis and management of TB protocols within SRH settings.</p> <p>Increase TB diagnosis and treatment of pelvic, genital TB through SRH and MCH</p>	<p>Increased quality of care offered to TB case women in reproductive age.</p> <p>More TB cases among women diagnosed, treated and cured.</p> <p>Reduced infertility due to pelvic and genital TB</p>	<p>Increased quality of TB and SRH care offered to women in reproductive age.</p> <p>More cases of pelvic and genital TB diagnosed and treated among women in reproductive age</p> <p>Reduced TB stigma in the population</p>
<p>Pre- and in-service retraining on integrated MCH and TB management including IMCI.</p>	<p>More TB cases diagnosed among women and children, treated and cured.</p> <p>Improved quality of care for women and children.</p>	<p>Effective and efficient care for women and children.</p>
<p>Education of community health workers and community involvement to increase awareness of TB linkages with SRH and MNCH</p>	<p>Decreased stigma</p>	<p>Improved care-seeking practices for TB, SRH, MCH attendance</p> <p>Improved acceptability and uptake of TB interventions - prevention, care, treatment and support</p>

5.2.4 Example

TB is an important cause of illness and death in children, especially in sub-Saharan Africa. TB can be diagnosed in most children in outpatient settings, based on careful clinical assessment. Contact history is a very important part of assessment for child TB diagnosis and prevention. Any child with suspected or confirmed TB should also be tested for HIV. Children (0-14 years) should be routinely registered with and reported by the national

tuberculosis control program (NTCP). Children with TB tolerate and respond well to anti-TB treatment. ANC settings offer an important opportunity to screen and treat TB and to diagnose and identify extrapulmonary genital TB.

In TB-endemic areas, such as India, 50 percent of infertile patients are estimated to have uterine TB. Several clinical trials have shown that a larger proportion of HIV positive women are infertile than the general population.

Key resources

(46) *Advocacy, communication & social mobilization (ACSM) for tuberculosis control: A handbook for country programmes*. Geneva, World Health Organization Stop TB 2007

http://whqlibdoc.who.int/publications/2007/9789241596183_eng.pdf

(47) *Guidance for national tuberculosis programmes on the management of tuberculosis in children*. Geneva, World Health Organization, 2006

http://whqlibdoc.who.int/hq/2006/WHO_HTM_TB_2006.371_eng.pdf

(48) *Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings* Geneva, World Health Organization 2011

http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf

(49) *Treatment of tuberculosis: Guidelines, Fourth edition* (WHO 2009)

http://whqlibdoc.who.int/publications/2010/9789241547833_eng.pdf

(50) *Rapid Advice: Treatment of tuberculosis in children* (WHO 2010)

http://whqlibdoc.who.int/publications/2010/9789241500449_eng.pdf

5.3 Malaria and MNCH integration

Every year, there are about 300 million acute cases of malaria, and more than one million deaths. Around 90 percent of these deaths occur in Africa, mostly in young children. Pregnant women are also among the most vulnerable and are at high risk of malaria. Where Roll Back Malaria Country Strategic Plans are in operation, improvements in access to key malaria interventions is being achieved through ongoing health sector reforms and linkages with MNCH initiatives, for example increasing women's visits to ANC clinics and using them as a key opportunity for prevention of malaria and other priority diseases affecting pregnant women.

5.3.2 Defining Malaria - RH and MNCH interventions

Malaria manifests acutely in children and pregnant women, which compels the patient to seek treatment. The range of malaria treatment entails diagnosis and treatment of fever at the peripheral level and, when appropriate, referral to higher level for treatment of severe and complicated illness that requires institution-based care. Thus the need for a response to malaria makes a compelling case for strengthening health systems in endemic countries.

5.3.3 Key interventions for inclusion of MNCH in malaria proposals

Table 3 provides an illustrative list of malaria interventions and related activities that can be supported by the Global Fund with the potential to contribute to MNCH outcomes. It includes also the importance of each intervention for prevention and care of malaria and the benefit for women and children in the general population.

Table 3. Synergistic interventions to support malaria- MNCH integration

Interventions	Importance for prevention and care of malaria for infected women and their children	Benefit for women and children in general population
Joint planning and revising of evidence-based policies regarding malaria-infected women and children	Strengthening national , sub-national service level planning; for integrated malaria with MCH and SRH programmes to scale up malaria prevention, treatment and care for women and children	Strengthened national and sub-national planning for integrated delivery of malaria programs with MCH and SRH programmes to improve health and survival for women and children
Prevention, case detection and successful treatment of malaria in and through ANC, child care and SRH services and application of integrated malaria protocols in ANC and child health and SRH services e.g. IMCI, MIP	<p>More malaria- infected women diagnosed and treated</p> <p>Elimination of cases of congenital malaria</p> <p>More malaria-infected women knowing prevention measures for their family and communities</p> <p>Decreased number of LBW infants, preterm births and infant deaths</p> <p>Reduction of severe maternal anaemia, complications and related mortality</p> <p>Increased numbers of malaria-infected children diagnosed and treated</p>	<p>Improved access to quality management and care within integrated malaria and MNCH/SRH services for women and children</p> <p>More women and children within the community knowing malaria prevention measures for themselves and their family</p> <p>Improved ANC for women</p> <p>Improved case management of other major child illnesses such as diarrhoea and pneumonia</p>
<p>Provision of basic malaria supplies for prevention, diagnosis and treatment (IMCI) algorithms, rapid diagnostic test (RDT), Artemisinin-based combination therapy (ACT), sulfadoxine-pyrimethamine (SP), antibiotics and Oral Rehydration Salts (ORS) etc. and supply chain management</p> <p>Strengthen the health equipment for diagnostic capacity</p>	<p>Malaria infected women and Children have regular , uninterrupted access to treatment</p> <p>Women and children malaria infected access more reliable and fast diagnostic test</p> <p>Malaria diagnosis accessible at MNCH related services at primary care level</p>	<p>Community 's trust in services increased, and healthier community</p> <p>Increased quality of prevention, diagnosis and care offered to women and children attending SRH/MNCH/ at primary care level</p> <p>Improved case management of other major child illnesses such as diarrhoea and pneumonia</p>
Support in-service retraining	Improved quality of care for	Improved knowledge on

Interventions	Importance for prevention and care of malaria for infected women and their children	Benefit for women and children in general population
and pre-service curriculum development	women and children Human resource competence improved	prevention, care and health-seeking behaviour for malaria Human resource competence improved
Education of community health workers and involvement of communities to increase their awareness on malaria and the linkages with MNCH and SRH	Decreased malaria cases and their severity Improved quality of care	Improved care seeking practices of malaria Improved quality of care Improved acceptability and up-take of malaria prevention

5.3.4 Examples

Over 100 countries are implementing the IMCI as the main strategy for building capacity of health workers in the management of childhood illnesses in an integrated manner. One of the IMCI intervention areas is to improve malaria case management through better diagnosis and enhanced quality of care for sick children under 5 years of age. The interventions to improve quality of care include training primary health care workers to manage fever (malaria) in children, and ensuring continuous availability of the necessary medicine and supplies.

Tanzania’s Global Fund-supported malaria programme has improved the quality of care for children in over 160 regional and district hospitals through IMCI training and addressing quality of care in general. Hospital staff were trained in emergency triage and treatment, and hospitals were equipped for management of severely ill children. This has not only benefited severe malaria but all severely ill patients in general. Rwanda and Kenya were also able to use GF support to train primary level health workers in IMCI in order to improve malaria case management and assessment of HIV and AIDS among children at the primary health facility level. These linkages and synergies will play an important role in the introduction of parasitological diagnosis of malaria as part of a full fever assessment in the context of IMCI.

ANC services are already reaching 90 percent of pregnant women. Strengthening these services could improve the coverage of malaria interventions such as long-lasting insecticidal nets (LLINs) and intermittent preventive treatment of malaria in pregnancy (IPTp), in addition to promoting skilled birth attendance at childbirth. Some examples of GF grants that demonstrate the potential for scaling up positive outcomes for women and children include: scaling up delivery of IPTp in ANC settings; and promotion of LLIN use of by pregnant women and children ANC services through subsidized voucher schemes in Ghana and Kenya.

Key resources

(51) *Home management of malaria*. Geneva, World Health Organization, 2011 (http://www.who.int/malaria/diagnosis_treatment/hmm/en/).

(52) *Malaria in infants*. Geneva, World Health Organization, 2011
(http://www.who.int/malaria/high_risk_groups/infants/en/index.html).

(53) *Policy recommendation on Intermittent Preventive Treatment during infancy with sulphadoxine-pyrimethamine (SP-IPTi) for Plasmodium falciparum malaria control in Africa*. Geneva, World Health Organization, March 2010
(http://www.who.int/malaria/news/policy_recommendation_IPTi_032010/en/index.html and
http://www.who.int/malaria/news/WHO_policy_recommendation_IPTi_032010.pdf).

6 Collected lists of Key resources

6.1 Key partners for proposal development and implementation

WHO websites:

Family and Community Health: <http://www.who.int/fch/en/>

Sexual and reproductive health: <http://www.who.int/reproductivehealth/topics/en/>

Maternal and perinatal health: http://www.who.int/topics/maternal_health/en/

Gender, Women and Health: <http://www.who.int/gender/en/index.html>

Stop TB: <http://www.who.int/tb/topics/en/>

Malaria: www.who.int/malaria

Roll Back Malaria Partnership Toolbox: <http://rbm.who.int/toolbox/index.html>

HIV/AIDS: <http://www.who.int/hiv/topics/en/>

The Partnership for Maternal, Newborn and Child Health: resources website
<http://www.who.int/pmnch/topics/en/>

The Global Fund: applications website (Round 11):
<http://www.theglobalfund.org/en/application/>

UNAIDS Technical Support Facilities:

Southern Africa <http://www.tsfsouthernafrica.com/>

Eastern Africa <http://www.tsfeasternafrica.org/>

West and Central Africa <http://www.tsfwca.org/>

Southeast Asia and the Pacific <http://www.tsfseap.org/>

South Asia <http://tsfsouthasia.org/>

UNFPA SRH & HIV linkages resource pack: www.srhivlinkages.org

UNICEF Maternal Health website: <http://www.unicef.org/maternalhealth/>

For civil society partners:

Civil Society Action Team: resources website
<http://www.csactionteam.org/?Resources=1>

International HIV/AIDS Alliance Regional Technical Support Hubs
<http://www.aidsalliance.org/Pagedetails.aspx?id=265>

6.2 Key resources - complete list

(1) Cotton M et al. *Guidance for national tuberculosis and HIV programmes on the management of tuberculosis in HIV-infected children: Recommendations for a public health approach*. Paris, World Health Organization and International Union Against Tuberculosis and Lung Disease, 2010
(<http://www.theunion.org/index.php/en/resources/scientific-publications/item/759-guidance-for->

[national-tuberculosis-and-hiv-programmes-on-the-management-of-tuberculosis-in-hiv-infected-children-recommendations-for-a-public-health-approach](#))

(2) *Countdown to 2015 Maternal, Newborn and Child Survival 2010 Report*. Geneva, World Health Organization and UNICEF, 2010 (<http://www.countdown2015mnch.org/reports-publications/2010-report/2010-report-downloads>)

(3) *Guidance on Global Scale Up of the Prevention of Mother-to-Child Transmission of HIV*. Geneva, World Health Organization and UNICEF, 2007 (http://www.unicef.org/aids/files/PMTCT_enWEBNov26.pdf)

(4) *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva, World Health Organization, 2007 (<http://www.who.int/hiv/topics/vct/PITCguidelines.pdf>)

(5) *Guidelines for the treatment of malaria*, 2nd ed. Geneva, World Health Organization, 2010 (<http://www.who.int/malaria/publications/atoz/9789241547925/en/index.html>)

(6) *Guidelines on HIV and infant feeding*. Geneva, World Health Organization, 2010 (http://www.who.int/child_adolescent_health/documents/9789241599535/en/index.html).

(7) *Integrated management of childhood illness*. Geneva, World Health Organization, 2011 (http://www.who.int/child_adolescent_health/documents/imci/en/index.html)

(8) *Integrating gender into HIV/AIDS programmes in the health sector: Tool to improve responsiveness to women's needs*. Geneva, World Health Organization, 2009 (http://www.who.int/gender/documents/gender_hiv/en/index.html)

(9) *Malaria in Pregnancy: Guidelines for Measuring Key Monitoring and Evaluation Indicators*. Geneva, World Health Organization, 2006 (http://www.who.int/making_pregnancy_safer/publications/MIP_ME_Framework_June_06.pdf)

(10) *Maternal and perinatal health*. Geneva, World Health Organization, 2011 (http://www.who.int/reproductivehealth/topics/maternal_perinatal/en/index.html)

(11) MCHIP-Maternal and Child Health Integrated Programme. Tools and Resources. Washington DC, United States Agency for International Development, 2011 (<http://www.mchip.net/resources>)

(12) *New progress and guidance on HIV diagnosis and treatment for infants and children*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/paediatric/Paediatricfactsheet/en/index.html>)

(13) *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. Geneva, World Health Organization (Department of Reproductive Health and Research), 2004 (http://www.who.int/reproductivehealth/publications/general/RHR_04_8/en/index.html)

(14) Roll Back Malaria Partnership. *RB Toolbox*. (<http://www.rbm.who.int/toolbox/index.html>)

(15) Stop TB Partnership. *Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resourceconstrained settings*. Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf)

(16) Stop TB Partnership. *Tuberculosis: Women and TB - Fact Sheet*. Geneva, World Health Organization, 2009 (<http://www.who.int/tb/womenandtb.pdf>)

(17) UNAIDS Inter-Agency Task Team on HIV and Young People. *Global Guidance Briefs: HIV Interventions for Young People*. New York, United Nations Population Fund, 2008 (<http://www.unfpa.org/public/iattyp/>)

(18) Williams K, Warren C, Askew I. *Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other*

- Reproductive Health and Primary Health Services*. New York, Population Council and United Nations Population Fund, 2011 (<http://www.unfpa.org/public/home/publications/pid/7287>)
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- (20) *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*. Geneva, UNAIDS, 2010
(http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf).
- (21) *Antiretroviral Therapy for HIV Infection in Adults and Adolescents - recommendations for a Public Health Approach - 2010 revision*. Geneva, World Health Organization, 2010
(<http://www.who.int/hiv/pub/arv/adult2010/en/index.html>).
- (22) *Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. Geneva, UNAIDS, 2004
(http://www.unicef.org/aids/files/Framework_English.pdf).
- (23) *Global strategy for the prevention and control of sexually transmitted infections: 2006-2015*. Geneva, World Health Organization
(http://www.who.int/hiv/pub/toolkits/stis_strategy%5b1%5den.pdf).
- (24) IAWG. *SRH & HIV linkages resource pack*. 2010
(<http://www.srhivlinkages.org/en/index.html>).
- (25) JHPIEGO. *Malaria in Pregnancy Resource Package*, 2nd ed. 2010
(<http://www.jhpiego.org/en/node/316>).
- (26) *Malaria in pregnancy*. Geneva, World Health Organization, 2011
(http://www.who.int/malaria/high_risk_groups/pregnancy/en/index.html).
- (27) *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*. Geneva, World Health Organization, 2006, 938.
- (28) *Skilled birth attendants - Fact Sheet*. Geneva, World Health Organization, 2008
(http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_sba.pdf).
- (29) *Technical guidance note for global fund HIV proposals: Gender responsive HIV and AIDS programming for women and girls*. Geneva, World Health Organization and UNAIDS, 2010
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- (30) United Nations Population Fund and World Health Organization. *Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings*. 2006
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- (39) Hardee K, Gay J, Dunn-Georgiou E. *Practical Guide to Implementing Reproductive Health and HIV/AIDS into Grant Proposals to the Global Fund*. Washington DC, Population Action International, 28 August 2009 (http://www.populationaction.org/Publications/Reports/A_Practical_Guide_to_Integrating_Reproductive_Health_HIV-AIDS/Summary.shtml).
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- (41) *PMTCT strategic vision 2010-2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals*. Geneva, World Health Organization, 2010 (http://www.who.int/child_adolescent_health/documents/9789241599030/en/).
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7 Annexes

Annex 1. Suggested lists of MNCH indicators for HIV, TB and malaria components

Antenatal care				
Intervention	HIV	Tuberculosis	Malaria	Additional indicators
<p>Essential preventive and promotive care in pregnancy including PMTCT, MIP and referral for TB suspect cases (in health facility and community level)</p> <p>Management of complications during pregnancy.</p>	<p>%of pregnant women who have been tested for HIV and screened and treated for syphilis.</p> <p>% of HIV positive pregnant women who are initiated on lifelong ART or who have received ARVs for PMTCT.</p>	<p>% of pregnant women receiving IPT under DOT (first dose, second dose, third dose, according to national guidelines)</p>	<p>%of pregnant women sleeping under an insecticide treated mosquito net (ITN) the previous night</p> <p>% of sulfadoxine-pyrimethamine (SP) stock outs at the ANC clinic.</p>	<p>Number of health facilities providing MIP services as an integrated component of maternal, child health services; specifically, through antenatal care</p> <p>% of LBW singleton live births (<2500g), by parity</p> <p>% of screened pregnant women with severe anaemia (Hb < 7g/dl) in the third trimester, by gravidity</p> <p>% of pregnant women receiving antenatal care by skilled personnel at least four times during pregnancy.</p> <p>% of pregnant women who are fully immunized against tetanus.</p>
Childbirth care				
Interventions	HIV	Tuberculosis	Malaria	Additional indicators
<p>Essential care during childbirth from the onset of labour up to 24hrs including promotive and preventive</p>	<p>ARV adherence during delivery</p> <p>MTCT (safer childbirth practices)</p> <p># HIV-exposed infants who are BF</p>	<p># infants initiated on co-trimoxazole prophylaxis</p>		<p>Proportion of women using a contraceptive method</p> <p>% of births attended by skilled health personnel.</p>

<p>care.</p> <p>Essential care for the mother and newborn immediately after childbirth.</p> <p>Early recognition and appropriate management of complications.</p> <p>Prevention of transmission and care of HIV positive pregnant women.</p>	<p>under ARV prophylaxis at 3m</p>			<p>% of births in facilities.</p> <p>% of all births by Caesarean section.</p> <p>Maternal mortality ratio, age disaggregated.</p> <p>Perinatal mortality rate.</p> <p>Stillbirth rate in facilities</p> <p>% women discharged with FP method</p> <p>Case fatality rates for maternal complications</p> <p>% of women and newborn receiving postnatal care within 1 day</p>
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Postpartum care for mother and newborn (24 hours to 6 weeks) in facilities and community

Intervention	HIV	Tuberculosis	Malaria	Additional indicators
<p>Essential promotive and preventive care following childbirth (24 hours to 6 weeks).</p> <p>Early identification and appropriate management of complications.</p> <p>Counselling and services for family planning/birth spacing</p> <p>Care and counselling for HIV positive mother.</p> <p>Support for breast feeding.</p> <p>Essential preventive interventions for the healthy</p>	<p>MTCT (safer childbirth practices)</p> <p># HIV-exposed infants who are BF under ARV prophylaxis at 3m</p> <p>ARV cover during entire BF period</p> <p>Infant feeding practices among HIV-exposed infants at 3 months</p> <p># HIV-exposed infants receiving CTM</p> <p># Early infant diagnosis</p>	<p># infants initiated on co-trimoxazole prophylaxis</p>	<p>% of under 5 children sleeping under a bed net</p>	<p>Proportion of post-partum women intending to use and are using a contraceptive method</p> <p>% of women receiving postpartum care within 7 days after childbirth</p> <p>% of women using a modern method of contraception at 6 weeks after childbirth</p> <p>Exclusive breastfeeding rates at 3m among all infants</p> <p>Reduction of neonatal sepsis</p> <p>Neonatal and early neonatal mortality rates.</p> <p>% of newborn infants put to the breast within 1 hour of birth (DHS,</p>

newborn infant; and Early identification and management of newborn problems, namely care for prematurely born or LBW infants.				MICS) % of newborns receiving postnatal care visit within 2 days of birth (DHS, MICS) Early neonatal deaths (within 7 days) of babies weighing 2500g or more in facilities
Child care				
Intervention	HIV	Tuberculosis	Malaria	Additional indicators
Interventions to improve nutrition. Promote Immunization and use of insecticide treated bed nets. Provision of Integrated management of childhood illnesses, care of children infected with HIV.	% of HIV-infected children 0-5 years receiving lifelong antiretroviral therapy.	% of children 0-59 months who received antimalarial treatment within 24 hours of onset of fever. % of children 0-5 yr. correctly diagnosed and treated for malaria % of children 0-5 yr. sleeping under an ITN	% of TB positive children detected, treated and cured	% of infants under six months exclusively breastfed. % infants with continued BF % of children 0-59 months with diarrhoea who received oral rehydration therapy and/or increased fluids, with continued feeding. % of children 0-59 months with signs of pneumonia who received an antibiotic. Infant and under 5 mortality rate.
Sexual and Reproductive Health				
Intervention	HIV	Tuberculosis	Malaria	Additional indicators
Provision of care for HIV, TB and malaria (e.g. screening, referrals) within SRH services Education and counselling for informed contraception decision making.	Contraceptive use among women living with HIV Unmet need for family planning among women living with HIV # new HIV infections in women of reproductive age	TB detection, cure and treatment rate (specified for women in reproductive age)	Age disaggregated indicator for malaria detection and care in adolescent, and pregnant women	% of women using a modern contraceptive method Unmet need for family planning among women Teenage pregnancy rate Service delivery points prepared

<p>Expand SRH services to adolescents</p> <p>Availability of and access to contraceptive supplies</p> <p>Family planning within integrated primary health care, including prevention and care for STIs (HIV included), TB and malaria care.</p> <p>Screening, treatment and referral for other sexual and reproductive health needs.</p>	<p>Percentage of Family Planning delivery points providing STI/HIV counselling/testing</p>			<p>(with stocks and trained providers) to provide at least three family planning methods</p> <p>Government funding for Family Planning measured as a proportion allotted for FP of total funding</p>
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Annex 2: Illustrative list of MNCH interventions linked to HIV, TB and malaria programs, with suggestions for gap analysis, benefits and value for money

Note: Each component is further developed in: *Packages of interventions for Family Planning, safe abortion care, maternal, newborn and child health*. WHO 2010 http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf

Components	Gap analysis	Benefits (additional to HIV, TB, malaria)	Value for money (additional to HIV, TB, malaria)
1. Antenatal Care			
<p>Essential preventive and promotive care in pregnancy including PMTCT of HIV and syphilis, MIP and referral for TB suspect cases (<i>in health facility and community level</i>)</p> <p>Management of complications during pregnancy.</p>	<p>Policies that address social, cultural and financial factors that affect access to care.</p> <p>Nationally agreed standards and local protocols for integrated antenatal care services, and timely referral and management of complications.</p> <p>Services organized to ensure ANC provided through facilities and outreach programmes.</p> <p>Services linked to a health care system providing continuity with childbirth and postnatal care.</p> <p>Skilled health professionals, counselling providers and tools.</p> <p>Essential medicines and medical devices.</p> <p>Functioning referral systems (communications, ambulance).</p>	<p>Improves healthy practices.</p> <p>Prevents tetanus, syphilis and anaemia.</p> <p>Increases uptake of PMTCT (see PMTCT indicators).</p> <p>Provides opportunities for preventing malaria.</p> <p>Pregnancy care increases uptake of IPT and ITNs.</p>	<p>Prevention and treatment of anaemia reduces maternal and neonatal mortality and reduces HIV transmission</p> <p>Diagnosis and treatment of syphilis in pregnancy reduces syphilis-attributable stillbirths and neonatal deaths by 50%, and averts more stillbirths than any other intervention besides emergency obstetric care.</p> <p>Tetanus immunization reduces the risk of neonatal deaths from tetanus by 90%.</p> <p>Screening for pre-eclampsia reduces risk of maternal deaths due to hypertension by 48% and neonatal deaths due to prematurity by 15%.</p> <p>IPTs and ITNs can reduce LBW by 35%</p>

Components	Gap analysis	Benefits (additional to HIV, TB, malaria)	Value for money (additional to HIV, TB, malaria)
	<p>Adequate recording and reporting systems.</p> <p>Use of data for quality improvement.</p>		<p>and IPTp can reduce neonatal mortality by up to 61%.</p>
2. Childbirth Care			
<p>Essential care during childbirth from the onset of labour up to 24hrs including promotive and preventive care.</p> <p>Essential care for the mother and newborn immediately after childbirth.</p> <p>Prevention of transmission and care of HIV positive pregnant women.</p>	<p>Nationally agreed standards and local protocols for childbirth care services and timely referral and management of complications.</p> <p>Policies that address social, cultural and financial barriers to access care, with free delivery care at point of service.</p> <p>Skilled health professionals available to provide all women with quality childbirth services, 24hours / 7 days a week service.</p> <p>Counselling providers and tools- Essential medicines and medical devices.</p> <p>Referral system (communication, ambulance).</p> <p>Recording systems.</p> <p>Regular maternal and perinatal death reviews at facility level to improve quality of care.</p>	<p>Has potential to reduce risks of maternal mortality and severe morbidity due to childbirth related issues.</p> <p>Reduces newborn deaths by 40%.</p> <p>Risks of postpartum haemorrhage reduced by 67%.</p>	<p>Increases safety for pregnant women and their babies in the childbirth process.</p>

Components	Gap analysis	Benefits (additional to HIV, TB, malaria)	Value for money (additional to HIV, TB, malaria)
3. Postpartum care for mother and newborn (24 hours to 6 weeks) - in facilities and community			
<p>Essential promotive and preventive care following childbirth for mother and baby (24 hours to 6 weeks).</p> <p>Early identification and appropriate management of complications.</p> <p>Counselling and services for family planning/birth spacing</p> <p>Care and counselling for HIV positive mother.</p> <p>Support for breast feeding.</p>	<p>Nationally agreed standards and local protocols for childbirth care services and timely referral and management of complications.</p> <p>Supportive policies to ensure availability and universal access to postnatal and newborn care service.</p> <p>Partnerships that foster community engagement to promote postnatal and newborn care, particularly for those in special need.</p> <p>Health services organized to ensure constant availability, accessibility and acceptability to all mothers and newborns, and to meet and maintain the standards of care required for the delivery of interventions.</p> <p>Skilled professionals e.g. midwives, nurses, doctors and community health workers available to provide quality PNC to all women and newborns.</p> <p>Facilities provide 24 hour services.</p> <p>Counselling providers and tools</p> <p>Essential medicines and medical devices, including contraceptives</p>	<p>Timely management of maternal sepsis will reduce risk of maternal mortality due to sepsis by 90%.</p> <p>Reduce mortality, morbidity and disabilities.</p> <p>Improves early newborn care at home and case management at health facilities</p> <p>Improves early initiation of exclusive breastfeeding</p> <p>Improves uptake and adherence to ARV interventions to improve maternal health and reduce HIV transmission to infants</p>	<p>Reduces maternal mortality and morbidity.</p> <p>Improves maternal and infant health by promoting birth spacing.</p> <p>It can reduce more than half of neonatal mortality when universally applied.</p> <p>Ensures a good start to life with practices and protections important for health, growth and development later in life.</p> <p>Improved early breastfeeding reduces newborn and infant mortality</p>

Components	Gap analysis	Benefits (additional to HIV, TB, malaria)	Value for money (additional to HIV, TB, malaria)
	<p>Referral system (communication, ambulance).</p> <p>Recording systems.</p> <p>Regular maternal and perinatal death reviews at facility level to improve quality of care.</p>		
4. Child care			
<p>Selected interventions to improve nutrition.</p> <p>Promote Immunization and use of ITNs.</p> <p>Provision of Integrated management of childhood illnesses, care of children infected with HIV.</p> <p>Provision of ARV interventions to reduce HIV transmission through breastfeeding</p>	<p>Access to free health care at the point of delivery for all children regardless of their socio-economic situation, including community-based services.</p> <p>National adaptation of recommendations on pneumonia management, diarrhoea, malaria, severe uncomplicated malnutrition by trained community health workers.</p> <p>National strategies based on IMCI, Global Strategy for Infant and Young Child Feeding (IYCF) and Global Immunization and Vaccines strategy (GIVS), Management of paediatric HIV.</p> <p>Costed national scale-up plans that promote comprehensive service delivery including linkages for timely referral and management of complications.</p> <p>Skilled human resources including</p>	<p>Improved care during infancy and childhood.</p> <p>Reduces important risk factors for cardiovascular disease in later life.</p>	<p>Saving 3 million lives each year if universally applied.</p> <p>Promotes child health, growth and development.</p>

Components	Gap analysis	Benefits (additional to HIV, TB, malaria)	Value for money (additional to HIV, TB, malaria)
	trained community health workers.		
Sexual & Reproductive Health			
<p>Family Planning services integrated within preventive and curative SRH care, and with HIV, TB and malaria service care</p> <p>Education and counselling for informed contraception decision making.</p> <p>Expand SRH services to adolescents</p> <p>Availability of and access to contraceptive supplies</p> <p>Family planning within integrated primary health care, including the prevention and care for STIs (including HIV, TB and malaria care).</p> <p>Screening, treatment, and referral for other SRH needs.</p>	<p>Enabling policy to increase access to contraceptive methods including expanding method choice.</p> <p>Defining and implementing strategies to eliminate unmet need for family planning</p> <p>Health systems strengthening including increase in direct funding and other sustainable mechanisms for FP.</p> <p>Integration of FP and RH services in MNCH throughout care continuum, including HIV, STI, TB and malaria care</p> <p>Education and counselling on contraceptive use for persons living with HIV, TB and malaria</p> <p>Community health workers with proper FP training and service supervision.</p>	<p>Promotes gender equity, empowers women and families.</p> <p>Improves capacity to negotiate for contraceptives</p> <p>Family planning can reduce maternal deaths by 32%, newborn, infant and child deaths by 10%, and unwanted pregnancies by 71%</p> <p>Can avert 80% of HIV sexual transmission with consistent and correct use of condoms.</p> <p>Slows population growth, contributing significantly poverty and hunger reduction, helps achieve MDGs.</p> <p>More TB infected women able to be detected, treated and cured.</p>	<p>Promotes benefits of dual protection with use of condoms</p> <p>Contraception can reduce the number of unintended pregnancies among women living with HIV and with TB</p> <p>Contraception reduces the number of new cases of HIV and TB resulting from unplanned pregnancies.</p> <p>Expansion of reproductive options of women with HIV, and TB, including safe and optimal conditions for a planned pregnancy</p> <p>Targeting adolescents would maximize effects of interventions in a high risk population</p>

