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REGIONAL MINIMUM STANDARDS FOR GUIDANCE ON PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) IN THE SADC REGION

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ABBREVIATIONS

AFASS	Affordable, Feasible, Accessible, Safe and Sustainable
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azido-Thymidine
CDC	Centres for Disease Control and Prevention (in the USA)
CICT	Client Initiated Counselling and Testing
CT	Counselling and Testing
CTX	Cotrimoxazole
EID	Early Infant Diagnosis
EPI	Expanded Programme on Immunization
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
IHP	Integrated Health Plan
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health
MS	Member State (of the SADC Region)
NAC	National AIDS Council
NERSA	National Emergency Response System for AIDS in Swaziland
NGO	Non Governmental Organisation
NVP	Nevirapine
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PICT	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RCH	Reproductive and Child Health
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TAC	Technical AIDS Committee

TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

The main aim of this project was to develop regional harmonized minimum standards for policies, protocols and guidelines for prevention of mother to child transmission (PMTCT) of HIV and AIDS in the Southern African Development (SADC) region. This is consistent with Article 10 of the SADC Protocol on Health, which calls for the harmonization of policies on disease prevention and control.

Several approaches were followed in developing these minimum standards. Firstly, an extensive literature review of both published and unpublished literature on PMTCT in the SADC region and globally was conducted as well as analysis of PMTCT policies, protocols and guidelines. Secondly, a technical meeting was held in Gaborone from 15-16 December 2008 with PMTCT experts and implementers from the region. The objective of the meeting was to discuss and share experiences on current national policies and programmes for PMTCT, and to give guidance on the approach for developing minimum standards.

Thirdly, policy discussions were held in 14 SADC Member States with representatives of Ministries of Health and National AIDS authorities, and local and international stakeholders, to gain more understanding on how the programmes work, and to identify major achievements, challenges and best practices. Based on information collected from the Member States, individual PMTCT reports were developed for each of the Member States. These were subsequently sent back to the Member States for verification.

Based on a review and assessment of PMTCT policies, protocols and guidelines in the Member States and global recommendations, minimum standards were developed. These include:

a) Minimum standards for prevention of HIV infection in women;
b) Minimum standards for preventing unintended pregnancies in HIV infected women;
c) Minimum standards for preventing transmission from an HIV infected woman to her infant; and
d) Minimum standards for providing care and support for HIV-infected women, their infants and their families.
e) Minimum standards for access to PMTCT
f) Minimum standards for integration of PMTCT into maternal and child health (MCH) and sexual and reproductive health (SRH) services

This document guides Member States on mechanisms and institutional arrangements for implementation of the minimum standards. It also guides MS on resources for implementation and systems for monitoring implementation.

1. BACKGROUND

One of the main aims of the Southern African Development Community (SADC) is regional economic and political integration. However, as the region progresses towards the achievement of this objective, it is challenged by the adverse effects of HIV and AIDS on social, political and economic development. The region leads the world in terms of HIV infections, the majority of Member States have adult HIV prevalence levels of over 15%, and several have adult prevalence of more than 20%.

Eleven Member States are among the 27 countries that are estimated to account for 80% of all children living with HIV worldwide, and HIV infection in children is predominantly a result of mother-to-child transmission (MTCT). MTCT has a major impact on the HIV epidemic, and is an underlying factor in many infant and childhood illnesses and deaths in the region. There are indications, however, that prevention of mother-to-child transmission of HIV (PMTCT) programmes are beginning to have a noticeable impact on the prevalence of HIV and AIDS in children. According to the SADC (2008) epidemic report, the uptake of PMTCT is on the increase in the region, although it is generally below universal access targets. Nine Member States recorded an increase in the uptake of PMTCT in 2007 compared to 2005. Although Universal Access targets for some of them seem ambitious, a number of the Member States may be able to attain them if they maintain the tempo of implementation. Data on the uptake of PMTCT show that the range is 1.6% to 91%, implying that the Member States are at different levels in terms of programme implementation. In 2007, four SADC Member States had at least 50% of the HIV-positive pregnant women receiving PMTCT services.

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

In line with the overall regional integration agenda and the control of communicable and other health problems, the SADC region has put together the Protocol on Health, which guides implementation of the regional health agenda. The Protocol calls for the harmonization of regional approaches as well as regional cooperation.

These regional minimum standards serve as a harmonization framework for regional approaches to PMTCT, and are, therefore, part of the operationalisation of the different declarations to which the region is signatory to. They are also in line with the regional agenda of integration.

1.1. Purpose and scope of the regional minimum standards

The regional minimum standards serve as a framework which guides regional harmonization of approaches to the scale-up of prevention of mother-to-child transmission of HIV.

1.2. Basis of minimum standards

The regional minimum standards are informed by the *SADC Protocol on Health*, and various articles of the Protocol address important issues which facilitate regional cooperation and integration. For example, Article 9 on communicable diseases calls for the harmonization of policies and the sharing of information by the region, while article 10, which deals specifically with HIV and AIDS, mandates Member States to:

a) harmonize policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of sexually transmitted diseases (STDs) and HIV infection;
b) develop approaches for the prevention and management of HIV/AID/STDs to be implemented in a coherent, comparable, harmonized, and standardized manner; and
c) develop regional policies and plans that recognize the intersectoral impact of HIV/AIDS/STDs and the need for an intersectoral approach to these diseases.

The specific focus on PMTCT is adopted from the Maseru Declaration which calls for "*rapid scale up of programmes for prevention of mother-to-child transmission of HIV and ensuring that levels of uptake are sufficient to reach the desired public health impact*"

1.3. Guiding principles for regional minimum standards guidelines for PMTCT

The regional minimum standards are informed by the WHO framework for a comprehensive approach to prevention of HIV infections in infants and young children. They will, therefore, be organized following the following four main components of the comprehensive approach framework:-

a) Prevention of HIV infection in women;
b) Preventing unintended pregnancies in HIV infected women;
c) Preventing transmission from an HIV infected woman to her infant; and
d) Providing care and support for HIV-infected women, their infants and their families.

2. SADC REGIONAL MINIMUM STANDARDS FOR PMTCT

The following proposed SADC regional minimum standards are derived from an in-depth assessment of the PMTCT policies, protocols, and guidelines in SADC Member states, with a special focus on the key challenges, needs and best practices. Again, two consultation meetings were held in 2008 and 2009, to obtain input from officials and experts managing the implementation of PMTCT services in the SADC region. The recommended minimum standards for PMTCT are described below.

2.1. Minimum standards for prevention of HIV infection in women

2.1.1. Women must be provided with health education and information on prevention and care for the following:

- HIV and sexually transmitted infections (STIs), including safer sex practices i.e. Abstinence, Being faithful, consistent and correct use of Condoms (ABC)
- Family planning counselling and related services
- Pregnancy including antenatal care, birth planning and delivery assistance, malaria prevention
- intra-partum and post-natal care
- Optimal infant feeding.

2.1.2. A communication strategy on HIV prevention must be established.

2.1.3. Women must be provided with HIV testing and counseling (HTC), couple, index and partner HTC, including support for disclosure.

2.1.4. There must be regular retesting for those with exposure to HIV.

2.1.5. Counselling and testing must be part of routine health care.

2.1.6. Safer sex practices must be promoted, including dual protection i.e. use of both male or female condoms and other contraceptive methods.

2.1.7. PMTCT policies or guidelines must include primary prevention.

2.2 Minimum standards for preventing unintended pregnancies in HIV infected women

2.2.1. Individuals and couples must be given family planning counseling and contraceptives at all opportunities such as the following:

- HIV care and treatment,
- voluntary counselling and testing,
- preconceptual, antenatal, and postpartum services.

2.2.2. Provider-initiated HIV testing and counseling (PITC) must be promoted during family planning services. It must be linked with counselling on reproductive choices and awareness of PMTCT as well as the promotion and provision of male and female condoms.

2.2.3. PMTCT policies or guidelines must include family planning and contraceptive options for pregnant HIV-positive women.

2.2.4. Services for the prevention of unintended pregnancies, including access to reproductive health commodities and contraceptives must be strengthened, expanded, and made more youth-friendly.

2.2.5. Integrated sexual and reproductive health services must be provided.

2.3. Minimum standards for preventing transmission of HIV from an infected woman to her infant

2.3.1. Routine quality antenatal and postpartum care must be provided for all women, regardless of HIV status. This might include the following depending on the context:

- maternal nutritional support
- birth planning and birth preparedness
- care by skilled birth attendants (SBAs),
- tetanus vaccination
- iron and folate supplementation
- syphilis screening and management of STIs
- risk reduction interventions for injecting drug users
- malaria prevention and treatment
- counselling, psychosocial support and referral for women who are at risk of or have experienced violence,
- counselling and referral for women with a history of harmful alcohol or drug use,
- de-worming, intra-partum care,
- safe obstetric practices.

2.3.2. Safe obstetric practices for HIV infected women must include the following:

- Delivery should be by a skilled birth attendant
- There should be minimal invasive procedures during delivery
- Care for newborns should include minimum suctioning of nostrils, immediate bathing, and administration of AZT as soon after birth as possible.

2.3.3. Information about MTCT of HIV and HTC must be given to all pregnant women during antenatal information sessions.

2.3.4. Provider Initiated Testing and Counselling (PITC) must be recommended by health care providers according to the status of the epidemic as follows:

- In generalized epidemics PITC for all persons attending health care facilities as a standard component of medical care and in all antenatal, childbirth, postpartum, and paediatric care settings
- In low and concentrated epidemics, PITC may be considered for pregnant women identified as being at higher risk of HIV exposure according to national or local criteria.

2.3.5. There must be retesting late in pregnancy in generalized epidemics.

2.3.6. Pregnant women with HIV infection, who do not yet require ART, must be given ARV prophylactic regimens for MTCT prevention.

- Programmes for the prevention of MTCT are strongly encouraged to implement the WHO recommended ARV regimens for preventing HIV transmission among women who do not have indications for ART.

2.3.7. Member States must support infant feeding and counselling on nutrition.

All HIV-infected mothers must receive counselling which includes provision of general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation.

The WHO recommendation for infant feeding for children of HIV infected mothers in resource limited settings should be followed. The recommendation states that women living with HIV must exclusively breastfeed their children for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS).

2.4. Minimum standards for providing care and support for HIV–infected women, their infants and families

2.4.1. Minimum standards for providing care and support for HIV–infected women

Antiretroviral therapy (ART) for all pregnant women who are eligible for treatment based on clinical staging or CD4 testing must be provided. The UN minimum standards of 350 CD4 cell counts as cut-off are recommended. MS must:

- Ensure that pregnant women requiring antiretroviral therapy (ART) get it.
- Ensure that co-trimoxazole prophylaxis is provided where indicated (i.e. clinical stage 4 or CD4 <200 cells/mm^3).
- Provide family planning counselling and contraceptive methods in the postpartum period in all settings providing PMTCT to all women, with specific attention to the needs of women living with HIV, either on site or through referral.

- Provide supportive care (psychosocial and community support), including adherence support and palliative care and symptom management,
- Promote and facilitate the active participation of people living with HIV, especially women and mothers living with HIV, in planning and delivering services, advocacy and community engagement.
- Make tuberculosis screening available for women living with HIV and TB treatment when indicated.
- Put in place tracking tools for the follow-up of mothers.
- Provide clinical and immunological assessment for all HIV-positive mothers.
- Implement interventions for the prevention and treatment of opportunistic infections (OI).
- Provide nutrition support for mothers who need it .

2.4.2. Minimum standards for providing care and support for HIV–infected children

With regard to providing care and support for HIV-infected children, MS must:

- Ensure completion of ARV prophylaxis regimen as necessary.
- Put in place tracking tools in place for the follow-up of HIV-infected babies.
- Provide routine newborn and infant care, including routine immunization and growth monitoring, according to the protocols of the Member States.
- Ensure that all HIV-exposed children born to mothers living with HIV start co-trimoxazole preventive treatment at 4–6 weeks after birth and continue until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding. Infants confirmed to be HIV uninfected, who are no longer breastfeeding, and, therefore, no longer at risk of acquiring HIV, can discontinue co-trimoxazole preventive treatment. WHO guidelines also recommend co-trimoxazole for infants and children who have HIV. All infants with HIV should continue co-trimoxazole preventive treatment up to the age of 5 years, at which point they may be reassessed.
- Scale up of co-trimoxazole prophylaxis for HIV-infected children.
- Ensure early HIV diagnostic testing and diagnosis of HIV-related conditions at 6 weeks where virological tests are available.
- Put in place standardized virological diagnostic services within national programmes.
- Provide antibody testing for young children at 18 months where virological testing is not available.
- Recommend provider-initiated age-appropriate HIV testing for all infants and children where HIV is possible, suspected, or HIV exposure is recognized.
- Ensure that if virological testing is not available, then infants who are suspected to be HIV infected or are HIV sero-positive, and who have signs and symptoms suggestive of HIV, need to be managed as if HIV infection may be the cause. CD4 testing, where available, should be performed to assess immunodeficiency, and facilitate recognition of presumptive severe HIV disease requiring immediate ART.
- Introduce systematic approaches to diagnostic testing in infants and children.
- Recommend HIV testing for all family members of infants and children known to be exposed or infected with HIV.

- Offer an HIV test to infants or children with suspected TB.
- If HIV antibody testing is negative in a child younger than 18 months, who is no longer breastfeeding and has not been breastfed in the last 6 weeks, the child is presumed to be uninfected, and virological testing is only indicated if clinical signs or subsequent events suggest HIV infection.
- Recommend confirmatory HIV antibody testing at or around 18 months for all HIV-exposed children.
- Start all infants below 12 months of age with confirmed HIV infection on ART, irrespective of clinical or immunological stage. Where virological testing is not available, infants below 12 months of age with clinically-diagnosed presumptively-severe HIV must start ART. For children age 12 months or older, clinical and immunological thresholds (<20% CD4 for 12-59 months, and <15 % CD4 for 5 years or over) should be used to identify those who need to start ART.
- What to start:
  - For HIV infected infants with no exposure to maternal or infant non-nucleoside reverse transcriptase inhibitors, or whose exposure to maternal or infant antiretrovirals is unknown, standard nevirapine-containing triple therapy should be started; and
  - For HIV infected infants with a history of exposure to single dose nevirapine or non-nucleoside reverse transcriptase inhibitor containing maternal antiretroviral therapy or preventive antiretroviral regimens, a protease inhibitor-based triple antiretroviral therapy regimen should be started. Where protease inhibitors are not available, affordable or feasible, nevirapine-based therapy should be used.
- Introduce treatment monitoring for all children receiving ART.
- Provide counselling on adherence support for caregivers.
- Provide nutritional support throughout the first year of life, including support for optimal infant feeding practices and provision of nutritional supplements and replacement foods if indicated.
- Provide screening and management of tuberculosis and other opportunistic infections.
- Ensure prevention and treatment of malaria, where indicated.
- Provide psychosocial care and support for HIV-infected children.
- Ensure symptom management and palliative care if needed. This includes diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illnesses (IMCI).

2.5. Minimum standards for access to PMTCT in SADC

The recommendations on PMTCT made in the Model law on HIV/AIDS in southern Africa (2009) are endorsed:

2.5.1. Member States must ensure that HIV testing is available to pregnant women as part of antenatal care (ANC) services.

2.5.2. Women living with HIV must have access to counselling, information, and services enabling them to make informed and voluntary decisions in matters affecting their health and reproduction.

2.5.3. Member States must ensure that programmes on the PMTCT of HIV are available to all pregnant women living with HIV. Such programmes shall include psychosocial support, follow-up services, and nutritional support for disadvantaged mothers. The State must also provide pregnant women living with HIV with relevant and scientifically proven information regarding breastfeeding and alternatives to breastfeeding with the view to reducing the risk of HIV transmission.

2.5.4. When possible, and with the consent of the pregnant woman living with HIV, her partner or spouse must receive information and counselling on the implications of the PMTCT programme.

The Declaration of Commitment on HIV/AIDS of the UNGASS aims to reduce the proportion of infants infected with HIV:

> *"... by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other prevention services available to them, increasing the availability of and by providing access to HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions in HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy, and where appropriate, breast milk substitutes and the provision of a continuum of care".*

Building on this, the following programme coverage levels are proposed to guide SADC country level efforts.

- At least 80% of all pregnant women attending antenatal care are provided with information on PMTCT.
- At least 80% of all pregnant women attending antenatal care are tested for HIV, including those previously confirmed to be living with HIV.
- At least 80% of pregnant women living with HIV receive antiretroviral prophylaxis or antiretroviral therapy to reduce the risk of mother-to-child transmission.
- At least 80% of eligible pregnant women living with HIV receive antiretroviral therapy for their own health.
- At least 80% of infants born to women living with HIV receive co-trimoxazole prophylaxis.
- At least 80% of pregnant women living with HIV receive infant feeding counselling and support at the first infant follow-up visit.
- At least 80% of women living with HIV are successfully referred and enrolled in comprehensive longitudinal care and treatment.

- At least 80% of infants born to women living with HIV receive a virological HIV test within two months of birth, and have a confirmation test at 18 months.
- At least 80% of HIV-positive infants requiring treatment must receive HAART when indicated, and must be properly monitored.

In countries with generalized HIV epidemics, governments must urgently scale up PMTCT programmes to ensure that quality national coverage is achieved, and that ARV prophylaxis is available to all women who test HIV positive, as well as their children.

SADC countries with high/generalized HIV epidemics should have scale-up plans for PMTCT. They should further decentralize implementation and service delivery, and, in particular, focus on developing and strengthening community structures and systems to include PMTCT services.

Good basic antenatal services and systems of access to PMTCT services across SADC countries must be created.

Facilitate access to PMTCT programmes for people with disability and adolescent mothers.

2.6. Minimum standards for integration of PMTCT into MCH and SRH services

Place PMTCT of HIV in a broader spectrum and position it as "women, newborn, child and family-centred HIV prevention and care". Support integrated, not vertical, programming for PMTCT.

Improve the integration of PMTCT into paediatric AIDS treatment and care activities and other health services.

2.7. National and SADC coordinating mechanisms

As SADC region, put mechanisms in place for coordination.

Promote good partner and sectoral coordination and donor support to enable better implementation of national policies.

Strengthen coordination and ensure accountability among all partners in line with the "Three Ones" principle, including developing and strengthening NGO capacity to respond in a coordinated manner.

Develop, implement, and supervise different mechanisms of quality assurance in PMTCT.

Harmonize monitoring and evaluation (M&E) indicators, and create systems of efficient data collection and transfer. Strengthen M&E systems and Member States should have costed scale-up plans with indicators to track progress. Integrate indicators with HMS, and track the numbers of

women re-rested for HIV. Countries must assess and report the impact of PMTC programmes in terms of HIV infections averted.

Establish and strengthen technical working groups (TWGs) at the country level.

Speed up the development and revision of policies and guidelines (on PMTCT, IYCF, etc.).

2.8. Resource mobilization at country level

The spectrum of PMTCT implementation in the 15 SADC nations is partially indicative of the differences in access to resources both internal and external for PMTCT programmes. Resource variations need be addressed at the SADC level to ensure that all countries are able to access global and United Nations funds.

In terms of task-shifting to other cadres of staff: utilize lay health workers for HIV counselling and testing and other PMTCT education activities; utilize professional nurses for some medical tasks; and have at least two staff members per health facility trained in PMTCT. Task-shifting should be well covered in the policies and protocols

2.9. Research or operational research to generate evidence

Operational research on community involvement in PMTCT, family planning, etc. must be used to guide targeted responses.

Member States must strengthen data collection and sharing of information on PMTCT indicators to allow better planning for service delivery. PMTCT indicators suitable for the SADC region must be clearly identified and stated. A reporting framework to assess progress regarding PMTCT in each member state must be established.

Documenting and sharing of best practices among Member States.

3. IMPLEMENTATION MECHANISMS

The SADC Secretariat, through the HIV and AIDS Unit will drive the implementation of the *Minimum Standards for Guidance on PMTCT* in collaboration with the HIV response machinery in Member States – the National AIDS Authorities (NAA), Regional Partners and international partners (IP). The success of the implementation of the minimum standards is therefore predicated on the various stakeholders playing their roles.

Principles for the implementation of the minimum standards

The implementation of the SADC *Minimum Standards for Guidance on PMTCT* will be aligned to the general principles of the RISDP and the Strategic Framework on HIV and AIDS. Specifically the following will apply:

Value addition – the interventions to be spearheaded at the regional level will be limited to those that clearly add value or generate solutions to the regional problem.

Broad participation and consultation – the implementation of the minimum standards must be based on broad participation and consultation to ensure ownership.

Suitability of implementation level – the implementation of the minimum standards will also recognize the need to ensure that programs and activities are delivered at levels where they can be best handled. To this end, the Secretariat will promote partnership with other regional institutions outside SADC Structures to facilitate the implementation of the minimum standards.

Pilot testing – The Secretariat will also give consideration to the implementation of some aspects in the minimum standards with limited number of Member States in order to draw lessons for replication.

Institutional arrangements

The key structures in the implementation of the *Minimum Standards for Guidance on PMTCT* would include the following:

- The HIV Unit of the SADC Secretariat
- The International Cooperating Partners
- Regional NGOs and Research Institutions
- SADC Technical Advisor Committee on HIV and AIDS
- The National AIDS Authorities

The HIV Unit of the SADC Secretariat will play the lead role for the implementation of the *Minimum Standards for Guidance on PMTCT*. The key activities will be integrated to the annual business plan of the Unit. The Unit will strengthen its capacity to make the standards more visible by employing a team leader to drive the PMTCT agenda. In addition, the Unit will facilitate the coordination of various activities among different stakeholders. The Unit will also mobilise resources to ensure that all critical activities are undertaken.

The International Partners, especially the UN system will be expected to play a key role in providing technical assistance to drive the implementation of the minimum standards. Other international partners will play an important role in providing resources for the implementation of the *Minimum Standards for Guidance on PMTCT*.

The regional NGOs and research institutions will serve a dual role as both implementing partners and in some cases technical advisors. Comparative advantage of the individual institution will be considered in assigning responsibilities.

The SADC Technical Advisory Committee on HIV and AIDS will monitor the implementation of the *Minimum Standards for Guidance on PMTCT*. The Committee will provide technical guidance/direction and quality control. In addition, it will approve the annual plans and advice on policy matters. The Committee may also establish ad hoc technical committees to assist in fast tracking and guiding the implementation of the standards.

The National AIDS Authorities (NAA) will remain the pillars to ensure the success of the programme and to ensure that the minimum standards are fully integrated into the national plans. The NAA will monitor the implementation of minimum standards at national level and provide the necessary feedback to the SADC Secretariat. In addition, they will identify and document any emerging best practices in implementation of minimum standards to fast track the response.

4. RESOURCES FOR IMPLEMENTATION OF MINIMUM STANDARDS

The *SADC Minimum Standards for Guidance on PMTCT* will be implemented through support from Member States. The resources will be sourced mainly from the SADC Regional Trust Fund. Additional resources will be sought from the development partners. Resource mobilisation will be aimed at securing technical assistance and pooled funding to support the minimum standards.

5. SYSTEMS FOR MONITORING IMPLEMENTATION

The SADC Secretariat, NAA, civil society organisations, development partners and external experts will monitor implementation of the SADC *Minimum Standards for Guidance on PMTCT* through periodic reviews of implementation progress.

The annual forum for NAA and the Partnership forums will be used to assess progress in implementation. The Technical Advisory Committee will monitor the implementation of the minimum standards more closely.

The monitoring and evaluation component of the SADC *Minimum Standards for Guidance on PMTCT* defines key activities that will be facilitated by the SADC Secretariat to create a conducive environment for the implementation of minimum standards at the Member States level. While the SADC Secretariat has control over the implementation of activities at the regional level, these activities will no doubt have down-stream effects at the Member States level. Thus, over and above measuring process and output indicators resulting from implementation of minimum standards, it is important to also have outcome and impact indicators that will be measured at the country level. The assumption is that effective implementation of *Minimum Standards for Guidance on PMTCT* will contribute to increased uptake of PMTCT in the Member States.

The outcome indicators will be integrated in the overall SADC Monitoring and Evaluation Framework. The progress on the implementation of the minimum standards will be documented annually through the SADC Epidemic Response Report.

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