August 2014

Prevention Services

December 2013

Prevention of Mother to Child Transmission (PMTCT)

Indicator code: PMTCT_ARV	**1**	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

Purpose:

This indicator measures the provision and coverage of antiretroviral prophylaxis and treatment, by regimen type, for HIV-positive pregnant women in order to:

- Identify progress toward the USG and global goals of increasing ARV coverage (prophylaxis and treatment) among pregnant women living with HIV and eliminating mother to child transmission of HIV
- Assess progress toward implementing more efficacious PMTCT ARV regimens
- Determine the coverage of HIV+ pregnant women on ARV prophylaxis and ART for life among all HIV+ pregnant women identified
- Provide data for models estimating the country-specific and global impact of USG-supported PMTCT programs

NGI Mapping:		P1.2.D continuing - same indicator; no impact on trend analysis
PEPFAR Support Target/Result Type:		Both Direct Service Delivery (DSD) and Technical Assistance-only (TA-only) targets and results should be reported to HQ
Numerator:	**1**	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission during pregnancy
Denominator:	**1**	Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)
Disaggregation(s):	**1**	**By regimen type (mutually exclusive choices):** 1. Life-long ART disaggregated by a. newly initiated on treatment during the current pregnancy b. already on treatment at the beginning of the current pregnancy 2. Maternal triple-drug ARV regimen provided with the intention to stop at the end of the breastfeeding period 3. Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery) 4. Single-dose nevirapine (with or without tail)
Data Source:		Facility registers and other program monitoring tools
Data Collection Frequency:		Data should be collected continuously at the facility level as part of service delivery. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review

Method of Measurement:

Numerator: The number of HIV-positive pregnant women who received antiretrovirals for prophylaxis or treatment during pregnancy or during labor and delivery (L&D), deduplicated.

Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)

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Explanation of Numerator:

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
1) Life-long antiretroviral therapy (including Option B+) Required disaggregations by: 1a) newly initiated on treatment during the current pregnancy 1b) already on treatment at beginning of pregnancy	A three-drug regimen intended to provide ART for life 1a) # of HIV-positive pregnant women identified in the reporting period newly initiated on ART for life 1b) # of HIV-positive pregnant women identified in the reporting period who were already on ART at their first ANC visit. If a woman is initiating ART for life (including Option B+) at L&D then she should be counted in category 1a.	Standard national treatment regimen, for example: • TDF+3TC (or FTC)+EFV • AZT+3TC+NVP
2) Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	A three-drug regimen provided for MTCT prophylaxis started antenatally or as late as during L&D with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) If a woman is receiving ARVs for the first time at L&D then she should still be counted in this category if the facility is implementing Option B.	• TDF+3TC (or FTC)+EFV • AZT+3TC+EFV • AZT+3TC+LPV/r
3) Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another NRTI) started as early as 14 weeks or as late as during L&D to prevent HIV transmission If a woman is receiving ARVs for the first time at L&D, then she should still be counted in this category if the facility is implementing Option A.	• AZT at any point before L&D + intrapartum NVP • AZT at any point before L&D + intrapartum NVP +7 day post-partum tail of AZT/3TC • Intrapartum NVP +/- 7 day post-partum tail + extended NVP for infant
4) Single-dose nevirapine (with or without a tail)	Count SD-NVP if: • It is the ONLY option provided to an HIV-positive pregnant woman either antenatally or during L&D (this includes use of a tail*) Do NOT count SD-NVP if: • NVP is provided as part of Option A antenatally or • An HIV+ pregnant woman is initiated on	• SD-NVP for mother ONLY at onset of labor • SD-NVP + 7 day AZT/3TC tail ONLY • SD-NVP for mother at onset of labor and SD NVP for baby ONLY

	Option A, B, or B+ at labor and delivery *The tail is used to prevent NVP resistance. It does not alter risk of transmission and therefore does not constitute a different regimen.	

The following should be considered in reporting:

- A woman should only be counted in a regimen category if she actually received the regimen. Referral alone for ARVs or ART should not be counted unless regimen initiation is confirmed.
- Each ARV regimen category is mutually exclusive. Each pregnant woman should only be counted once. If a pregnant woman receives different ARV regimens at different points during the pregnancy, count only the most recent regimen provided to her in the reporting period.
- Because ARVs can be provided to HIV-positive women at different sites including ANC, L&D and HIV care & treatment, steps should be taken to de-duplicate patients counted at multiple sites. For example:
    - A woman who is already on treatment, becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive. While she may not be receiving drugs at the ANC/PMTCT site, she should be counted within the life-long ART disaggregation for this indicator.
    - In settings with high facility delivery rates (>90%), countries may consider aggregating the numerator entirely from the L&D register by counting the number of HIV-positive pregnant women who received a specific ARV regimen by the time of delivery. This method likely minimizes double-counting.
- The disaggregation of newly initiating on treatment during the current pregnancy vs already on treatment at the beginning of the current pregnancy are important distinctions for program planning, target setting, and forecasting. Clients who transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be counted as new on treatment.
    - A woman receives AZT prophylaxis at her first ANC visit. After receiving her CD4 results, she is moved to a life-long ART regimen. In this case she should be counted and reported only once under life-long ART
- The number of HIV-positive pregnant women receiving ART (disaggregation of the PMTCT ARVs/ART indicator) and the number individuals newly initiated on ART who are pregnant (disaggregation of the new on treatment indicator) likely have large overlaps, but in many countries are not the same groups of women. The indicator narrative should clearly explain the source of the data for PMTCT ARVs/ART disaggregation and how it relates to what is reported in the new on treatment indicator.

Explanation of Denominator:

Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)

This denominator includes a sum of categories a-d below, at USG-supported sites:

a. Number of pregnant women who were tested and received an HIV+ result at ANC
b. Pregnant women *known* to be HIV-positive attending ANC for a new pregnancy
c. Pregnant women tested during L&D and received a new HIV+ result
d. Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested for HIV and received their HIV + result

Interpretation:

It is recognized that due to the way in which data is collected and reported in many countries, some level of duplication may be inevitable. Additionally, there may be over or undercounting of certain regimens based on

data collection methodologies.

PEPFAR Direct Support:

Direct Service Delivery (DSD)
Individuals receiving HIV related services will be counted as **directly supported by PEPFAR** when the service receives support that:

1. Is critical to the delivery of the service (such as commodities, human resource salary support) to the counted individuals.
    - For PMTCT this can include: funding of test kits, ARVs/T, lab commodities, or funding of salaries of HCWs

AND

2. Requires an established presence at and/or routinized, frequent (at least quarterly) support to those services to those individuals at the point of service delivery.
    - For PMTCT this can include: training of PMTCT service providers, clinical mentoring of PMTCT service sites, infrastructure/renovation of facilities, support of PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/retention, support of mother mentoring programs.

Both conditions must be met in order to count individuals as directly supported by PEPFAR.

Technical Assistance-only Support (TA-only)
Individuals will be counted as supported through TA-only when the HIV service receives support that meets the following criterion:

2. Requires an established presence at and/or routinized, frequent (at least quarterly) technical assistance to the specified capacity at the point of service delivery.
    - For PMTCT this can include: clinical mentoring and supportive supervision of staff at PMTCT sites, Quality Improvement services support, patient and MIP tracking system support, routine support of PMTCT M&E and reporting, commodities consumption forecasting and supply management

Additional References:

- Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive Monitoring Framework (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-HIv-Children_en.pdf)
- Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009. (http://data.unaids.org/pub/manual/2009/jc1676_core_indicators_2009_en.pdf)
- HIV-P13. The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit 4th Edition. November 2011. (http://www.theglobalfund.org/en/me/documents/toolkit/)
- 3.1. Global AIDS Progress Reporting 2013: Construction of Core indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf)
- Refer to the PMTCT/Peds Treatment TWG with further inquiries.