WHO Technical Guidance Note:
Strengthening the inclusion of reproductive, maternal, newborn and child (RMNCH) health in concept notes to the Global Fund
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About this document

This document, WHO RMNCH Technical Guidance Note, offers technical and programmatic guidance to country teams and stakeholders that are developing concept notes to the Global Fund to Fight AIDS, Tuberculosis and Malaria. It specifically focuses on information that supports the inclusion of reproductive, maternal, newborn and child health (RMNCH) within disease-specific and cross-cutting health systems strengthening (HSS) proposals.

The aim is to assist countries in accelerating progress towards achieving the health-related Millennium Development Goals (MDGs) and beyond, for women, children and people living with and affected by HIV, tuberculosis (TB), malaria and other major communicable diseases, by maximizing synergies with RMNCH and linking policy and programmatic interventions to achieve greater impact on health outcomes within national contexts.

The first WHO RMNCH Technical Guidance Note was published in July 2011. It has been updated in March 2014 to include new policies and guidelines, as well as up-to-date lists of resources from key partners on specific aspects of RMNCH, HSS, HIV, TB and malaria. It also provides the necessary technical background information to support practical guidance documents from other organizations on these topics.
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Abbreviations and acronyms

ACT artemisinin-based combination therapy  
ANC antenatal care  
ART antiretroviral therapy  
ARV antiretroviral (drug)  
COIA Commission on Information and Accountability for Women’s and Children’s Health  
DOT directly observed treatment  
EID early infant diagnosis  
EMTCT elimination of mother-to-child transmission of HIV  
EPI Expanded Programme on Immunization  
FGM female genital mutilation  
GBV gender-based violence  
GIVS Global Immunization Vision and Strategy  
HCT HIV counselling and testing  
HMIS health management information system  
HSS health systems strengthening  
IATT The Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children  
iCCM integrated community case management  
iERG independent Expert Review Group  
IMCI integrated management of childhood illness  
IPT isoniazid preventive therapy  
IPTi intermittent preventive treatment of malaria in infants  
IPTp intermittent preventive treatment of malaria in pregnancy  
ITN insecticide-treated mosquito nets  
IYCF infant and young child feeding  
MCH maternal and child health  
MDG Millennium Development Goal  
MiP malaria in pregnancy  
MTCT mother-to-child transmission  
ORS oral rehydration salts  
PMNCH Partnership for Maternal, Newborn and Child Health  
RBM Roll Back Malaria  
RDT rapid diagnostic test  
RMNCH reproductive, maternal, newborn and child health  
RTI reproductive tract infection  
SMC seasonal malaria chemoprevention  
SP sulfadoxine-pyrimethamine  
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  
WHO World Health Organization
1. Introduction

The World Health Organization (WHO) is the lead agency for the development of normative guidance within the health sector and, in conjunction with key partners, works to ensure that such guidance supports country policies and programmes that are technically sound and firmly based on scientific evidence and the principles of human rights.

Since its initial publication in July 2011, the WHO RMNCH Technical Guidance Note has been updated. This new version is now being published to assist countries in considering how grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) can be used to improve health outcomes more broadly among women and children. In this document, WHO provides access to key technical information and normative guidance on reproductive, maternal, newborn and child health (RMNCH) for country teams and other stakeholders. This information is focused on the integration of proven priority HIV, tuberculosis (TB), malaria and health systems strengthening (HSS) interventions into programming for RMNCH, and vice versa, depending on the context and priorities in each country. This document offers guidance across the full range of RMNCH interventions; countries and partner agencies will be able to use it to support the selection of their own priorities within their particular context.¹

The publication of this updated Guidance Note is timely. Although much progress has been made against infectious diseases such as HIV, TB and malaria, the burden of these diseases, including related deaths, is still substantial and disproportionately affects women and children. 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 reasons for the relative lack of recent progress in reducing maternal and child mortality are complex and vary by country, but the following factors often play a role:

- Policies, approaches and interventions for women, newborns and children are often developed and implemented independently of each other.
- Policies, programmes and interventions for women, newborns and children often do not incorporate a human rights-based approach.
- The continuum of care concept is not well understood and does not yet figure prominently in the process of planning RMNCH activities.
- Partners and decision-makers focus on the interventions to be delivered and not on the common social and health system elements that could support (or hinder) the effectiveness and efficiency of the responses and interventions.
- The actions of global donors in supporting national agencies are often fragmented, each working with different national partners to provide support for RMNCH. This system of siloed funding continues to drive vertical programming. These programmes often use independent service-delivery infrastructures, sometimes even in the same geographic locations, without any

¹ The use of “RMNCH” in this document is consistent with currently accepted terminology for describing the continuum of care for reproductive, maternal, newborn and child health. This includes integrated service delivery for mothers and children from pre-pregnancy to delivery, postpartum and childhood (see: PMNCH Fact Sheet: RMNCH Continuum of care; available at: http://www.who.int/pmnch/about/continuum_of_care/en/). It should also be noted that the scope of the guidance specifically for reproductive health covers multiple aspects of sexual and reproductive health and rights, including family planning, maternal health, sexually transmitted infections, other reproductive tract infections and gender-based violence.
coordinating input from the national counterpart. This lack of collaboration and coordination tends to decrease efficiency in health systems.

- There is a lack of integration of HIV, TB and malaria interventions in RMNCH programmes leading to reduced efficiency.

- Recent efforts made by large financing entities to support health systems strengthening still largely focus on disease-specific programmes and outcomes.

In response, many organizations are now reprioritizing high-quality, integrated interventions for women and children, and establishing interagency working groups focusing on RMNCH, such as the United Nations Commission on Life-Saving Commodities for Women and Children, the H4+ Partnership, the independent Expert Review Group (iERG) established by the Commission on Information and Accountability (COIA) for Women’s and Children’s Health, the Interagency Task Team (IATT) on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children, the Ending Preventable Maternal Mortality Working Group, and, most recently, the RMNCH Steering Committee. There are also concurrent initiatives focused on reducing the impact of major infectious diseases such as HIV, TB and malaria as they relate to sexual and reproductive health (SRH), with a view to improving outcomes for women and children.

The diagram below presents an overview of the Global Strategy for Women’s and Children’s Health and represents a sampling of current global initiatives in RMNCH.
In this context, the Global Fund is also committed to maximizing the impact of its investments for women and children. With the adoption of a new Global Fund Strategy Framework 2012–2016, there has been a push to improve the Global Fund business model such that investments will be more strategically designed to have a greater impact on HIV, TB and malaria and to support the broader Millennium Development Goals (MDGs) and the post-2015 development agenda. This is an opportunity to improve the overall impact and sustainability of Global Fund contributions to disease-specific programmes by financing integrated and high-quality interventions that improve RMNCH outcomes. The Global Fund has developed a range of guidance documents that focus on the inclusion of RMNCH within funding proposals and contain links to the other guidance documents.2

Countries should aim to leverage the current collective impetus and funding opportunities generated by these initiatives to strengthen the linkages, integration and outcomes for RMNCH and HIV, TB and malaria. They should also utilize these opportunities for strengthening health systems and community engagement, which are essential for rights-based and successful health outcomes.

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2 Available at: http://www.theglobalfund.org/en/accessfunding/notes/
Key resources


World Health Organization (WHO). WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting.
Strengthening the inclusion of RMNCH health in concept notes to the Global Fund


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

2.1 HIV

HIV contributes both directly and indirectly to increased mortality in women and children. Recently released estimates report that HIV contributes to 24% of deaths in pregnant or postpartum women in sub-Saharan Africa. In some African countries, previously recorded declines in mortality have now been reversed by HIV. Pregnant women and mothers with HIV are at greater risk of death due to both nonpregnancy- and pregnancy-related infections before and after delivery. HIV-related stigma and discrimination further constrains access to quality services and results in the denial of women’s rights.

In addition, HIV infection affects a mother’s ability to care for her family, increasing her children’s risk of death, whether or not the child is living with HIV. 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. However, recent reports show that child mortality can be significantly reduced when primary health care services coordinate and deliver effective antiretroviral (ARV) interventions that can decrease HIV transmission to infants and support mothers to breastfeed correctly.

HIV is estimated to be directly responsible for 12–15% of all child mortality, and up to 35% of child mortality in the southern African countries that have a high burden of HIV. In nine countries in southern Africa, at least 1 young person in 20 is living with HIV, and in Botswana, Lesotho and Swaziland, more than 1 in 10 young people are living with HIV. Southern Africa accounts for about 85% of all HIV transmission in both women and children. Africa is home to 21% of all children under the age of five years, but 47% of all deaths in children under five occur in Africa.

Cervical cancer is also crucial to consider in women infected with HIV. Women with HIV have a higher risk of having persistent HPV infections, and a higher risk of developing pre-cancer. In addition, women with HIV are more likely to develop cervical cancer earlier and to die sooner from it. Because they develop pre-cancer at a younger age and the time for pre-cancer to progress to cancer can be shorter, women with HIV are advised to follow a different screening schedule: after a negative screening test result, they should be re-screened within three years.

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7 UNICEF analysis based on estimates of the number of young people aged 15–24 living with HIV in 2008 and age-specific population estimates.
WHO new recommendations for cervical cancer screening states that screening for cervical pre-cancer and cancer should be done in women and girls who have initiated sexual activity as soon as the woman or girl has tested positive for HIV, regardless of age.

Family Planning is an essential component of health care provided during the antenatal period, immediately after delivery and during the first year postpartum. Postpartum Family Planning focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. Postpartum Family Planning should be an integrated part of existing maternal and child health and family planning efforts.

Finally, addressing the epidemic of violence against women is an integral part of addressing HIV. Worldwide nearly 1 in 3 women have experienced intimate partner violence or nonpartner sexual violence in their lifetime. Evidence suggests that intimate partner violence is associated with a 1.5 fold increased risk of sexually transmitted infections (STIs), including HIV in some settings.

### 2.2 TB

Despite being preventable and curable, TB ranks as the second leading cause of death from a single infectious agent after HIV. In 2012, 2.9 million women fell ill with TB, and it claimed some 410 000 female lives worldwide. TB and HIV have a lethal synergy. At least one third of the estimated 33 million people living with HIV worldwide have a latent TB infection, which is more likely to progress to active disease because the person’s immune system is compromised. People living with HIV and infected with TB are up to 50 times more likely to develop active TB in a given year than people who are HIV-negative. HIV infection is the most potent risk factor for converting latent TB into active TB. However, the majority of people living with HIV who also have TB are unaware of their HIV status. They have not been tested for HIV and, therefore, are not accessing life-saving antiretroviral therapy (ART). Almost 90% of the HIV-associated TB deaths among women were in Africa, where TB is estimated to have claimed more female lives than male lives. Pregnant women with HIV and active TB face far higher risks of maternal and infant mortality than they would if they did not have HIV.

Undiagnosed TB in pregnancy also puts the newborn at risk for congenital TB. Increasingly, researchers have noted the emergence of perinatal TB in locations most affected by the HIV epidemic. Some studies suggest that TB in pregnant women with HIV more than doubles the risk of in-utero transmission of HIV. 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 and prevention in antenatal clinics.
In addition, extra-pulmonary TB and genital tract TB are difficult to identify and manage, and consequently they receive less attention from health-care providers, contributing significantly to maternal morbidity and infertility.

Children are also at risk of TB infection from their main caregivers, almost always women. Children with HIV tend to get more severe forms of TB and so are much more likely to become extremely ill or die of the disease. Diagnosing and treating TB in children is often very challenging. In addition, children with HIV are especially vulnerable to contracting TB if exposed to the disease, which increases the risk of child mortality. TB accounts for some 20% of all deaths in children with HIV.

2.3 Malaria

About 3.4 billion people – almost half of the world’s population – are at risk of malaria. In 2012, there were an estimated 207 million cases of malaria and 627,000 deaths. Country-level malaria estimates show that 80% of the estimated malaria deaths occur in just 17 countries, and approximately 80% of the estimated cases occur in 18 countries. Children under five are most affected and, notably, prevalence rates in children are highest among poorer populations and in rural areas. In highly endemic areas, a child under the age of five can have up to four to six febrile episodes a year, many of these due to malaria. Where malaria is highly endemic, it can account for up to 40% of outpatient attendances among children and 30% of paediatric hospital beds.

Pregnant women are also among the most vulnerable and are at high risk for malaria. The risk is even greater among pregnant women with impaired immunity due to HIV or other causes. Approximately 125 million women living in malaria-endemic countries throughout the world become pregnant every year, of whom over 30 million live in tropical areas of Africa where there is intense transmission of Plasmodium falciparum. In these areas, malaria infection directly contributes to adverse maternal and newborn outcomes, including maternal anaemia, stillbirth, spontaneous abortion, low birth weight, preterm labour and neonatal death. An estimated 10,000 women and 200,000 infants die annually as a result of malaria infection during pregnancy, and approximately 11% (120,000) of neonatal deaths are due to low birth weight resulting from Plasmodium falciparum infections in pregnancy.

Women and children combined carry a significant percentage of the malaria burden, especially in highly malaria-endemic areas. Effective preventive and curative interventions against malaria are available, and an estimated 3.3 million malaria deaths were averted between 2001 and 2012 due to the scale-up of efforts to distribute and use insecticide-treated mosquito nets (ITNs), artemisinin-combination therapies (ACTs) and rapid diagnostic tests (RDTs). Considerable gains have been achieved, and there are some important lessons emerging in key affected countries. Poor access, weakened health systems and social and economic inequities, however, continue to contribute to the high burden of disease, including an excessive number of deaths.

2.4 Health systems

Health systems strengthening (HSS) is aimed at addressing all the systemic obstacles to scaling up effective health interventions. HSS also implies creating synergies and complementarity among public health programmes and services, and preventing individual programmes and services from being planned and run separately from other related priority programmes.

Weak health systems affect access to and delivery of HIV, TB, malaria and RMNCH services to the most vulnerable groups, including women and children. Strengthening primary health care services is essential for women of childbearing age, to ensure timely access to antenatal care, family planning, cervical cancer screening and STI prevention and control, childbirth services, immunization services and support for improved infant and young child feeding (IYCF). Strengthening of emergency obstetric, neonatal and childcare services is also needed, including systems for referring urgent cases and ensuring that they are able to promptly access affordable emergency care.

2.5 Human rights and health determinants affecting women and children

Unacceptably high global rates of preventable maternal and child mortality and morbidity remain a health, development and human rights challenge. Women and children in the poorest families bear the greatest burden of poor health and death. They are more exposed to health risks and often have lower resistance to illness. Their access to health care is also limited in most developing countries.

Poverty and income inequality, gender discrimination in law and practice, and marginalization based on ethnicity, race, caste, national origin and other grounds are social determinants that affect multiple rights. Measures, therefore, are required to address the social determinants of health that affect the enjoyment of civil, political, economic, social and cultural rights for women and children. Human rights require particular attention to “vulnerable or marginalized groups.” Among other groups, this includes sex workers, women living with HIV, women living in underserved areas and other stigmatized and excluded populations.

Inequality and unfairness towards women 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 living with HIV and TB, especially when pregnant, are often further disadvantaged by stigma and discrimination associated with their medical conditions. Further, they are often denied the right to make voluntary, informed and responsible choices about their own sexual and reproductive health; for example, they may be denied care or forced to accept surgical sterilization as a condition of access to services.

Lack of equity affects women and children most when:

• they live in rural and remote areas or poorly resourced urban areas;
• they are members of minority ethnic groups, castes or religions – especially if they are also poor, lack education, experience restrictive cultural practices and/or racial discrimination;

- 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;

- they are displaced by conflict or live in conflict-affected areas;

- they are subject to sexual violence and the consequent risks of unsafe abortion and STIs, including HIV.

Women are active agents who are entitled to participate in decisions that affect their sexual and reproductive health. To be effective, participation should enable women to challenge political and other forms of exclusion that prevent them from exercising power over decisions and processes that affect their lives, including their sexual and reproductive health. However, gender inequalities continue to affect women in several ways:

- Harmful gender norms expose women to practices that adversely affect their health (e.g. child marriage, widow inheritance) and impede their access to health information and services.

- Unequal access to and control over resources can prevent women from seeking and accessing health services and can expose them to greater risks (e.g. transactional sex).

- Unequal power in intimate relationships and within families can prevent women from adopting safer health behaviours, and from making good decisions related to their own and their families’ health and well-being.

- Many women (1 in 3 women worldwide) are subjected to violence and are thus at increased risk of associated health consequences, including adverse pregnancy outcomes, induced abortion, STIs (including HIV) and mental health disorders (e.g. depression and anxiety).

The effects of the lack of equity and gender equality and the denial of women's and children's rights have many negative health consequences. Addressing issues of gender equality and health equity and removing stigma and discrimination are directly relevant to interventions aimed at improving the health of women and children and reducing high levels or mortality and morbidity, especially RMNCH interventions. Efforts to address these issues should include attention to the needs of adults and adolescents for services and education on sexuality and health, and respect for the rights of children to access the services and support they need.
Key resources


3. Added value of integrated RMNCH, disease-specific and health systems strengthening (HSS) interventions in Global Fund proposals

Under the Global Fund’s new funding model, which replaces the round-based funding mechanism, each eligible country will receive an indicative funding amount for the three-year period 2014–2016, which will contribute to covering the costs of the eligible disease-specific programmes and relevant HSS needs. Countries are encouraged to proactively identify opportunities for designing high-impact disease-specific and cross-cutting HSS interventions that positively affect RMNCH outcomes.

In order to maximize the impact of investments on reproductive, maternal, newborn and child health, each country needs to have a comprehensive understanding of the issues surrounding RMNCH, HIV, TB, malaria and health systems in the national context. Key data from national statistics authorities and other sources should be used for analysis of programmatic and funding gaps, as well as for the development of disease-specific plans and health sector strategies. In order to achieve the maximum benefit from financial and human investments, responses need to be evidence-based, effective and integrated, yet also efficient, sustainable and able to capitalize on existing health delivery mechanisms. This information should be included in the concept note. The concept note is the principal document through which a country requests new funds from the Global Fund for projects addressing any of the three diseases or for cross-cutting support for HSS under the new funding model.

3.1 Performing a situation analysis and a gap analysis

Deciding which interventions are the “best fit” to maximize outcomes within the country requires knowledge of the national context (and the subnational context, in some countries) and requires a thorough analysis of the needs and gaps related to RMNCH. As such, it is important for a country to first perform a situation analysis and then, from this, derive a gap analysis. These activities are interrelated and both are critical steps before a country develops a concept note.

The situation analysis should provide the following information:

• a summary of the RMNCH epidemiological situation;

• a summary of the disease burden, RMNCH 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 health system context as relevant for RMNCH outcomes, including a brief overview of the service delivery infrastructure, human resources and health-care financing;

• a summary of laws and policies, as applicable to RMNCH, and how these laws and policies (often restrictive and punitive measures) impact an individual’s realisation of her sexual and reproductive health;

• a summary of the past and current status of the following:
  – gender inequality, human rights and other determinants of women’s reproductive health;
  – activities currently funded from national resources with corresponding values and programme costs, and needs that are currently not funded, with information on value for money and the current national response;
activities currently funded from international resources with corresponding values and programme costs, and needs that are currently not funded, with information on value for money and the current national response.

Using the above information, a **gap analysis** should be conducted, and the results should:

- indicate specific programming strategies and criteria for prioritization;
- identify areas of existing integration and potential links;
- map out partners already supporting these areas and their respective contributions;
- identify weaknesses and bottlenecks in the health system;
- identify policy, programming and funding gaps in the country;
- identify key affected and underserved populations (such as migrants, sex workers and difficult to reach communities) as well as inequalities in service coverage (for example, whether children have the same access as adults to ART, TB or malaria interventions).

### 3.2 Choosing appropriate interventions for concept notes

Countries are encouraged to request funding for interventions that primarily benefit one or more of the three diseases but also have linkages to broader RMNCH outcomes. Such interventions may be included either within a disease-specific concept note or within a cross-cutting HSS concept note.

Countries should focus on cost-effective and evidence-based RMNCH interventions that have clear potential for synergy. They should select interventions that are most relevant and suitable for inclusion in a Global Fund concept note based on the following criteria:

- The intervention should address a problem that is amenable to improvement in a short- to medium-term time frame.
- There should be natural areas of synergy between specific interventions and routine RMNCH services.
- There should be evidence that the intervention is effective; it should be possible to assess and measure its effectiveness.
- The intervention should address not only access to commodities but also improvements in overall quality of care, especially for facility-based interventions.
- There should be complementarity; in other words, a modest investment will result in significant gains for both disease-infected populations and for the women and children living in the same communities.
- The intervention should address missing links in service delivery that are commonly described in gap analyses.

Sections 4 and 5 of this document provide guidance on interventions that have most or all of the above features. Annex 1 also provides an illustrative list of interventions for all three diseases, including potential benefits and suggestions for performing the gap analysis. Some specific interventions will, however, require other monitoring and evaluation approaches or implementation research methods to estimate their impact.
4. Developing RMNCH content in funding proposals for HIV, TB and malaria

4.1 HIV and RMNCH integration

4.1.1 Defining HIV–RMNCH interventions

Comprehensive interventions for the elimination of mother-to-child transmission of HIV (EMTCT) provide a major opportunity for improving maternal, newborn and child health. By implementing all four prongs of EMTCT as recommended in the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive (the Global Plan), there is the prospect of addressing the needs for HIV prevention, care, treatment and support of women, children, adolescents and families living with, and in communities affected by, HIV.

Primary prevention of HIV is essential for improving the lives of women and children. It is particularly important for pregnant women, who may be at double the risk of acquiring HIV. Pregnancy provides an opportunity to offer women HIV-related services, including HIV counselling and testing (HCT), which places them on the pathway for HIV prevention, treatment, care and support services. Helping women to remain HIV-negative, especially during pregnancy and breastfeeding, protects infants and children from contracting HIV by eliminating the possibility of mother-to-child transmission (MTCT).

For pregnant women with HIV, comprehensive and integrated care is essential for eliminating MTCT. WHO’s updated consolidated guidelines on the use of ARV drugs (2013) now include recommendations to provide lifelong ART to all pregnant and breastfeeding women with HIV, irrespective of CD4 cell count or clinical stage (previous WHO guidance referred to this as “Option B+”), which will boost EMTCT services and increase the likelihood that infants will remain HIV-negative. In this context, delivering and sustaining high-quality services for women will be essential for ensuring retention in care. Strong SRH services are needed to ensure no missed opportunities across the continuum of care (such as maternal health, STI prevention and control, cervical cancer screening20 and family planning/contraception – where postpartum care presents an opportune moment when women should be counselled on birth spacing and family planning services), newborn and child health clinics, as well as HIV care and treatment clinics, are all required for the delivery of continuous and comprehensive HIV prevention and treatment services. Support for

\[\text{[17]}\] The implementation framework for the Global Plan is based on the four prongs of EMTCT: (1) Primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum and postnatal care and other health and HIV service delivery points, including working with community structures; (2) Providing appropriate counselling and support to women living with HIV to enable them to make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies; (3) For pregnant women with HIV, ensure HIV testing and access to the antiretroviral drugs that will help mothers’ own health and prevent infection from being passed on to their babies during pregnancy, delivery and breastfeeding; and (4) Better integration of HIV care, treatment and support for women found to be positive and their families (http://www.emtct-iatt.org/global-plan/).


\[\text{[20]}\] Any of the following screening tests: VIA, HPV test or cytology, can be used for women with HIV, as can cryotherapy and loop electrosurgical excision procedure (LEEP) treatments (http://www.who.int/reproductivehealth/publications/cancers/screening_and_treatment_of_precancerous_lesions/en/).
integrating these groups of services can be included as part of cross-cutting HSS concept notes (e.g. developing a human resources capacity-building plan, strengthening procurement and supply chain management systems, and integrating laboratory capacity) or as a core part of activities in disease-specific concepts note for HIV, depending on the country context, priorities and strategies.

By strengthening RMNCH platforms, the integration of other related services will also be improved. There is an important opportunity for increasing synergy by integrating other interventions with HIV and pregnancy services. For example, syphilis testing can be performed during an antenatal care (ANC) visit for all woman. The identification and treatment of syphilis in a pregnant woman is an important HIV prevention intervention because a pregnant woman living with HIV who also has syphilis is twice as likely to transmit HIV to her baby as a pregnant woman living with HIV who doesn’t have syphilis. Furthermore, a syphilis diagnosis is an opportunity to engage male partners in both HIV and syphilis prevention and care interventions.

During labour, delivery, the first 24 hours and the first week postpartum, mothers and their newborns are especially vulnerable to complications of childbirth and, for women living with HIV, mother-to-child transmission of HIV. Global Fund financing can be used to promote and expand access to skilled birth attendants and facilities equipped to ensure safe delivery and provide postnatal care, including ARV medicines if needed, and support for the initiation of breastfeeding within an hour of delivery and postnatal home visits. Absence of postnatal care services contribute significantly to the lower uptake of important subsequent services, including access to family planning, early infant diagnosis (EID), co-trimoxazole prophylaxis, cervical cancer screening, HIV screening, STI prevention and control and early ARV treatment for infants and their mothers when needed.

Global Fund finances can also support improved infant feeding practices. The key principles and recommendations state that women attending ANC should be advised on infant feeding practices and any associated issues regarding the use of ARV medicines, and women should be supported on these issues after delivery through the maternal and child health services. Mothers living with HIV should be counselled on the effectiveness of ARV interventions to reduce postnatal MTCT and how breastfeeding can improve the chances for HIV-exposed infants to survive while remaining HIV-free. Countries can ask for Global Fund support to simplify their messages about infant feeding and to strengthen the support provided in the context of ANC.

Finally, family planning and contraceptive use have an important role in the prevention of unintended pregnancies among women living with HIV, so support for these interventions should be included in Global Fund concept notes as well. Reducing unintended pregnancies will reduce the number of complicated pregnancies and unsafe abortions, as well as the number of children who could potentially be infected with HIV.

All four prongs of the Global Plan’s comprehensive EMTCT need to take into account and address gender inequalities as a central aspect of any component intervention. Specifically, it is important to integrate and address gender-based violence (GBV) faced by women in the context of HCT, disclosure of HIV status, risk-reduction counselling, and efforts to promote treatment uptake and adherence. The evidence is increasing that GBV undermines women’s ability to reduce risk and to access services because it can be a barrier to disclosure of HIV status since this disclosure may jeopardize the safety of a woman who is in a violent relationship. According to WHO guidelines, providers need to be trained to: understand the nature and health consequences of GBV;

identify women who are experiencing GBV; provide first-line support that includes assessing and promoting women’s safety (particularly in the context of disclosure of HIV status); provide relevant clinical care, including acute post-rape care and psychological support (i.e. mental health assessment and basic stress management in accordance with WHO mhGAP guidelines); and provide referrals to other services for health, social and legal support. 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 (including safer sex), improve access to and utilization of SRH services (including contraception, HCT and ART), and support women in disclosure of their HIV status.

EMTCT services should also include men’s health education and access to SRH services and family planning, as well as support and promotion of gender-equitable decision-making for EMTCT-related behaviours. This should include efforts to work with men and boys and wider communities to promote gender equality. This requires an approach that identifies and capitalizes on existing strengths and opportunities in addition to strengthening HIV-specific services. RMNCH programmes have struggled with how to constructively engage men. Research shows that including the male partner in HIV counselling and testing reduces HIV incidence by half, because it identifies serodiscordance. HCT for couples is also associated with halving the risk of MTCT compared with HCT for pregnant women who do not come in with their partner. Welcoming fathers at ANC visits also improves HIV-free child survival by almost 60% because fathers who come to ANC are concerned enough to remain engaged beyond childbirth.

In addition to strengthening EMTCT interventions, efforts to treat new and existing paediatric HIV infections can also supported by the Global Fund. UNAIDS estimates that children are only half as likely as adults to receive ART. Thus, while ART for children is expanding, it is making only half as much progress as ART for adults. In the Global Plan countries, only one out of three children needing ART is receiving it, compared to two thirds of adults. WHO’s 2013 consolidated guidelines on the use of ARV drugs call for expanded paediatric treatment, including the immediate initiation of ART for all HIV-infected children under five years of age, irrespective of CD4 count. ART should be initiated and maintained in RMNCH settings, with links and referrals to other HIV care and support services where appropriate.

WHO’s 2013 consolidated guidelines on the use of ARV drugs also provide recommendations on how to optimize and simplify the use of ARV drugs and how to use innovative approaches to eliminate existing barriers to initiation of treatment for children. The release of these guidelines, as well as the increasing political commitment to the paediatric HIV agenda, have created a momentum to reverse the unacceptably low rates of ART use in children. Integrating HIV-related screening and services into a wider range of child health, community and support services, particularly at the local level, will be very important for identifying HIV-exposed and HIV-infected children, and retaining them in care as needed. As part of efforts under the Global Plan, and aligned with the declaration at the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria, a Framework for Action on the “Double Dividend” was launched at the International Conference on AIDS and STIs in Africa (ICASA) in 2013 to accelerate action to address these challenges, and in support of the dual goals of improving child survival and accelerating access to treatment, care and support for these children.


4.1.2 Key interventions for inclusion of RMNCH in HIV concept notes

Table 1 provides an illustrative list of RMNCH interventions that can be included in HIV concept notes to the Global Fund. These interventions support the implementation of WHO’s 2013 consolidated guidelines on the use of ARV drugs, WHO’s guidelines on HIV and infant feeding,24 and the Preventing HIV and Unintended Pregnancies Strategic Framework 2011–2015 of the Interagency Task Team (IATT) on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children (2012).25 Collectively these interventions contribute to achieving the fullest health benefits for women living with HIV and their children.

**Table 1: Synergistic interventions to support HIV–RMNCH integration**

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Importance for HIV prevention and care for women and children living with and affected by HIV</th>
<th>Benefit for women and children in general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint HIV and RMNCH planning; coordination and revision of:</td>
<td>• Strengthens and influences programme planning at the national level and in decentralized regions</td>
<td>• Strengthens RMNCH planning and programming, including integrated and quality service delivery in all settings for improved survival for women, adolescents and children</td>
</tr>
<tr>
<td>• evidence-based policies for EMTCT of HIV and syphilis, and</td>
<td>• Supports scale-up of comprehensive and sustainable HIV prevention, treatment and care for women and children</td>
<td></td>
</tr>
<tr>
<td>• policies for women, adolescents and children related to HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community engagement with policy-making and programme planning, including people living with HIV and from key affected populations</td>
<td>• Improved acceptability and uptake of all HIV interventions</td>
<td>• Improved care seeking practices, including early ANC attendance and postnatal follow-up</td>
</tr>
<tr>
<td></td>
<td>• Increased involvement of communities and people affected by or living with HIV</td>
<td>• Reduced stigma and discrimination</td>
</tr>
<tr>
<td>Improve access to and quality of family planning services for women living with HIV, including contraception, safe abortion and safe conception for serodiscordant couples</td>
<td>• Fewer unintended pregnancies</td>
<td>• Fewer unintended pregnancies</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of planned pregnancies including initiation of antiretroviral therapy (ART) preconception or early in pregnancy</td>
<td>• Improved capacity to negotiate use of contraceptives</td>
</tr>
<tr>
<td></td>
<td>• Increased acceptability and use of condoms for dual protection</td>
<td>• Primary prevention of HIV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Healthier conception</td>
</tr>
<tr>
<td>Children and adolescents need age and developmentally appropriate education and counselling on their emerging sexuality/reproduction and on sexual and reproductive health – starting early at home, at school and when required at health facilities</td>
<td>• Fewer unintended pregnancies and sexually transmitted infections (STIs)</td>
<td>• Fewer unintended pregnancies and STIs</td>
</tr>
<tr>
<td></td>
<td>• Increased access to condoms</td>
<td>• Improved management of sexual concerns</td>
</tr>
<tr>
<td></td>
<td>• Improved management of sexual concerns</td>
<td>• Improved support for women’s well-being in primary health care and sexual and reproductive health (SRH) care settings</td>
</tr>
<tr>
<td></td>
<td>• Improved support for women’s well-being in primary health care and sexual and reproductive health (SRH) care settings</td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>Interventions</th>
<th>Importance for HIV prevention and care for women and children living with and affected by HIV</th>
<th>Benefit for women and children in general population</th>
</tr>
</thead>
</table>
| Improve HIV counselling and testing (HCT) including of partners within SRH services; components should include: repeat testing, couples counselling, counselling of discordant couples, and treatment as prevention (i.e. treatment of the HIV-positive partner to prevent transmission to the HIV-negative partner, and/or to prevent mother-to-child transmission [MTCT]) | • More men understand the importance of HIV prevention within relationships, and understand women’s roles and rights  
• Improved access to care and counselling which supports the prevention of HIV transmission in discordant couples | • Reduced risk of HIV transmission to women in relationships and consequent reduced risk of MTCT of HIV                                           |
| Improve and expand the areas of adolescents to quality sexuality education and SRH services | • Improved health and prevention of new HIV infections and other STIs in adolescents                                                                                                              | • Improved primary prevention of HIV and other STIs among adolescents                                                                   |
| Improve access to and quality of ANC, including HIV Counseling and Testing, blood safety and anaemia prevention to reduce blood-related transmission, and syphilis testing and treatment | • More women and partners know their HIV status and can start earlier on improved ARV regimens for EMTCT and lifelong ART  
• Improved prevention and treatment of syphilis in women and children (syphilis increases the risk of HIV transmission) | • Improved coverage and quality of services along the RMNCH life-cycle continuum of care  
• Increased and improved childbirth services at healthcare facilities  
• Improved maternal and neonatal outcomes, including decreases in stillbirth, neonatal mortality and congenital syphilis |
| Integrate identification of gender-based violence (GBV) and provision of medical and psychological care for survivors of GBV into SRH services, including ANC, in accordance with WHO guidelines | • Improved pregnancy outcomes for women  
• By facilitating disclosure of GBV experience and HIV status, more women can receive help to access STI and HIV post-exposure prophylaxis, and referral services | • Improved quality of SRH services, including ANC services  
• Improved EMTCT and pregnancy outcomes  
• Improved access for women to other supportive care, including mental health and psychological care and support. |
| Strengthen obstetric and newborn care at health-care facilities                | • Opportunity for HCT, including retesting as needed  
• Safer childbirth practices  
• Improved early resuscitation and care for newborns                                                                                   | • Reduced obstetric complications  
• Reduced maternal and newborn complications and deaths                                                                                   |
Interventions | Importance for HIV prevention and care for women and children living with and affected by HIV | Benefit for women and children in general population
--- | --- | ---
Promote early postnatal visits for mothers and infants | • Improved ART adherence  
• Improved 6 week immunization attendance, early infant HIV diagnosis and co-trimoxazole prophylaxis  
• More timely assessment and treatment of postpartum maternal sepsis  
• Improved birth spacing and fewer unintended pregnancies due to provision of contraceptive information and services | • Improved immunization coverage and growth monitoring up to 3 months for all infants (including HIV-exposed infants)  
• More timely assessment and treatment of postpartum maternal sepsis  
• Improved birth spacing and fewer unintended pregnancies due to provision of contraceptive information and services |
Joint support for ARV prophylaxis and infant feeding counselling | • Improved rates of initiation of and adherence to ARV prophylaxis to prevent transmission of HIV during breastfeeding  
• Improved rates of early initiation of exclusive breastfeeding | • Improved early infant feeding practices |
Pre- and in-service training and retraining on integrated RMNCH and HIV prevention, care and treatment and addressing GBV | • Improved knowledge of all HIV-related interventions for EMTCT and care of women and children living with HIV | • Improved management of health services for all women and children, including cases of GBV |
Education of community health workers and community involvement to increase awareness of the links between HIV and RMNCH | • Improved knowledge and dissemination of HIV-related information and care | • Improved RMNCH preventive and curative care in the community |


### 4.1.3 Examples

It is important to note that programmes aimed at improving HIV and RMNCH outcomes will also contribute to HSS and the benefits will extend across the three diseases and wider health services. A good example of this is South Africa’s HIV Round 9. The EMTCT component of this proposal includes all four prongs with the following activities: provision of condoms, family planning services, safer sex counselling, HIV Counselling and Testing for pregnant women and their partners during ANC, provision of ARV medicines, nutritional support and infant feeding advice to pregnant women living with HIV, in addition to training patient supporters to promote adherence to ART, and identification of women experiencing GBV and improving referrals to community-based organizations. The proposal also includes funding for the provision of youth-friendly integrated HCT, STI screening and contraceptive services, as well as forensic medical exams, post-exposure prophylaxis and psychosocial and legal support for women survivors of sexual violence.

Another example is Eritrea’s HIV Round 8. This proposal includes a range of activities to protect women against GBV and create a supportive environment, including training sessions for women’s peer groups and support for income-generation activities. The proposal also includes funding for the provision of STI screening with HCT in the context of ANC, as well as for life skills education for young people, including information about sexual health.
Key resources


4.2 Tuberculosis and RMNCH integration

4.2.1 Defining TB–RMNCH interventions

Comprehensive interventions for prevention and management of TB in women and children are based on client-centred, nonvertical approaches that offer the best opportunities for maximizing improvements in maternal, newborn and child health and survival. These interventions include components aimed at TB prevention, detection and subsequent treatment and support, combined with opportunities to make links with SRH and HIV prevention services, in addition to health education on self-care for women who have TB as well as those who don’t. The benefits of these interventions also reach their infants and families in communities affected by high TB prevalence.

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 having poor access to health services, making them particularly vulnerable to poorer outcomes associated with undetected or late detection of HIV and TB disease. Providing TB screening, prevention and care services during ANC visits is crucial because pregnant women with HIV and active TB face far higher risks of maternal mortality and their infants face higher risks of infant mortality.

4.2.2 Key interventions for inclusion of RMNCH in TB concept notes

Table 2 provides an illustrative list of TB interventions and RMNCH activities that can be supported by the Global Fund.

Table 2: Synergistic interventions to support TB–RMNCH integration

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Importance for prevention and care of TB for women and children with TB</th>
<th>Benefit for women and children in general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint planning and revision of evidence-based policies for TB prevention, diagnosis and care in women and children</td>
<td>• Strengthens national, subnational and service-level planning for integrated TB–RMNCH programmes, in support of efforts to scale up TB prevention, treatment and care for women and children</td>
<td>• Strengthens national and subnational planning for integrated TB–RMNCH programmes, which will improve health and survival for women and children</td>
</tr>
<tr>
<td>Routine TB symptom screening among women with HIV at each visit for RMNCH services; those who do not have a current cough, fever, weight loss or night sweats are unlikely to have active TB</td>
<td>• Improved rate of early TB case detection among women with HIV; these services also determine eligibility for isoniazid preventive therapy (IPT)</td>
<td>• Enhanced case detection</td>
</tr>
<tr>
<td>Provision of at least 6 months of IPT to women living with HIV in whom active TB is ruled out</td>
<td>• Improved TB prevention for women and children</td>
<td>• Improved TB prevention for women and children • Reduces the risk of TB in people living with HIV</td>
</tr>
<tr>
<td>Interventions</td>
<td>Importance for prevention and care of TB for women and children with TB</td>
<td>Benefit for women and children in general population</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Ensure early TB diagnosis and treatment during ANC services for pregnant women who have signs or symptoms of TB; for women living with HIV or at risk of multidrug resistant TB, the first diagnostic test should be Expert MTB/RIF<sup>a</sup> | • More TB cases among women diagnosed, treated and cured  
• Reduced risk of congenital TB  
• Reduced risk of mother-to-child transmission of HIV if the pregnant woman is living with HIV | • Reduced risk of TB transmission to the family and within the community                                      |
| Improved case management of TB in children, including TB screening for any child who has had contact with TB-positive patients, and referral for TB services as needed | • More TB cases in children diagnosed, treated and cured  
• Better survival for children with TB | • Effective and efficient healthcare services for children                                                 |
| Provision of IPT for all children under the age of 5 years and all children of any age living with HIV if they are household contacts of a TB case AND do not have any signs or symptoms of TB<sup>b</sup> | • Reduced risk that children receiving IPT will develop TB | • Reduced morbidity and mortality among children                                                              |
| Provision of a single dose of BCG vaccine for all infants in settings were TB is highly endemic or where there is a high risk of exposure to TB.<sup>c</sup> | • Protection against the more severe types of TB such as miliary TB and TB meningitis, which are most common in young children. | • Reduced morbidity and mortality among children                                                              |
| Community-based interventions for TB through RMNCH outreach                   | • More TB cases among women and children diagnosed, treated and cured | • Improved TB notification for women and children                                                            |
| Application of the protocols for diagnosis and management of TB within SRH settings, including diagnosis and treatment of pelvic and genital TB | • Improved quality of care for women of reproductive age with TB  
• More TB cases among women, including pelvic and genital TB, diagnosed, treated and cured  
• Reduced infertility due to pelvic and genital TB | • Increased quality of TB and SRH care offered to women of reproductive age                                  |
| Pre- and in-service training and retraining on integrated RMNCH and TB management, including integrated management of childhood illness (IMCI) | • More TB cases among women and children diagnosed, treated and cured | • Improved quality of care for women and children                                                            |
| Education of community health workers and community involvement to increase awareness of the links between TB and RMNCH | • Decreased stigma | • Improved care seeking practices among women and children with concerns about TB and/or RMNCH  
• Improved acceptability and uptake of TB interventions – prevention, care, treatment and support |
For contact investigation and management of children, priority should be given to: children under 5 years of age; children with known or suspected immunocompromising conditions (especially those living with HIV); and child contacts of index cases with multi-drug resistant or extensively drug-resistant TB (proven or suspected). Children under 5 years of age who are household or close contacts of people with TB and who, after an appropriate clinical evaluation, are found not to have active TB should be given 6 months of IPT. The recommended dose is 10 mg/kg per day (range 7–15 mg/kg), for a maximum dose of 300 mg/day.

In children who are known to be HIV-infected, BCG vaccine should not be given. In infants whose status is unknown and who are born to HIV-positive mothers and who lack symptoms suggestive of HIV, BCG vaccine should be given after considering local factors.

4.2.3 Examples

The following are two examples of how the Global Fund has supported TB–RMNCH activities. In Kenya, the Global Fund has provided funding for the integration of TB screening into EMTCT programmes, which also brings the benefits of integrated TB–ANC services, since EMTCT and TB services have increasingly been integrated into ANC clinics. In Lesotho, the Global Fund has supported intensified case-finding at relevant service points, including integrated EMTCT–ANC settings, and also supports training for village health workers to conduct symptomatic TB screening, including for pregnant women.
Key resources


4.3 Malaria and RMNCH integration

4.3.1 Defining malaria–RMNCH interventions

There are several well-documented malaria prevention interventions that can be successfully implemented through existing RMNCH platforms for the prevention of malaria in pregnant women and in children. These include the distribution and use of insecticide-treated mosquito nets (ITNs), the provision of intermittent preventive treatment in pregnancy (IPTp),26 the provision of intermittent preventive treatment in infancy (IPTi) and seasonal malaria chemoprevention (SMC). Likewise, interventions for the treatment of malaria in pregnant women and children, including prompt and appropriate case management, can also be successfully implemented through existing RMNCH services.

Three strategic RMNCH service delivery platforms that can be used to accelerate malaria prevention and treatment interventions have been identified and can be included as part of cross-cutting HSS concept notes or as a core part of activities in disease-specific concept notes for malaria, depending on the country context, priorities and strategies for malaria prevention and treatment. These three RMNCH service delivery platforms are as follows:

- **Integrated community case management (iCCM):** One of the strongest opportunities to use Global Fund financing to support RMNCH activities relates to iCCM. Many countries are now seeing a reduction in the percentage of fevers that are due to malaria, as a result of increased and sustained malaria control activities. Instead, they are facing the issue of how to manage non-malaria febrile cases (after negative results on RDTs), many of which are due to pneumonia. Delivering interventions for the three diseases together (diarrhoea, pneumonia and malaria) has been shown to improve the timeliness, quality and efficiency of treatment for childhood illnesses.

- **Expanded Programme on Immunization (EPI):** Immunizations constitute the single most important point of contact of children under the age of five with the health system. Effective integration of malaria interventions, such as ITN distribution, with routine immunization services could significantly increase coverage and have a positive overall impact on child health outcomes.

- **Antenatal care (ANC):** To achieve the full life-saving potential of ANC, at least four visits and a package of proven high-impact interventions – including the three-prongs of malaria-in-pregnancy (MiP) activities (i.e. ITN distribution, IPTp and case management) – are required. ANC service delivery must be expanded and strengthened to ensure that pregnant women have sufficient access to malaria protection and treatment. The impact of these MiP interventions is further increased when complementary interventions are provided during ANC for the prevention and treatment of anaemia.

4.3.2 Key interventions for inclusion of RMNCH in malaria concept notes

Table 3 provides an illustrative list of malaria interventions and RMNCH activities that can be supported by the Global Fund with the potential to improve the health outcomes of women and children. The table also indicates the importance of each intervention for prevention and care of malaria, and the benefit for women and children in the general population.

26 WHO recommends IPTp with sulfadoxine-pyrimethamine (IPTp-SP) in all areas of Africa with moderate to high malaria transmission. As of October 2012, WHO recommends that SP be given to all pregnant women at each scheduled ANC visit, starting as early as possible in the second trimester until the time of delivery, provided that the doses are at least one month apart.
Table 3: Synergistic interventions to support malaria–RMNCH integration

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Importance for prevention and care of malaria for women and children with malaria</th>
<th>Benefit for women and children in general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint malaria and RMNCH planning and harmonization of evidence-based policies and national-level guidelines and standards of care for women and children, with consideration also for integration of HIV and/or TB programmes</td>
<td>• Strengthens national- and subnational-level planning for integrated malaria–RMNCH programmes, in support of efforts to scale up malaria prevention, treatment and care for women and children</td>
<td>• Strengthens national- and subnational-level planning for integrated malaria–RMNCH programmes, which will improve health and survival for women and children</td>
</tr>
<tr>
<td>Application of integrated malaria protocols in ANC and child health services (e.g. IMCI, iCCM, three-prongs of MiP)</td>
<td>• More malaria cases in women and children promptly diagnosed and accurately treated</td>
<td>• Improved quality of management and care within ANC and child health services, and improved access</td>
</tr>
<tr>
<td></td>
<td>• More women with malaria know about prevention measures for their families and communities</td>
<td>• More women and children in the community know about malaria prevention measures for themselves and their families and communities</td>
</tr>
<tr>
<td></td>
<td>• Fewer low-birth-weight infants, preterm births and infant deaths</td>
<td>• Improved case management of other major childhood illnesses such as diarrhoea and pneumonia, leading to progress towards achieving MDGs 4 and 5</td>
</tr>
<tr>
<td>Provision of an integrated package of interventions to prevent and address the causes of anaemia during pregnancy</td>
<td>• Fewer complications arising from malaria during pregnancy</td>
<td>• Fewer cases of severe maternal anaemia and related mortality</td>
</tr>
<tr>
<td>Provision of basic supplies for prevention, diagnosis and treatment algorithms used for IMCI, including:</td>
<td>• Improved (regular and uninterrupted) access to preventive measures for women and children</td>
<td>• Increased community trust in services, and healthier community</td>
</tr>
<tr>
<td>• rapid diagnostic tests (RDTs) for malaria</td>
<td>• More reliable and faster diagnostic testing available for women and children with fever</td>
<td>• Improved quality of prevention, diagnosis and care offered to women and children attending RMNCH facilities at the primary care level</td>
</tr>
<tr>
<td>• artemisinin-based combination therapy (ACT)</td>
<td>• Improved access to malaria diagnostic services by making these available in the community and at the primary care level</td>
<td>• Improved case management and treatment of other major childhood illnesses such as diarrhoea and pneumonia by leveraging complimentary and additional funding from donors other than the Global Fund</td>
</tr>
<tr>
<td>• sulfadoxine-pyrimethamine (SP)</td>
<td>• Improved (regular and uninterrupted) access to prompt and appropriate treatment with quality-assured medicines for women and children with malaria</td>
<td></td>
</tr>
<tr>
<td>• insecticide-treated mosquito nets (ITNs)</td>
<td>• Oral rehydration salts (ORS) and zinc for diarrhoea</td>
<td></td>
</tr>
<tr>
<td>• antibiotics and respiratory timers for pneumonia</td>
<td></td>
<td>• Improved case management of other major childhood illnesses such as diarrhoea and pneumonia by leveraging complimentary and additional funding from donors other than the Global Fund</td>
</tr>
<tr>
<td>• Support for development of human resources for health through pre- and in-service training and retraining</td>
<td>• Improved quality of care for women and children</td>
<td>• Access to quality care provided by competent human resources</td>
</tr>
<tr>
<td></td>
<td>• Improved competence of human resources</td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>Importance for prevention and care of malaria for women and children with malaria</td>
<td>Benefit for women and children in general population</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Education of community health workers and community involvement to increase awareness of the links between malaria and RMNCH</td>
<td>• Fewer malaria cases and decreased severity of cases</td>
<td>• Improved care seeking practices for symptoms of malaria</td>
</tr>
<tr>
<td></td>
<td>• Improved quality of care</td>
<td>• Improved quality of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improved acceptability and uptake of malaria prevention</td>
</tr>
</tbody>
</table>

### 4.3.3 Examples

Tanzania’s Malaria Round 7 complimented its Round 4 programme by increasing access to ACTs and improving the quality of care for children in over 160 hospitals and 100 health centres through implementation of integrated management of childhood illness (IMCI) training and addressing quality of care in general. Hospital staff have been trained in emergency triage and treatment, and hospitals have been equipped for management of severely ill children. This has not only benefited patients with severe malaria but all severely ill patients in general.

Rwanda and Kenya have also been able to use Global Fund support to train primary-level health workers in IMCI in order to improve malaria case management and assessment of HIV/AIDS among children at the primary health care level.

In addition, Global Fund investments to date have also played an important role in supporting iCCM. For example, funding from Ethiopia’s Malaria Round 5 was used to deploy over 30 000 community health extension workers who support not only HIV, TB and malaria services, but also iCCM for malaria, pneumonia and diarrhoea, especially in rural areas.
Key resources


5. Developing RMNCH content in health systems strengthening (HSS) investments

5.1 Rationale

Strong health systems are a prerequisite for effectively improving health outcomes, rather than a “spill-over effect” of disease control efforts. Evidence indicates that in spite of the availability of interventions that can effectively address health problems of women and children, a weak and fragmented health system environment is often a major bottleneck to successful implementation of these interventions. Health systems in many low-resource settings are unable to deliver the volume and the quality of services that are needed, and are unable 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 while ensuring that there is complementarity and synergy among the programmes, including sharing of resources and inputs.\(^{27}\) With support from the Global Fund, HSS programming can be a shared pathway that benefits key priority areas while improving overall delivery of health care. HSS objectives that contribute to better RMNCH outcomes can be achieved through a wide range of health systems interventions.

5.2 A new approach to funding HSS

The Global Fund’s investments in HSS are synergistic with its core investments in HIV, TB and malaria programmes. While disease-specific grants provide preventive, diagnostic, treatment, care and support services, HSS investments contribute to addressing health system constraints that hinder the effective and efficient delivery of the programmes for each disease.

Under the Global Fund’s new funding model, each eligible country will receive an indicative funding amount for the three-year period 2014–2016, which will contribute to covering the costs of the eligible disease-specific programmes and relevant HSS needs. Recognizing the important catalytic role of the health system in optimizing HIV, TB and malaria outcomes, the Global Fund encourages countries to allocate a portion of their funding envelope for HSS, based on robust analytical assessment of existing health system constraints.

In the previous rounds-based funding system, the Global Fund distinguished between disease-specific HSS and cross-cutting HSS interventions. Under the new funding model, however, the notion of disease-specific HSS has been abolished. The Global Fund’s support for HSS is now dedicated to cross-cutting interventions that contribute to strengthening the performance of health system functions and that benefit more than one disease programme (including HIV, TB, malaria and beyond).

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\(^{27}\) WHO’s 2007 framework document on strengthening health systems proposed a practical way to organize health systems into six 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. See: Everybody’s business: strengthening health systems to improve health outcomes: WHO’s framework for action. Geneva: World Health Organization; 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 13 March 2014).
5.3 Defining RMNCH interventions in HSS concept notes

Strategic use of Global Fund financing for HSS should aim to foster cohesive programming and appropriate inclusion of RMNCH interventions within HIV, TB and malaria services and vice versa. This specifically includes antenatal care (ANC), childbirth, postpartum care, family planning and preventive and curative care for newborns and children, as well as medical and psychological care for survivors of gender-based violence, aiming to ensure that all these services are more client-centred and that they address the needs of women and children in a more holistic, accessible and user-friendly manner.

There are substantial negative consequences when diseases are managed in separate, vertical programmes. This is particularly the case when a combination of HIV–TB or HIV–malaria is present during pregnancy. Living with more than one of these conditions has an exponential effect on the probability of poor health outcomes for women and children. Strengthened, integrated health systems that support the continuum of care should be used to address these and other disease combinations as part of the continuum of maternal and child health care.

While HSS objectives related to improving RMNCH outcomes are specific to the country context and should be based on a robust situation analysis, overall it is important to create operational synergies between the different programmes and services that the health system is meant to deliver, and to address health system weaknesses in order to support the scale-up and increased impact of RMNCH interventions.

Under the new funding model, the Global Fund is prioritizing five specific components of the health system for investment: procurement and supply chain management; health management information systems (HMIS); health workforce; service delivery; and financial management. There are many opportunities to link high-impact RMNCH interventions with HIV, TB and malaria programmes through cross-cutting HSS support in these areas.

Following are descriptions of interventions that can be considered for inclusion in Global Fund HSS proposals. When considering these interventions and preparing the concept note, both the explicit link to HIV, TB and/or malaria control activities and the potential impact on health outcomes for women and children should be described. A brief relevant example of activities funded by the Global Fund is provided for each intervention.

**Service delivery:** Services should be continuously available and accessible, including emergency services, and they should be appropriate to the communities and contexts in which they are provided. To ensure this, it may be necessary to improve service delivery platforms with added capacity to integrate HIV, TB, malaria services into primary care, and to improve referrals to and coordination with other services (both within and outside the health system) to improve women's access to comprehensive care and support. In particular, strengthening the platform of ANC as part of HSS proposals should be prioritized. ANC visits provide a unique opportunity for the delivery of a comprehensive RMNCH services, including EMTCT, prevention of maternal and neonatal tetanus, prevention of congenital syphilis, prevention and case management of malaria in pregnancy and prevention of maternal anaemia and malnutrition. Inadequate care and/or a poor patient–provider relationship during the prenatal period can have a negative impact on the continuum of care during childbirth and the postnatal period and can adversely affect mothers, newborns and children.

- In Nigeria, the Global Fund has recently started supporting a government assessment of rural primary care centres and ANC facilities to identify sites where integration of EMTCT is feasible.
**Infrastructure, equipment and supplies:** Optimal delivery of certain services – such as ANC and treatment of malaria, HIV, TB and other illnesses affecting women, newborns and children – require the availability of basic infrastructure, medical equipment and essential commodities (including medicines). Therefore, it may be necessary to build an integrated and effective supply chain to support improved service delivery. Interventions to be considered for Global Fund proposals can include, but should not be limited to: strengthening of the supply chain, particularly the “last mile/kilometre” of the supply chain, to ensure reliable availability of essential commodities at the point of treatment (i.e. at the community level) and establishment or strengthening of supporting systems for procurement and replenishment of equipment and supplies, such as solar systems, bicycles, test kits, job aids and decision support items (e.g. educational materials, registers and referral cards). If included, the applicant should explain specifically how these infrastructure, equipment and commodities would contribute to improving disease-specific and RMNCH outcomes.

- Procurement and supply chains are integrated in Kenya across diseases through the Kenya Medical Supplies Agency (KEMSA). The Global Fund has supported KEMSA by funding the rental of storage facilities and procurement of containers, benefitting both disease-specific and broader RMNCH interventions.

**Human resources for health:** Availability of skilled and motivated front-line staff (e.g. community health workers and supervisors) is essential for effective delivery of RMNCH services, particularly for populations without easy access to health-care facilities. Ensuring continuous access to appropriate services may thus require strengthening human resources for RMNCH by building health workers’ capacity. Interventions to be considered for Global Fund proposals can include, but should not be limited to: baseline assessment of competencies, identification of gaps that need to be addressed through capacity-building, hiring and remuneration practices, motivation and training of health and community workers to build a critical mass for service delivery, particularly in geographic and programmatic areas that are most underserved.

- Ethiopia uses Global Fund support to fund malaria and HIV–TB modules of the 28-day Integrated Refresher Training for Health Extension Workers to provide training on basic preventive and treatment services for malaria, TB and HIV, as well as immunization, nutrition and iCCM issues. Part of the funding for the malaria module is used for iCCM training. Additional RMNCH-related components are funded by the Ethiopian Government.

**Supervision:** On-the-job support of service providers through supervision is important to ensure that staff training is up to date and to keep staff interested and motivated, as well as to monitor performance and maintain quality of care. Interventions to be considered for Global Fund proposals can include, but should not be limited to: hiring supervisors and purchasing equipment such as motorcycles for supervision of community health workers in remote villages. If included, the applicant should explain specifically how the additional personnel and equipment would contribute to improving disease-specific and RMNCH outcomes.

- In Lesotho, the Global Fund has provided financial support for the establishment of district-level joint supervisory and monitoring teams to conduct integrated supervision. In addition, the Global Fund has funded mentoring programmes for health-care providers (especially nurses) to assist them in provision of integrated services, including EMTCT. This mentoring includes supportive supervision to ensure that protocols and standard operating procedures are implemented.

**Monitoring and strategic information:** Regular review of data with key public, private and civil society stakeholders is essential to foster a culture of accountability as well as to make best use of
the data for timely local decision-making. Strengthening of the health information and monitoring and evaluation (M&E) systems may be needed. Interventions to be considered for Global Fund proposals can include, but should not be limited to: improvement of community monitoring systems and vital registration systems, integration of information/data into HMIS, assessment and improvement of data quality, recruitment and remuneration of data clerks, monitoring meetings of stakeholders and management teams, and performance-based incentives to reward staff for good performance. Innovations such as mHealth technologies can also be included, if the planned usage is based on relevant evidence and if effective implementation can be assured, in addition to appropriate scale-up plans for the introduction of the technology.

- In Ghana, the Global Fund supports the District Health Information Management System (DHMIS), an online data management system that allows unified reporting of routine health information, including RMNCH outcomes. The system is currently still at the pilot stage, but there are indications that use of the DHMIS has already improved the flow of information.

**Demand creation and behaviour change:** It is critical to understand and address barriers to demand for health services in order to ensure that key interventions and approaches undertaken are equitable, relevant and acceptable to the local community. Examples of such barriers can include: lack of knowledge, financial constraints, opportunity costs, sociocultural norms, beliefs about the etiology of disease, limited autonomy for decision-making, women’s lack of agency, and the perceived acceptability and/or benefit of an intervention. Activities to be considered for Global Fund proposals can include, but should not be limited to: qualitative and quantitative assessments of the most relevant demand-side barriers (e.g. through focus group discussions and/or household surveys), and collaborative approaches to prioritize and implement solutions to address the barriers (e.g. through mass media, community mobilization and/or interpersonal communication strategies).

- The Global Fund directly supports community mobilization activities to increase demand for services in Zimbabwe.

Applicants are encouraged to refer to the Global Fund’s *Information Note on Health Systems Strengthening and the Information Note on Maximizing the Impact on Reproductive, Maternal, Newborn and Child Health (RMNCH)* for more details and information on its investments in HSS and RMNCH.

### 5.4 Monitoring and evaluation for HSS and RMNCH interventions

The success of HSS interventions will be measured by how much they improve the performance of targeted health system components, as well as by their impact on health outcomes for HIV, TB, malaria and RMNCH. A set of coverage, output, outcome and impact indicators are provided in the Global Fund “modular template”, which is part of the concept note. Applicants are encouraged to refer to the Global Fund’s *Information Note on Maximizing the Impact on Reproductive, Maternal, Newborn and Child Health (RMNCH)* for more information on the modular template and recommended indicators.

Annex 1 of this Guidance Note provides an illustrative list of RMNCH interventions linked to HIV, TB and malaria programmes, with suggestions for gap analysis, and information about potential benefits and value for money. Countries are also encouraged to document best practices and consider engaging in operational research on how to best to measure the impact of HSS investments on RMNCH outcomes.
Key resources


6. Additional resources for concept note development and programme implementation

**WHO Departments/Programmes:**

- Global Malaria Programme: [www.who.int/malaria](http://www.who.int/malaria)
- Sexual and Reproductive Health: [http://www.who.int/reproductivehealth/topics/en/](http://www.who.int/reproductivehealth/topics/en/)

**Global or interagency partnership programmes:**

- Roll Back Malaria Partnership – Toolbox: [http://rbm.who.int/toolbox/](http://rbm.who.int/toolbox/)
- Stop TB: [http://www.stoptb.org](http://www.stoptb.org)
- The Partnership for Maternal, Newborn and Child Health: [http://www.who.int/pmnch/topics/en/](http://www.who.int/pmnch/topics/en/)
- Every Women, Every Child: [http://www.everywomaneverychild.org](http://www.everywomaneverychild.org)

**UNAIDS Technical Support Facilities:**

- Southeast Asia and the Pacific: [http://www.tsfseap.org/](http://www.tsfseap.org/)
- South Asia: [http://tsfsouthasia.org/](http://tsfsouthasia.org/)

**Resources for civil society partners:**

- Civil Society Action Team (CSAT) – Resource Library: [http://www.csactionteam.org/?Resources=1](http://www.csactionteam.org/?Resources=1)
Annex 1. Illustrative list of RMNCH interventions linked to HIV, TB and malaria programmes, with suggestions for gap analysis, potential benefits and value for money

<table>
<thead>
<tr>
<th>Interventions*</th>
<th>Gap analysis</th>
<th>Potential benefits</th>
<th>Value for money</th>
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</thead>
<tbody>
<tr>
<td>1. Antenatal care (ANC)</td>
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</table>
| Essential preventive and promotive care in pregnancy including EMTCT, MiP and referral for suspected TB cases (at health-care facility and community level) | Policies that address social, cultural and financial factors that affect access to ANC  
Nationally agreed standards and local protocols for ANC services, and timely referral and management of complications  
Services organized to ensure that ANC is provided through health-care facilities and outreach programmes  
Services are linked within an integrated health system, providing continuity with childbirth and postnatal care  
Skilled health-care professionals, counsellors and counselling tools  
Essential medicines and medical devices  
Functioning referral systems (communications, transportation)  
Adequate recording and reporting systems  
Use of data for quality improvement | Improves healthy practices and health status of individuals, families and communities  
Improves prevention and increases treatment of tetanus, syphilis and anaemia  
Increases uptake of EMTCT  
Increases uptake of IPTp and ITNs for prevention of malaria  
Increases detection and treatment of TB during pregnancy | Prevention and treatment of anaemia reduces maternal and neonatal mortality and reduces HIV transmission.  
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.  
Tetanus immunization reduces the risk of neonatal deaths from tetanus by 90%.  
Screening for pre-eclampsia reduces the risk of maternal deaths due to hypertension by 48% and neonatal deaths due to prematurity by 15%.  
IPTs and ITNs can reduce the rate of LBW by 35%, and IPTp can reduce neonatal mortality by up to 61%. |
### 2. Childbirth care (from onset of labour until 24 hours after delivery)

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<tr>
<th>Interventions</th>
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<tbody>
<tr>
<td>Essential care during childbirth from the onset of labour up to 24 hours after delivery, including promotive and preventive care</td>
<td>Nationally agreed standards and local protocols for childbirth care services and timely referral and management of complications</td>
<td>Has the potential to reduce the risks of maternal mortality and severe morbidity due to childbirth-related complications</td>
<td>Essential care during childbirth by a skilled provider increases safety for pregnant women and their babies.</td>
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<tr>
<td>Essential care for the mother and newborn immediately after childbirth</td>
<td>Policies that address social, cultural and financial barriers that affect access to care</td>
<td>Reduces newborn deaths</td>
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<tr>
<td>Early recognition and appropriate management of complications</td>
<td>Skilled health-care professionals available to provide all women with quality childbirth services, 24 hours a day, 7 days a week</td>
<td>Reduces risks of postpartum haemorrhage</td>
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<tr>
<td>Prevention of transmission and care of pregnant women living with HIV and their newborns</td>
<td>Counsellors and counselling tools</td>
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<td>Safe blood supply for women who require a transfusion</td>
<td>Essential medicines and medical devices</td>
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<td>Functioning referral systems (communications, transportation)</td>
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<td>Recording systems</td>
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<tr>
<td></td>
<td>Regular maternal and perinatal death reviews at the health-care facility level to improve quality of care</td>
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### 3. Postpartum care for mothers and newborns at health-care facilities and in the community

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<tr>
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<th>Value for money</th>
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<tr>
<td>Essential promotive and preventive care following childbirth (from 24 hours to 6 weeks postpartum)</td>
<td>Nationally agreed standards and local protocols for childbirth care services and timely referral and management of complications</td>
<td>Timely management of maternal sepsis will reduce risk of maternal mortality due to sepsis by 90%. Reduces mortality, morbidity and disabilities</td>
<td>Essential postpartum care reduces maternal mortality and morbidity.</td>
</tr>
<tr>
<td>Early identification and appropriate management of complications</td>
<td>Supportive policies to ensure availability and universal access to postnatal and newborn care service</td>
<td>Improves early newborn care at home and case management at health-care facilities</td>
<td>Promotion of birth spacing improves maternal and infant health.</td>
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<tr>
<td>Counselling and services for FP/birth spacing</td>
<td>Partnerships that foster community engagement to promote postnatal and newborn care</td>
<td>Improves early initiation of exclusive breastfeeding</td>
<td>Essential postpartum care can reduce more than half of neonatal mortality when universally applied.</td>
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<tr>
<td>Care and counselling for mothers living with HIV</td>
<td>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</td>
<td>Improves uptake and adherence to ARV interventions to improve maternal health and reduce HIV transmission to infants</td>
<td>Essential postpartum care ensures a good start to life with healthy practices and protection that is important for health, growth and development later in life.</td>
</tr>
<tr>
<td>Support for breastfeeding</td>
<td>Skilled health-care professionals available to provide quality postnatal care to all women and newborns</td>
<td>Improved early breastfeeding reduces newborn and infant mortality.</td>
<td>Improved early breastfeeding reduces newborn and infant mortality.</td>
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<tr>
<td>Essential preventive interventions for the healthy newborn infant</td>
<td>Health-care facilities provide 24-hour services</td>
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<tr>
<td>Early identification and management of prematurely born and LBW infants</td>
<td>Counsellors and counselling tools</td>
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<td></td>
<td>Essential medicines and medical devices, including contraceptives</td>
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<tr>
<td><strong>4. Childcare</strong></td>
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<tr>
<td>Interventions to improve child nutrition</td>
<td>Access to free health care at the point of service delivery for all children, regardless of their socioeconomic situation, including community-based services</td>
<td>Improves care during infancy and childhood</td>
<td>These interventions for childcare promote child health, growth and development (they can save 3 million lives each year if universally applied).</td>
</tr>
<tr>
<td>Promotion of immunization and use of ITNs</td>
<td>National adaptation of recommendations on management of pneumonia, diarrhoea, malaria and severe uncomplicated malnutrition by trained community health workers</td>
<td>Reduces important risk factors for cardiovascular disease in later life</td>
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<tr>
<td>Provision of IMCI, and care of children infected with HIV</td>
<td>National strategies based on IMCI, the Global Strategy for Infant and Young Child Feeding (IYCF), and the Global Immunization Vision and Strategy (GIVS)</td>
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<td>Management of paediatric HIV</td>
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<td></td>
<td>Costed national scale-up plans that promote comprehensive service delivery including linkages for timely referral and management of complications</td>
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<td>Skilled human resources, including trained community health workers</td>
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<td>Interventions</td>
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<tr>
<td><strong>Sexual and reproductive health (SRH)</strong></td>
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<tr>
<td>Provision of care for HIV, TB and malaria (e.g. screening, referrals) within SRH services</td>
<td>Enabling policy to increase access to contraceptive methods, including expanding method choice</td>
<td>Promotes gender equity, empowers women and families</td>
<td>Promotion of condom use supports dual protection.</td>
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<tr>
<td>Education and counselling for informed contraceptive decision-making</td>
<td>Defining and implementing strategies to eliminate unmet need for FP</td>
<td>Improves capacity to negotiate use of contraception</td>
<td>Contraception can reduce the number of unintended pregnancies among women living with HIV and with TB, and all women.</td>
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<tr>
<td>Expand SRH services to adolescents</td>
<td>Health systems strengthening including an increase in direct funding and other sustainable mechanisms for FP</td>
<td>FP can reduce maternal deaths by 32% and unwanted pregnancies by 71%</td>
<td>Contraception reduces the number of new cases of HIV and TB in children resulting from unplanned pregnancies.</td>
</tr>
<tr>
<td>Availability of and access to contraceptive supplies</td>
<td>Integration of FP throughout the continuum of care, including HIV, STI, TB and malaria care</td>
<td>Can avert 80% of sexual transmission of HIV with consistent and correct use of condoms</td>
<td>SRH services expand the reproductive options of women with HIV and/or TB, including supporting them with safe and optimal conditions for a planned pregnancy.</td>
</tr>
<tr>
<td>FP within integrated primary health care, including prevention and care for STIs (including HIV), TB and malaria</td>
<td>Education and counselling on contraceptive use for people living with HIV, TB and malaria</td>
<td>Slows population growth, contributing significantly to reductions in poverty and hunger, while helping to achieve the MDGs</td>
<td>Targeting adolescents would maximize the effects of SRH interventions.</td>
</tr>
<tr>
<td>Screening, treatment and referral for other SRH needs</td>
<td>Community health workers with proper FP training and supervision</td>
<td>More TB cases in women can be detected, treated and cured</td>
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<td>Cervical cancer screening</td>
<td>Provision of comprehensive post-rape care (medical and psychological)</td>
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<td>Identification of survivors of gender-based violence and provision of appropriate clinical care and psychological support</td>
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ANC: antenatal care; ARV: antiretroviral; EMTCT: elimination of mother-to-child transmission; FP: family planning; HIV: human immunodeficiency virus; IMCI: integrated management of childhood illnesses; IPT: intermittent preventive treatment (of malaria); IPTp: intermittent preventive treatment (of malaria) in pregnancy; ITN: insecticide-treated mosquito net; LBW: low birth weight; MDGs: Millennium Development Goals; MiP: malaria in pregnancy; SRH: sexual and reproductive health; STI: sexually transmitted disease; TB: tuberculosis
Strengthening the inclusion of RMNCH health in concept notes to the Global Fund
WHO Technical Guidance Note:
Strengthening the inclusion of reproductive, maternal, newborn and child (RMNCH) health in concept notes to the Global Fund