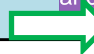
Challenges identified during sites mentoring	Corrective strategies at site, district and national levels	
A- Immunologic assessment	***Facility-based***	***District or national levels***
• Limited number of CD4 machines at district level, resulting in limited access to CD4 screening by PMTCT sites located at health center level.		1- Four district laboratories equipped with CD4 machines and staff trained to perform CD4 screening to all patients including pregnant women en ANC.
• Efficiency issues for the CD4 testing system at site and district levels (Delay between day of HIV testing and day of CD4 blood draw, reliance on laboratory technician for CD4 blood draw, dependence on ART unit for the CD4 code and blood draw for pregnant women, turnaround time for CD4 cell count results averaging 2-4 weeks)	1- First ANC clinic days re-scheduled to match CD4 testing days to allow for the same-day point-of-care routine blood sample collection for CD4 assessment in pregnant women 2- PMTCT codes used to label CD4 blood samples collected directly by nurses in ANC on the same day as HIV diagnosis	1- A coordinated district-wide system for CD4 testing involving a network of health centers established around the district hospital laboratory (scheduled weekly CD4 sample processing), with ongoing quality assurance by the National Reference Laboratory
• Reaching and tracing back to care all HIV+ pregnant women who had missed a visit	1- Home visits conducted to track women who missed appointments	
B- Initiation of md-ARV regimens		
• Non availability of HAART for eligible women in *stand-alone* PMTCT sites		1- The Ministry of Health/TRACPlus authorized stand-alone sites to start requesting HAART for pregnant women, but treatment initiation remained the responsibility of the visiting doctor
• Insufficient capacity to prescribe HAART among nurses, and reliance on the phsycian from the district hospital for the initiation of HAART even in health centers with ART programs	1- Refresher training conducted for all PMTCT health care staff 2- Patients eligible for HAART were escorted to the ART clinic and transportation was ensured in stand-alone sites for long distance referrals 	1- Job aids provided to all sites to guide decision making regarding HAART-eligibility, and the management of HIV-infected pregnant women and their infants 2- Regular clinical mentorship visits conducted by the site support team with standardized assessment of quality of care 3- Revised and implemented monitoring and evaluation tools for longitudinal follow-up of patients (integrated PMTCT care components into ANC, maternity and exposed infant follow-up registers)
• Lack of organized support groups for psychological support of pregnant women 	1- Support groups organized for psychosocial support and adherence counseling during pregnancy	