Kenya Vertical Transmission Program Progress

Dr. Nelly Pato, PMTCT NASCOP

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HIV Impact Network for Vertical Transmission Elimination

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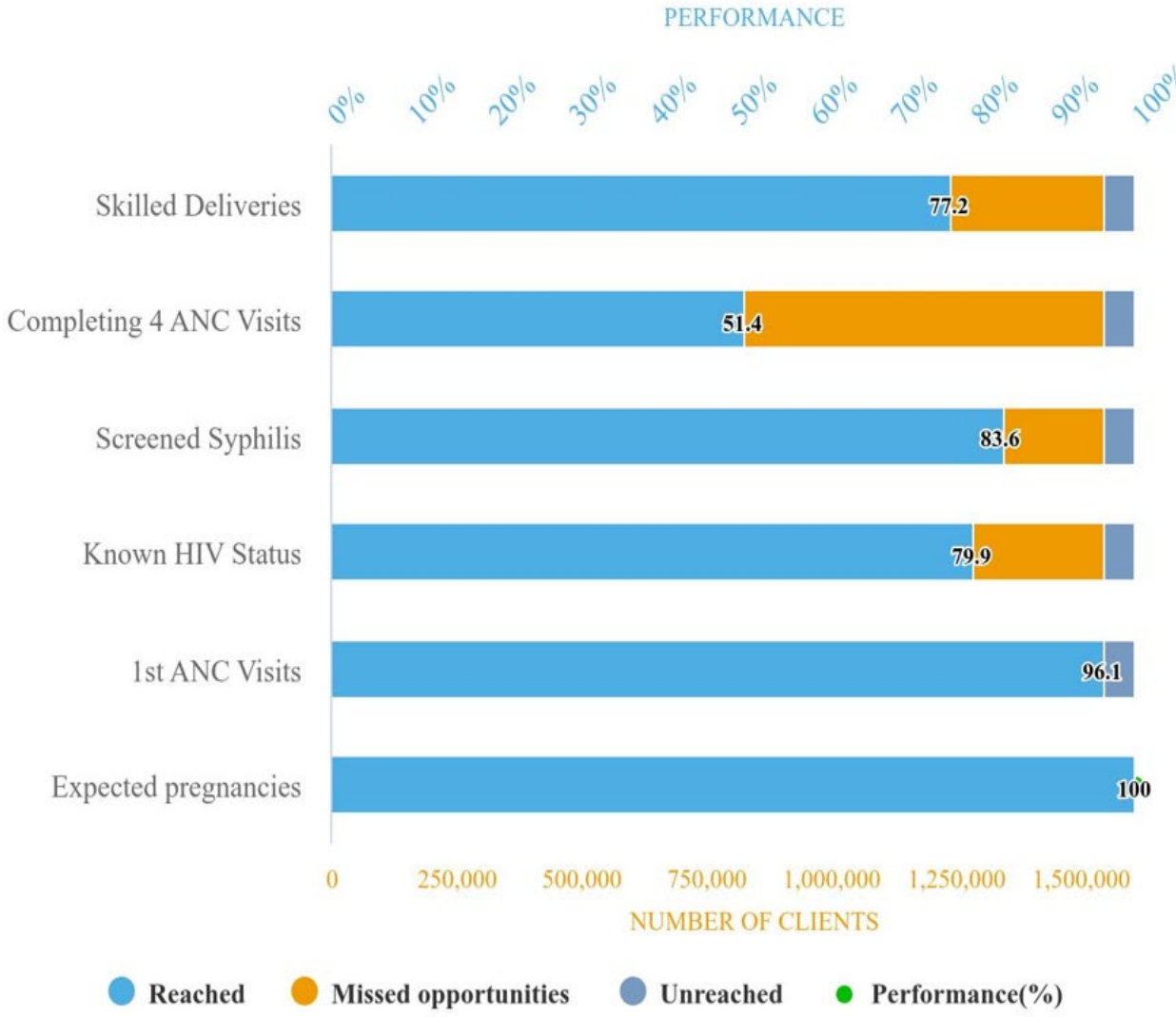
HIV Vertical Transmission prevention Program Data

Indicator	Year - 2023
Maternal testing rate	85%
Antiretroviral treatment (ART) coverage among pregnant and breastfeeding women (PBFW)	94%
Retention in care among PBFW	91%
VL coverage among PBFW	88%
Vertical transmission rate	8.6%

Source: KHIS, NDWH

HIV Vertical Transmission Prevention Cascade (ANC data 2023)



Category	Performance(%)	Unreached	Missed opportunities	Reached
Skilled Deliveries	77.2	62568	305197	1242384
Completing 4 ANC Visits	51.4	62568	719798	827783
Screened Syphilis	83.6	62568	201766	1345815
Known HIV Status	79.9	62568	260327	1287254
1st ANC Visits	96.1	62568		1547581
Expected pregnancies	100			1610149

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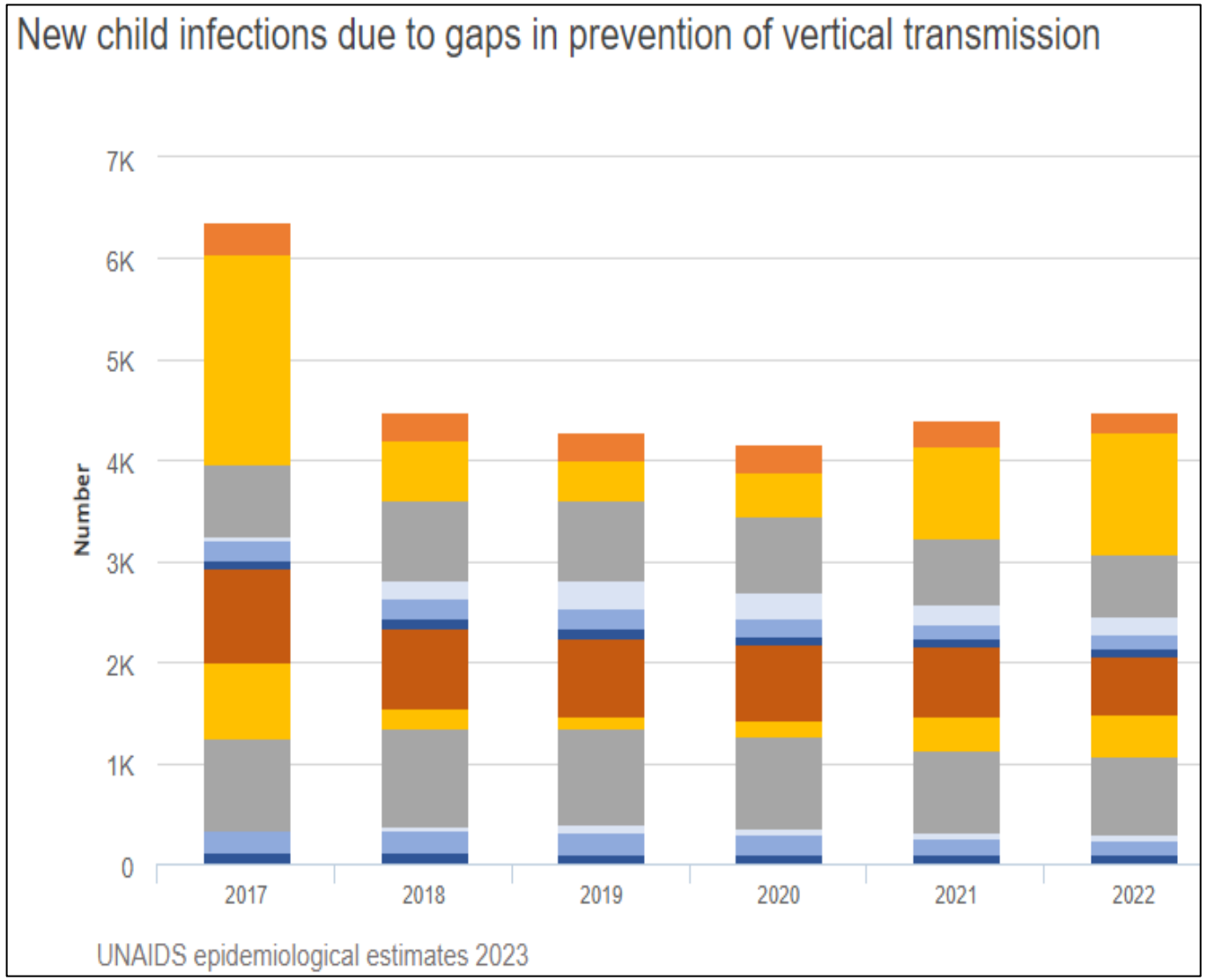
Kenya Vertical Transmission Prevention Stack Bar Analysis



12 children infected with HIV every day

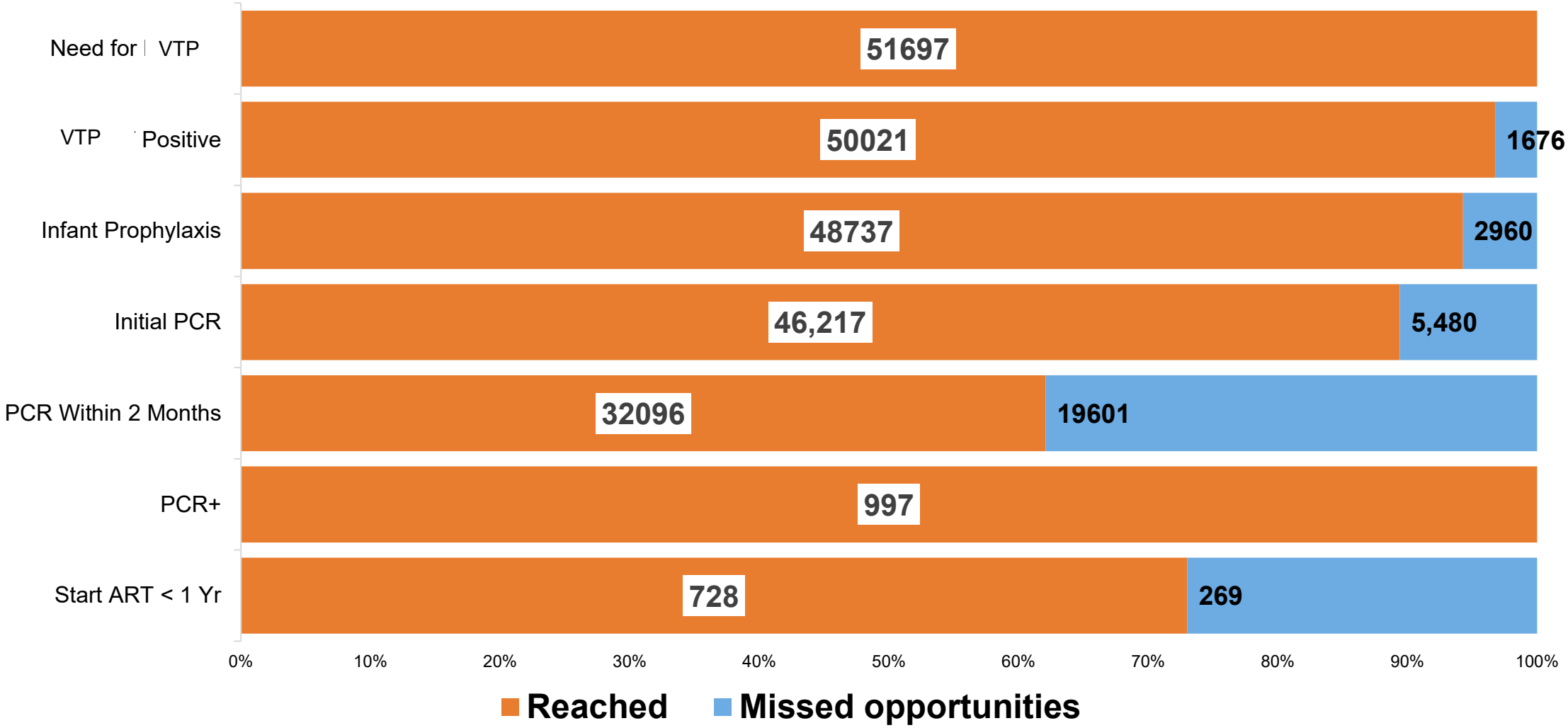
Sources of NEW Pediatrics HIV Infections

- Women not on ART: 35%
- Seroconversions: 17%
- Treatment interruption: 32%

UNAIDS 2023

- Mother infected during pregnancy; child infected during pregnancy
- Did not receive ART during pregnancy; child infected during pregnancy
- Mother dropped off ART during pregnancy; child infected during pregnancy
- Started ART late in pregnancy; child infected during pregnancy
- Started ART during in pregnancy; child infected during pregnancy
- Started ART before the pregnancy; child infected during pregnancy
- Mother infected during breastfeeding; child infected during breastfeeding
- Did not receive ART during breastfeeding; child infected during breastfeeding
- Mother dropped off ART during breastfeeding; child infected during breastfeeding
- Started ART late in pregnancy; child infected during breastfeeding
- Started ART during in pregnancy; child infected during breastfeeding
- Started ART before the pregnancy; child infected during breastfeeding

Infant Cascade 2023



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Strategies for Identifying PBFW Living With HIV

Approaches for identifying (testing) PBFW living with HIV

- Routine testing and retesting for all pregnant and breastfeeding women
- HIV testing integrated into 6 weeks infant immunization visit.
- All mothers are tested for HIV and for those who are negative risk assessment is done to determine women at high risk of HIV infection
- Use of both DUO Kit and HIVST

Approaches for identifying incident HIV infection during pregnancy and breastfeeding (Re-testing)

- Retesting of all pregnant women during 3rd trimester, labor and delivery and postnatal testing at 6 weeks and every 6 months till complete cessation of breastfeeding
- Infants screening at immunization, newborn units and in patient departments

- HIV testing services
  - All pregnant women (unless known HIV positive) should be counselled and tested for HIV, syphilis and Hepatitis B during their first ANC visit and if negative, repeat HIV and syphilis testing in the third trimester.
  - All pregnant and breastfeeding mothers with continued HIV risk (Key populations) should be counseled and tested for HIV every 3 months until post-cessation of breastfeeding.
  - Pregnant and breastfeeding mothers should be educated and offered a self-test kit for their sexual partner(s)
  - At Labour and delivery, HIV testing should be done for all women with unknown HIV status or that previously tested negative, even if tested during the third trimester
  - All breastfeeding mothers (unless known HIV positive) should be counselled and tested at the 6-week infant immunization visit. The HIV test (if negative) should be repeated every 6 months until complete cessation of breastfeeding. **Note:** key population mothers (FSWs and PWIDs) get retested every 3 months (Table 2.5)
  - Women should be counselled about the schedule for repeat HIV testing in pregnancy and postnatally as part of routine ANC and postnatal education
  - All pregnant and breastfeeding women who are not tested, opt-out or decline HIV, Syphilis or Hepatitis testing during the first contact should be offered counselling and testing in subsequent visits with appropriate linkage and referral for prevention, care and support services. Daily Witnessed Ingestion (DWI) is advised to support Viral suppression for newly initiated clients and those whose regimens are being switched. This is to support viral suppression among women with high viral load.
  - All HIV positive pregnant and breastfeeding women enrolled into care should receive counselling and support (including assisted disclosure), case management linkage and follow-up for comprehensive treatment and prevention (including lifelong ART)
  - All Syphilis and Hepatitis B positive clients should be given appropriate care as defined in Table 7.3 "triple elimination".
  - All partners of pregnant and breastfeeding women should be offered HIV testing and counselling and all biological children if the mother is HIV positive
- All pregnant and breastfeeding women should receive information on risk reduction, including PrEP where appropriate
- Post-partum contraception: counsel on contraception methods and help patient develop a plan for effective contraception from 6-weeks post-partum to avoid unplanned pregnancies

Continuity of Antiretroviral Treatment During Pregnancy and Breastfeeding Strategies

- Synchronizing of ANC and PNC visits with VTP follow-up; DSD implementation for PBFW
- Mentor mother program for follow up and support
- Psychosocial support groups
- Case reviews and case management
- Utilization of the ushauri platform
- Risk categorization to determine those that need closer follow-up
- Linkage to structural intervention

Approach to Early Infant Diagnosis

1. Aligning EID services with the expanded program on immunization to improve coverage (6 weeks, 6 months, 12 montha and 18 months)
2. Integration of sample collection processes into MCH to limit client movement
3. Electronic EID results transmission system to reduce turn around time (TAT)
4. Screening all infants for HIV exposure in immunization, well baby clinics and in patient pediatric care and other clinics that may see babies like TB clinics when they accompany the mother
5. Point of care (POC) testing in 68 facilities to reduce TAT

Postnatal Prophylaxis (PNP) for Infants with Perinatal HIV Exposure

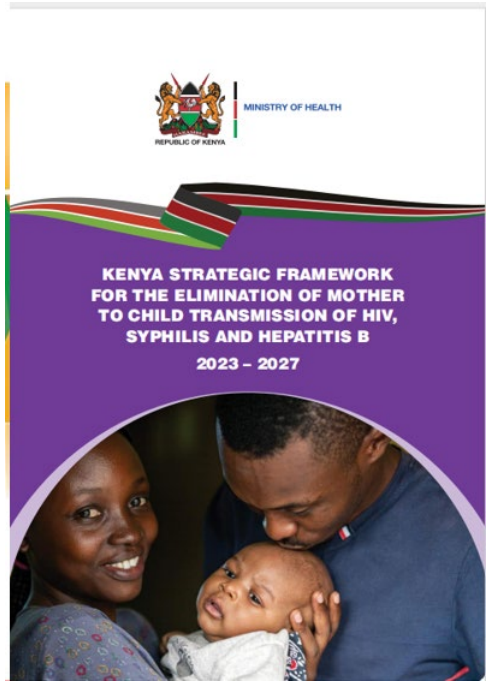
1. Kenya policy guidance provides for AZT + NVP for 6 weeks followed by extended nevirapine prophylaxis for the duration of breastfeeding
2. Prophylaxis is provided at point of maternal HIV diagnosis (ANC 1st visit or 1st contact thereafter)
3. Tools for monitoring prophylaxis
4. Follow up for both eID and prophylaxis by mentor mothers

Strategies for Preventing Incident HIV among Women during Pregnancy and Breastfeeding

- PrEP intergartion into Maternal, Newborn and Child Health (MNCH) clinics - M &E tools revised to include PrEP in MNCH
- Risk assessment is done to determine PBFW at high risk of HIV infection.
- PBW testing negative during ANC or PNC respectively, are assessed for continued risk of HIV infection using a risk assessment tool. Those at risk are then screened for PrEP eligibility. PrEP is thereafter offered based on risk.
- Other prevention methods are offered incase one is not eligible for PrEP
- Combination prevention is offered.
- Once initiated on PrEP, follow up visits are synchronized with maternal visits for antenatal and postnatal visits
- Adherence and continuity of care is enhanced through counselling, reminder system and peer support
- Facility-based and community-based PrEP delivery models are also implemented

Best Practices on Prevention of Vertical Transmission of Hepatitis B and Syphilis

1. Revision of M&E tools to include hepatitis B and Syphilis
2. Development and ongoing implementation of the Kenya Strategic framework for elimination of VT (eVT)
3. Scale-up on the utilization of the MNCH EMR module
4. Ongoing development of the triple elimination curriculum
5. Kenya mentor mother program (KMMP) to include Hepatitis B and syphilis
6. Adopt a county strategy for technical assistance (TA) to counties
7. Formation and activation of county eVT task forces with eVT work plans
8. Quarterly performance reviews up to county level
9. Development of a triple elimination COE work plan



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Key Challenges in Implementation of HIV Vertical Transmission Prevention Program

- Missed opportunities in HIV testing and re-testing of mothers
- Late ANC attendance and hence late diagnosis
- Interruption in treatment among PBFW living with HIV on ART
- Lack of access to data from private health facilities
- Low utilization of electronic medical records in Maternal, Newborn and Child Health (MNCH) clinics
- Stigma and delayed disclosure leading to late or no ART initiation of mothers
- Limited capacity in the counties to conduct early infant diagnosis and hence long TAT for results
- Limited capacity for point of care technology for early infant diagnosis in the country
- VTP commodity stock outs.
- Socio-economic practices like nomadism, religious practices

2025 HIV Vertical Transmission Prevention Priorities

1. Promote universal access to VTP by decentralization and integration of services
2. Enhance targeted commodity security for VTP health products and technologies to mitigate supply interruptions and frequent stock-outs.
3. Scale-up targeted placement of innovative technologies and point of care (POC) devices to reduce turnaround time for results and improve quality.
4. Leverage the use of disaggregated data to identify VTP gaps for decision-making.
5. Promote the use of EMR for the longitudinal follow up of mother-infant pairs.

2025 HIV Vertical Transmission Prevention Priorities

6. Promote community-led interventions to support demand creation for ANC services and strengthen referral mechanisms for VTP programs
7. Training of health care workers at all levels including affected communities
8. Strengthen-private sector engagement
9. Shift VTP programming interventions to include sub-populations like AGYW.
10. Focus VTP services to diverse needs of pregnant and breastfeeding WLHIV in arid and semi-arid land (ASAL) regions

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