

# Keeping Mothers and Infants in Care: Challenges and Opportunities

Thursday, October 23, 2025





# Welcome & Introductions

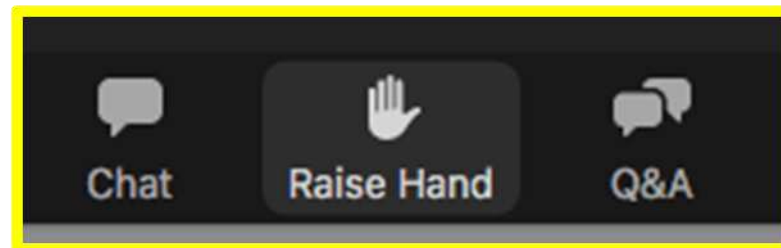
**Maureen Syowai**

Program Director (CQUIN/HIVE)

ICAP in Kenya

# Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion with Q&A
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the “raise hand” function on the toolbar and we will unmute you so that you have control of your microphone
- Slides and recording will be available on the HIVE website ([hiveimpactnetwork.com](http://hiveimpactnetwork.com))



# Agenda

- **Welcome, Introductions and Framing Remarks** – Maureen Syowai, Program Director, ICAP in Kenya
- **Presentations:**
  - **Programmatic Implementation of Longitudinal Follow-Up of Mothers and Infants: Successes and Challenges** – Michael Msangi, National PMTCT Coordinator, MOH Tanzania
  - **Monitoring and Evaluation Systems for Longitudinal Follow-up of Mothers and Infants** – Mukome Nyamhagatta, Head, Strategic Information, PMTCT Program, MOH Tanzania
  - **Community Follow-up of Mothers and Infants and VTP CLM: Successes and Challenges** – Nkechi Okoro, M&E Manager, NEPHWAN, Nigeria
- **Panel Discussion & Q&A**
  - Moderators: Bernadeta Msongole, HIVE Regional Clinical Advisor, ICAP in Tanzania, and Yasteel Maharaj, HIVE Regional Program Manager, PATA
- **Closing and Next Steps** – Maureen Syowai, HIVE Program Director, ICAP in Kenya

# Keeping Mothers and Infants in Care

Maureen Syowai

Program Director (CQUIN/HIVE)



**HIV**  
Impact Network for  
Vertical Transmission  
**E**limination



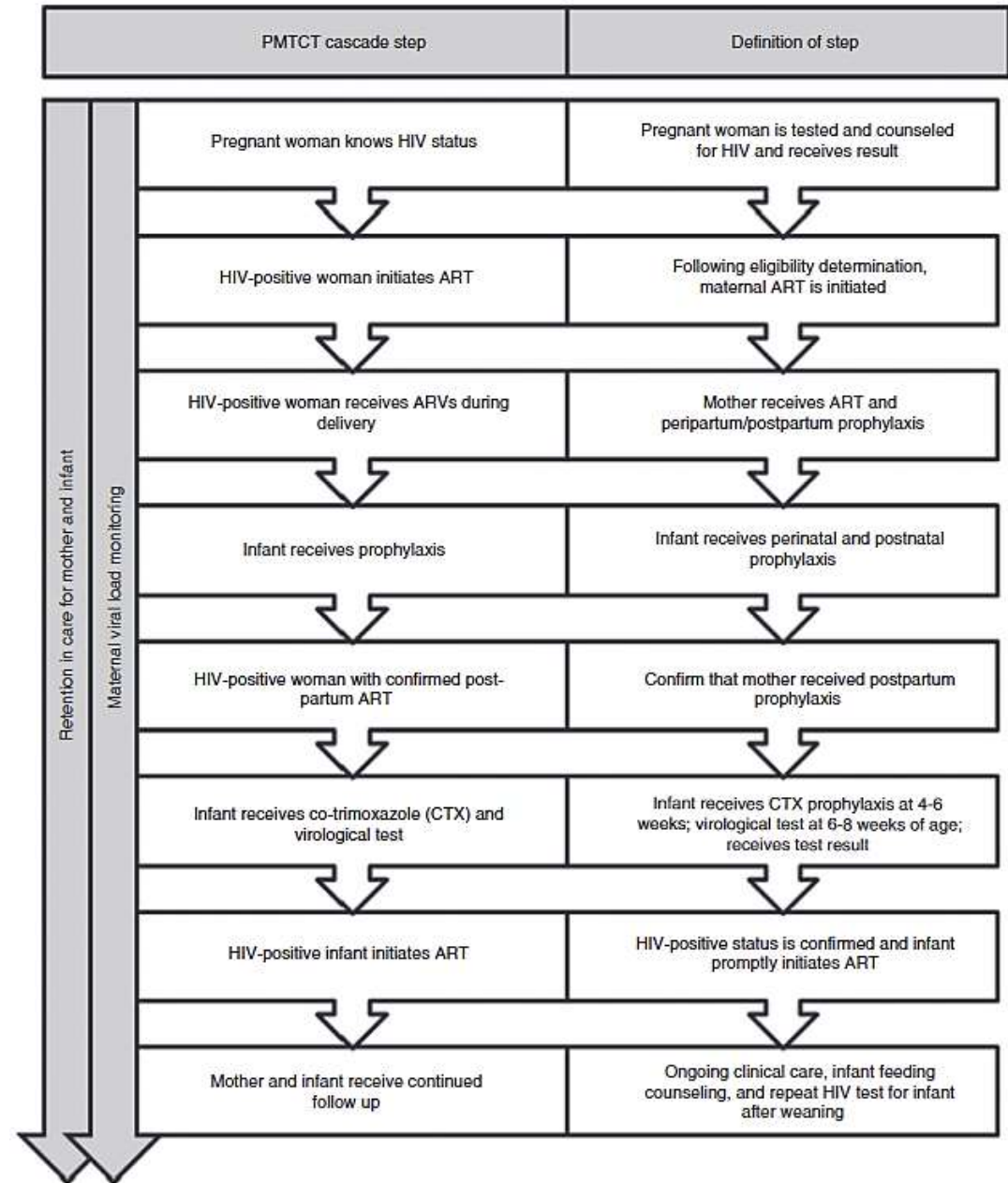
**icap** Global Health

# Keeping Mothers and Infants in Care

- In 2024, HIV treatment coverage among pregnant women living with HIV was **84% globally** [72–98%], and **93% in Eastern and Southern Africa** [81–98%].
- In addition, **new infections among infants and children persist with 36% of all pediatric HIV infections occurring in Western and Central Africa.**
- Too often, **mothers disengage from care before their infant's HIV status is confirmed.**
- **Why does this happen and what must we do differently?**

# Keeping Mothers and Infants in Care

- The VTP cascade has multiple transition steps, **from pregnancy to delivery, postpartum, and infant diagnosis, postnatal prophylaxis**, with each step posing a risk for disengagement.
- In a 2018 publication, *Vrazo A. C., et al* detailed the VTP cascade and interventions across this cascade that are essential to improve VTP service uptake and retention.
- Sustaining care across these steps remains challenging in real-world settings. Studies report **loss-to-follow-up rates of 38-88%** due to challenges with ART adherence and retention. (*Ferguson L., et al, 2012*)



**Figure 1** Steps of the PMTCT cascade. Abbreviations: PMTCT, prevention of mother-to-child transmission; ART, antiretroviral therapy; ARV, antiretrovirals; CTX, co-trimoxazole prophylaxis.

# Keeping Mothers and Infants in Care

- Retention of mothers during pregnancy and postpartum and of infants exposed to HIV, is central to the success of VTP programs.
- Yet, despite advances in **early infant diagnosis** and **maternal ART coverage**, retention remains a persistent challenge.
  - Across nine studies comparing attrition 12 months after ART initiation, before and after “Treat All” was implemented in Sub-Saharan Africa, **being pregnant or breastfeeding was consistently associated with higher attrition** (*Makurumidze, R., Decroo, T., Jacobs, B.K.M. et al., 2023*). This underscores the need for tailored follow-up and retention strategies across each step of the cascade.

# Effective Interventions

- Investigators have identified effective interventions to improve follow-up and retention across the VTP cascade including:
  - Integrated care
  - Lay healthcare providers
  - Community and peer support
  - Family-centered approaches
  - Group antenatal care (G-ANC)
  - Digital health and technology
  - Quality improvement (CQI)

# Objectives for the Webinar

- Understand the programmatic process of longitudinal follow up of mothers and infants, successes, and challenges.
- Learn about the monitoring and evaluation systems and tools used for recording, reporting and monitoring of mothers and infants in VTP programs.
- Understand community follow-up of mothers and infants, and the potential for community led monitoring (CLM) for VTP.

# Thank You!



**HIV**  
Impact Network for  
Vertical Transmission  
**E**limination



# Presenters



**Michael Msangi**  
National PMTCT Coordinator  
MOH, Tanzania



**Mukome A. Nyamhagatta**  
Head of SI, PMTCT Program  
MOH, Tanzania



**Nkechi Okoro**  
M&E Manager  
NEPHWAN, Nigeria



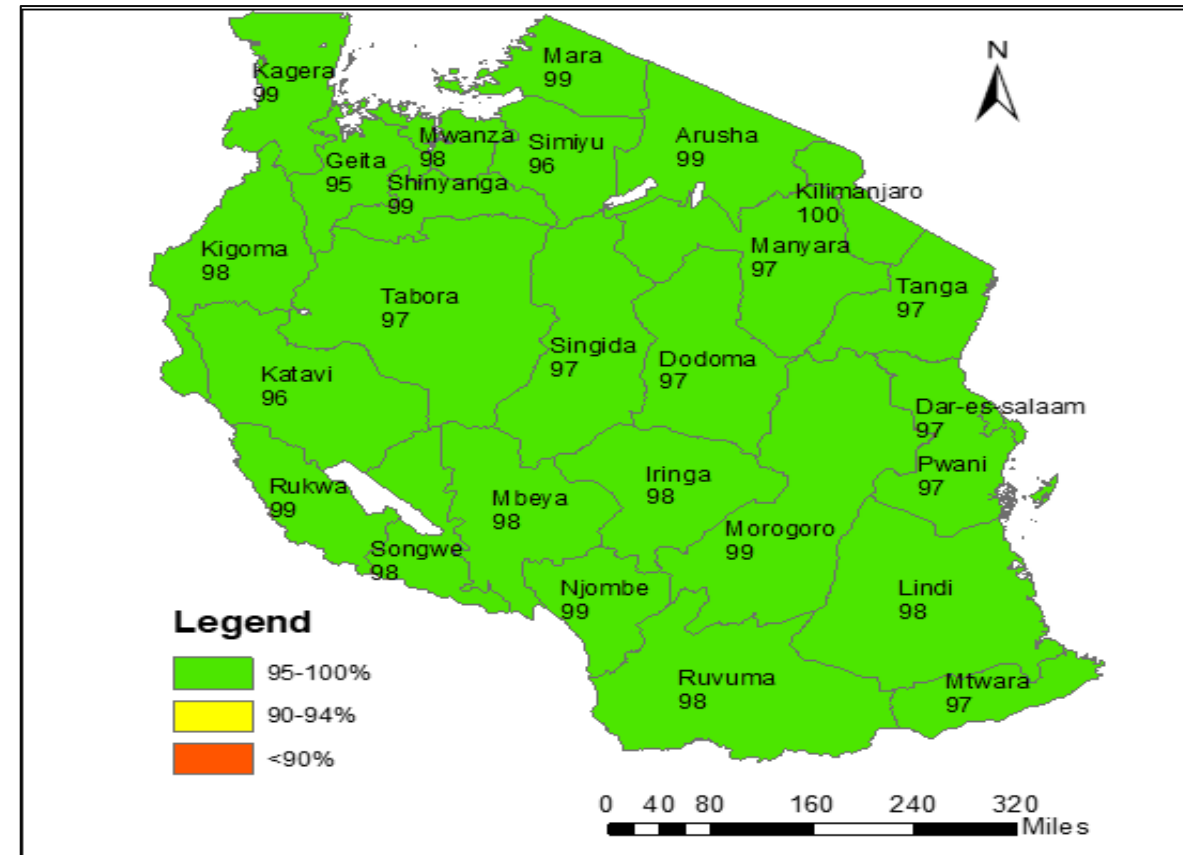
# Programmatic Implementation of Longitudinal Follow-Up of Mothers and Infants: Successes and Challenges

Michael Msangi  
National PMTCT Coordinator  
MOH, Tanzania

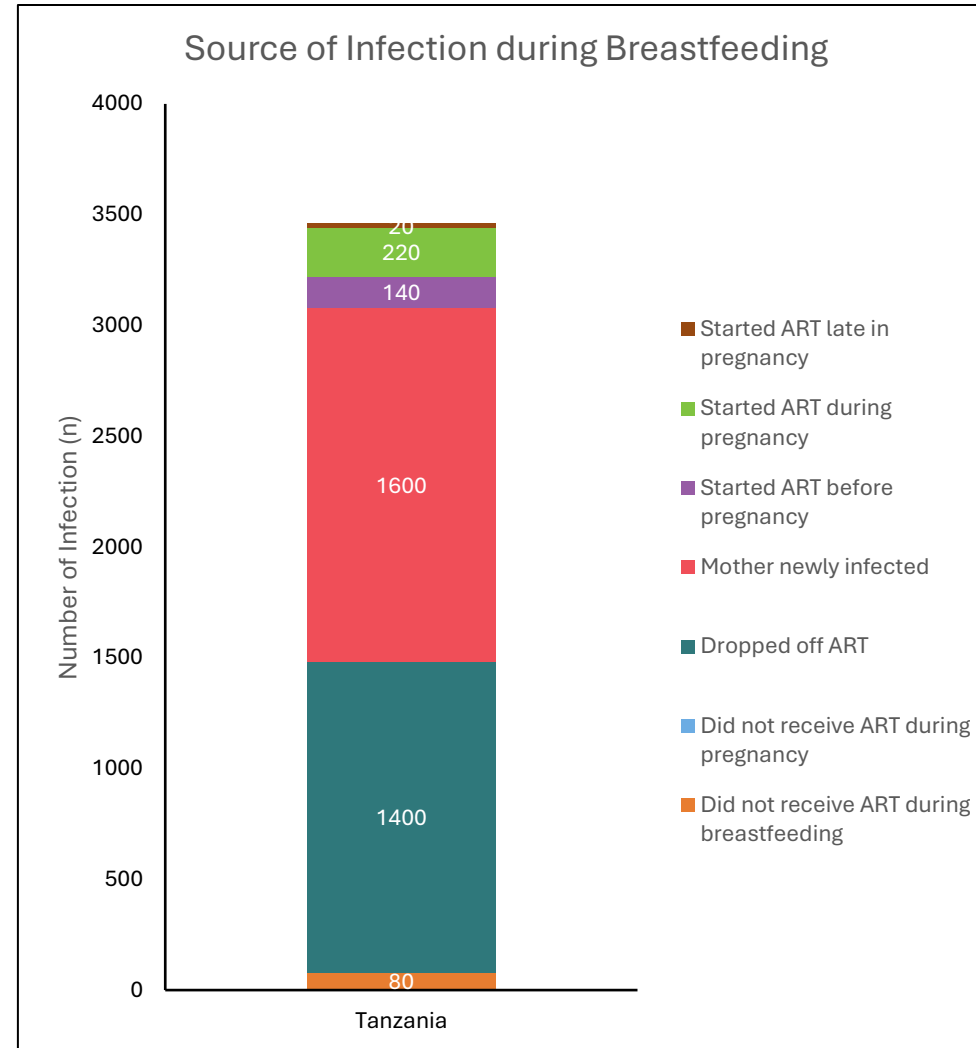
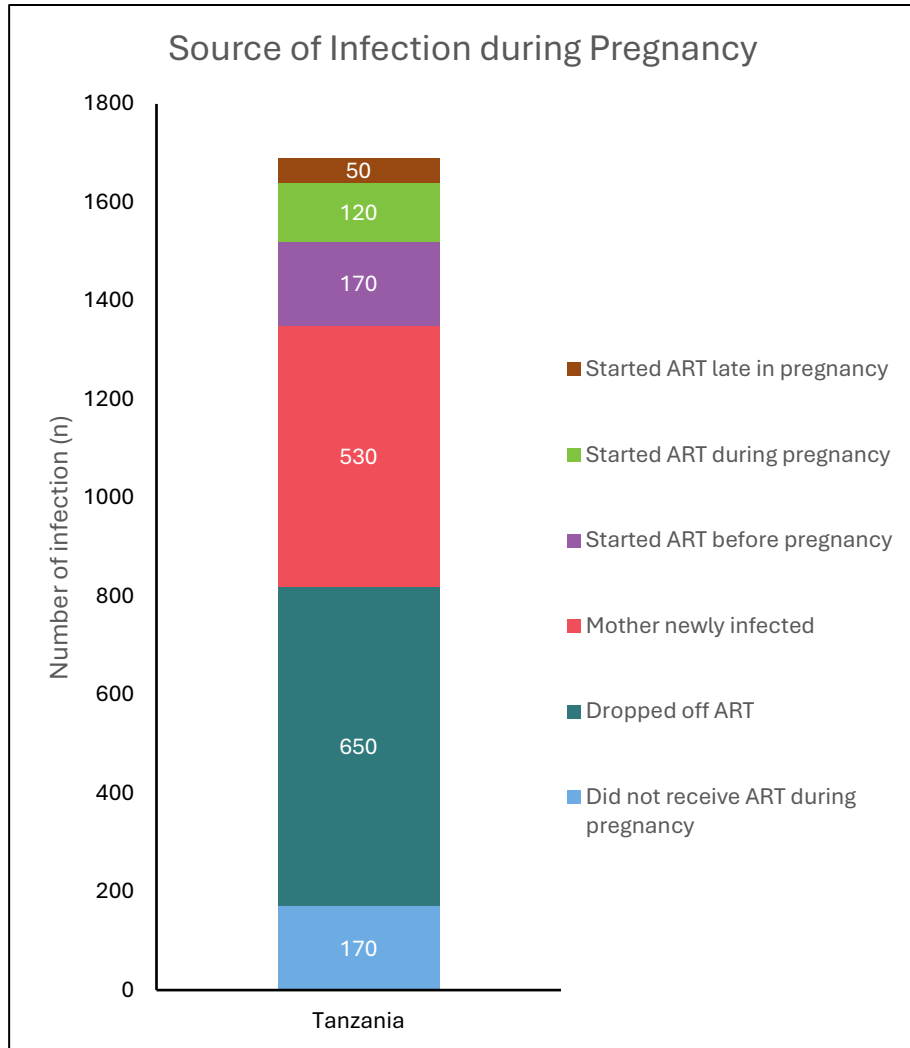
# Background

- High VTP service coverage > 95% (2024)
- High ANC1 testing coverage > 95%, positivity rate of 0.6% (2025)
- High vertical transmission rate – 7.6% (2024)
  - Estimated 67,000 children are living with HIV

## VTP service coverage among facilities with RCH clinics (2024)

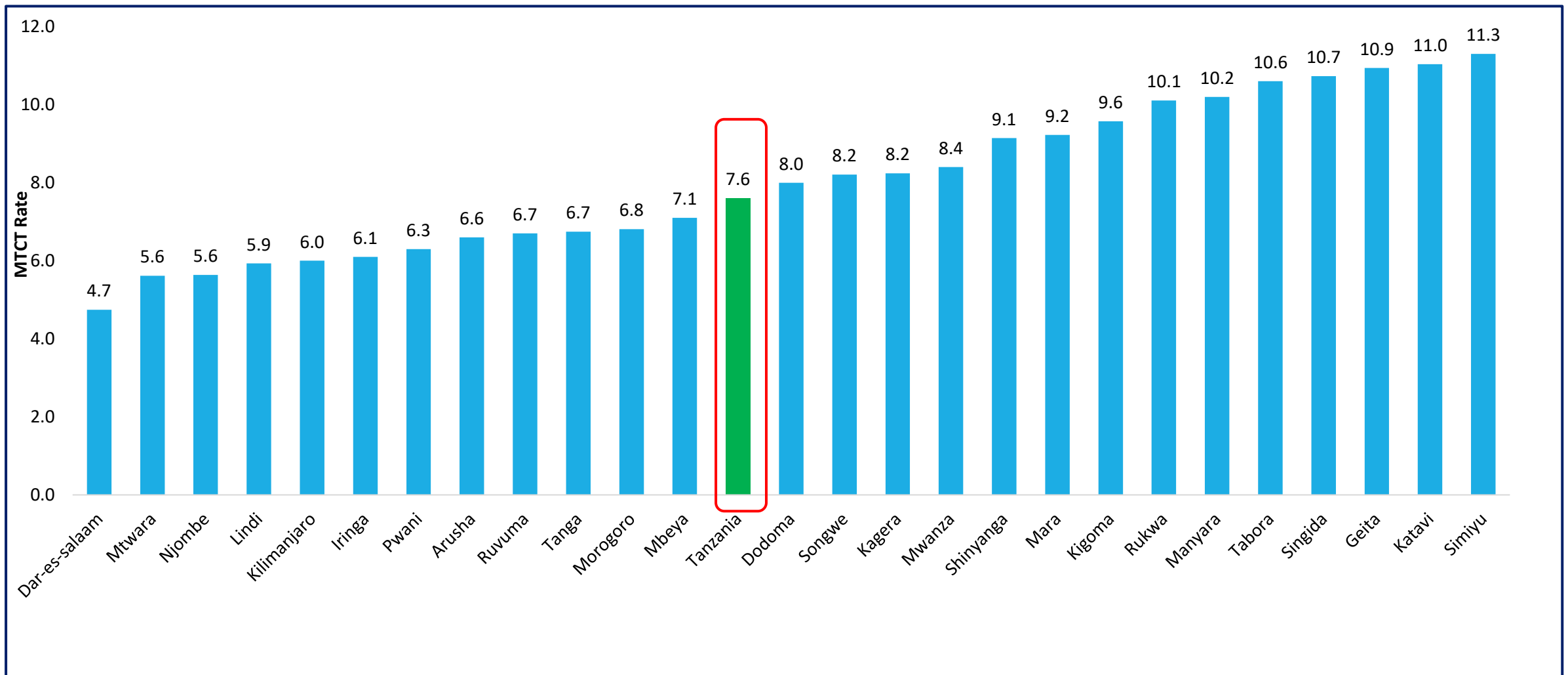


# Sources of Infant HIV Infection During Pregnancy and Breastfeeding (UNAIDS Spectrum 2024)



- Majority of the new pediatric infections resulted from incident maternal HIV infection during pregnancy and breastfeeding and dropping off ART

# Vertical Transmission Rate (VTR), National and by Regions, 2024 (UNAIDS Spectrum 2024)



# Facility and Community-Based Approaches

Health Facility



Community



ART service delivery points

Mentor mothers/peer mothers/champion mothers - work at both facilities and communities, they facilitate bidirectional referrals between facilities and communities

**Care & Treatment Clinic (CTC)**  
(with/without Pediatric HIV clinic)  
**Population served:**  
(Adult & Pediatric ROC)

**Reproductive and Child Health (RCH) Clinic**  
**Population served :** PBFW, Infants with perinatal exposure to HIV

- Follow up of mothers and infants is conducted at RCH clinic for up to 24 months
- If final HIV status of infant is negative** (18-24 months), the mother is referred to general HIV clinic, **the child will exit VTP program** but will continue to attend RCH clinic for other childhood services
- If the infant HIV test is confirmed positive** at any point in time both **mother and infant are referred to Adult /Pediatric HIV clinic** (exit VTP program)
- In health facilities with pediatric clinics, mother (and father) and the child will be attended together at Pediatric clinic as a family

**Services at RCH clinic:**  
ART, Post natal and CTX prophylaxis, AHD screening and management, infant testing, viral load monitoring, adherence counseling, and other integrated post natal services and child services

**Community services for PBFW and infants**

- Tracking of mothers and infants
- Psychosocial support
- Adherence support
- Linkage/facilitated referrals to health facilities


Appointment reminders, health education, psychosocial and adherence support

# Programmatic Follow-Up of Mothers and Infants

## At entry into the VTP program

- Key information is captured including physical address, phone numbers and contacts of treatment supporters
- Healthcare workers prepare a follow up plan together with the client and ensure the mother knows the time, location, contact person and purpose of all follow-up appointments

**THE UNITED REPUBLIC OF TANZANIA  
MINISTRY OF HEALTH**



CTC 2 Card No:

FACILITY REGISTERED NAME \_\_\_\_\_ PATIENT'S FILE NUMBER \_\_\_\_\_ COUNCIL \_\_\_\_\_

UNIQUE CTC ID NUMBER \_\_\_\_\_ Sex  Female  Male

NAME (first, middle, last) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)\* \_\_\_\_\_ MARITAL STATUS (see code 1) \_\_\_\_\_

AGE \_\_\_\_\_ (Years/Months) \_\_\_\_\_ NHCI\*\*\*\* \_\_\_\_\_ NHCI TYPE (see code 19) \_\_\_\_\_

HEIGHT \_\_\_\_\_ cm (Adults) \_\_\_\_\_ FINGER PRINT CONSENT YES  NO

**CLIENT REFERRED FROM (tick appropriate)**

OPD  
 STI  
 TB CLINIC  
 RCH / PMTCT / EID  
 INPATIENT  
 SELF REFERRAL/CITC  
 COMMUNITY INDEX  
 FACILITY INDEX  
 PLHIV GROUP  
 CBHS  
 VMMC  
 SELF TESTING  
 Other Facility (specify) \_\_\_\_\_  
 OTHER (specify) \_\_\_\_\_

**TRANSFER IN (tick those applicable)**

WITH RECORDS (referral form and CTC 1 card)  
 NO RECORDS AVAILABLE  
 IN CARE  
 ON ART

**CLIENT ADDRESS**

COUNCIL / DIVISION / WARD \_\_\_\_/\_\_\_\_/\_\_\_\_  
 STREET / VILLAGE \_\_\_\_\_  
 STREET / VILLAGE CHAIRPERSON \_\_\_\_\_  
 NAME OF TEN CELL LEADER \_\_\_\_\_  
 NAME OF HEAD OF HOUSEHOLD \_\_\_\_\_  
 CONTACT OF HOUSEHOLD HEAD   
 CLIENT'S PHONE No. \_\_\_\_\_  
 SMS CONSENT YES  NO

**CLIENT SUPPORT**

NAME OF TREATMENT SUPPORTER \_\_\_\_\_  
 PHONE No. OF TREATMENT SUPPORTER \_\_\_\_\_  
 SMS CONSENT YES  NO   
 NAME OF COMMUNITY SUPPORT GROUP JOINED \_\_\_\_\_  
 DATE JOINED \_\_\_\_/\_\_\_\_/\_\_\_\_

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17)

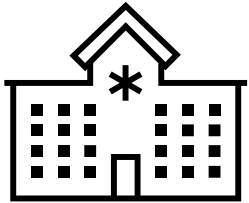
# Programmatic Follow-Up of Mothers and Infants: Appointment and Tracking System

- **Appointment Register:** A standardized register that has been designed to help monitor clinic attendances, list PBFW appointments by dates
  - In facilities with electronic database (CTC2), the appointment list is generated automatically
- **Tracking Register:** A register used mostly by mentor mothers to track back to care PBFW who have missed their appointments and those who are confirmed as lost to follow up
  - It records PBFW who have been tracked and returned to care, transferred out, or stopped using services



# Follow Up and Tracking: Facility and Community

## Health Facility



### Appointment Reminder

- Mentor Mothers and/or health care workers (HCWs) review list of appointments
- Appointment reminders are sent by SMS or through phone calls

### Tracking

- Health care workers and mentor mothers review list of Breastfeeding women (BFW) with missed visits and lost to follow
- Mentor mothers or HCWs conduct initial tracking by phone call or SMS
- BFW with missed visits and lost to follow up not reached through SMS or phone call are documented in the tracking form for follow up in the community

**After return to care:** Health care worker provide supportive counseling, addressing reasons for missed visits and/or treatment interruption

## Community



### Tracking in the community

- Mentor Mothers track mothers who have missed appointments or are lost to follow-up in the communities
- Ensure confidentiality not to disclose ROC HIV status during tracking
- Facilitate the process of re-engaging mothers and their infants back to care
- Documented tracking outcome in the tracking form

# Programmatic Challenges & Opportunities

## Challenges

- Reduced funding to support the Mentor Mothers community program
- Limited scale and financial resources for program oversight activities
- Sub-optimal retention of mother-baby pair at 24 months follow up

## Opportunities

- Resource commitment by the Government for HIV, TB and Malaria interventions
- Presence of AIDS Trust Fund (ATF) to support HIV responses
- Integrated VTP/RCH Services

# Thank you.



**HIV**  
Impact Network for  
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# Monitoring and Evaluation Systems for Longitudinal Follow-Up of Mothers and Infants

Mukome Nyamhagatta  
Head, Strategic Information  
PMTCT Program  
MOH, Tanzania

# Active Monitoring of Mother–Infant Pairs

- Monitoring is conducted using both paper-based tools and an electronic system.
- Healthcare providers document information in the tools during service delivery.
- The recorded data are then entered into the CTC2 database daily and reported in DHIS2 monthly.
- Aggregated report are generated and visualized in DHIS2 and National Database(CTC3 Macro)



## Paper tools

Mother Child (MC)  
Cohort register  
HIV Exposed Infant (HEI)  
card  
CTC2 Card



## Electronic system

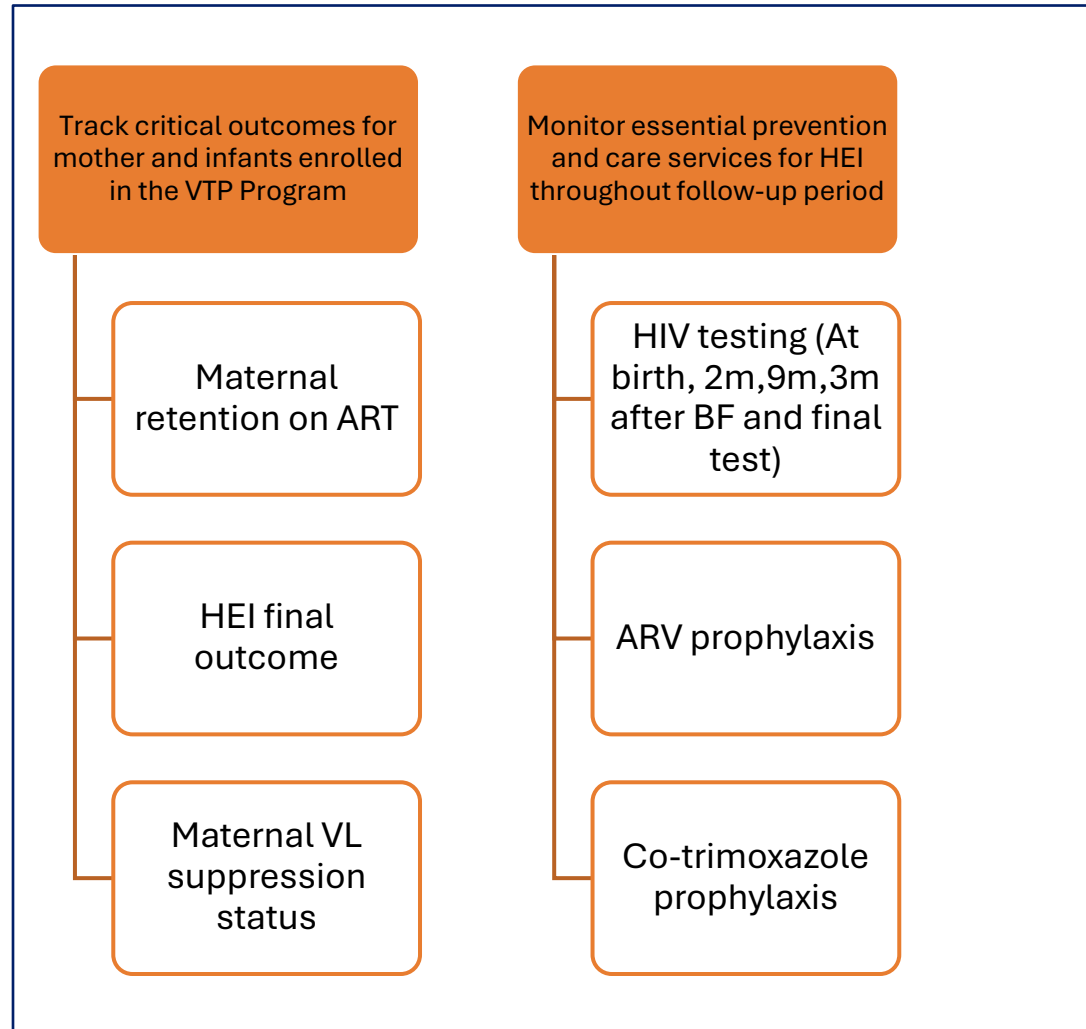
CTC2 Database  
(include module for  
Infant Follow up)  
Unified Community  
System (UCS) - PMTCT  
case management



## Aggregated report

DHIS2  
National Database  
(CTC3 Macro)

# Cohort Monitoring Using Mother-Child Cohort Register



## Mother – Child Cohort Register



# Cohort Monitoring: Mother-Child Cohort Register

## JAMHURI YA MUUNGANO WA TANZANIA: PMTCT MOTHER-CHILD COHORT REGISTER

JINA LA KITUO: \_\_\_\_\_ MKOA : \_\_\_\_\_  
 NAMBA YA CTC: \_\_\_\_\_ WILAYA: \_\_\_\_\_  
 MATERNAL COHORT (M0): \_\_\_\_\_ MWEZI: \_\_\_\_\_ MWAKA: \_\_\_\_\_

| Mama  |                                   | Mtoto                               |  |   |  | Jina                                       |              | Mtoto          |  | Taarifa ya vipimo vya VVU kwa mtoto |                                       |   |   |                                      |  |  |   |                                    |   |   |  |   |   |                                    |   |
|-------|-----------------------------------|-------------------------------------|--|---|--|--|--------------|----------------|--|-------------------------------------|---------------------------------------|---|---|--------------------------------------|--|--|---|------------------------------------|---|---|--|---|---|------------------------------------|---|
| 1     | 2a / 2b                           | 3                                   | 4  | 5a / 5b   | 6a / 6b  | 7  | 8a / 8b      | 9              | 10   | 11                                  | 12a / 12b                             | 13  | 14  | 15a / 15b                            | 16a/16b/16c  | 17   | 18a / 18b   | 19a/19b/19c                        | 20a / 20b   | 21a / 21b   | 22   | 23a / 23b   | 24  | 25a / 25b                          |   |
| Namba | Tarehe ya kuandikishwa (dd/mm/yy) | Namba ya utambulisho ya mama ya CTC | Hali ya maambukizi ya VVU (Wenzi 0)<br>1=Amegundulika kwa mara ya kwanza katika ujuzi huu<br>2=Tayari ana maambukizi ya VVU kabla ya ujuzi huu | Tiba ya ART (Wenzi 0)<br>1= ART<br>2= Taya<br>3= Taya yupo kwenye tiba kabla ya ujuzi huu | Matokeo ya Ujuzi 1= LB<br>2= SB<br>3= Abortion | Namba ya utambulisho ya Mtoto (HEI number) | Jina la Mama | Jinsi ya Mtoto | Mahali alipozaliwa mtoto<br>1= HF<br>2= SBA<br>3= TBA<br>4= HD | Tarehe ya Kuzaliwa Mtoto (dd/mm/yy) | Tarehe ya hudhuria la kwanza la mtoto | Uwasili wa ulishaji wa mtoto na vitendo<br>EBF<br>RF<br>MF<br>BF+<br>RF+<br>SBF | Kinga ya ARV kwa mtoto<br>1. Ameanzishwa<br>2. Hakuandishwa | Umri mtoto alipoanzishwa CTX (Meezi) | Amechukuliwa Kipimo Siku ya kuzaliwa (At birth) Majibu (P N) | Umri wa Mtoto wakati wa kipimo cha VVU (EID) (Meezi) | Aina ya Kipimo cha VVU cha mtoto<br>PCR = DBS<br>AS = Kipimo cha Antibodi | Majibu ya Kipimo cha VVU kwa mtoto | Majibu ya Kipimo cha VVU Meezi 9 ya umri wa mtoto | Majibu ya Kipimo cha VVU wiki 12 baada ya kuacha kunyonya | Ulishaji wa mtoto (Wakati wa kipimo kwenye umri wa miezi 18) | Majibu ya Kipimo cha VVU kwa mtoto<br>AB (Kipimo cha Antibodi) test | Kipimo cha PCR Kuchukuliwa<br>Tarehe (dd/mm/yy) | Majibu ya Kipimo cha VVU kwa mtoto | Majibu ya Kipimo cha VVU kwa mtoto<br>Tarehe ya wazazi/wazazi kupokea majibu (dd/mm/yy) |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
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|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |
|       |                                   |                                     | 1  | 2 3   |  |  |              | ME             | 1  |                                     |                                       |   | 1   | ≤2 >2                                | P N  | ≤2 >2 >12  | PCR AB  | P N                                | P N   | P N   |  | P N   |   | P N                                |   |
|       |                                   |                                     | 2  |   |  |  |              | KE             |  |                                     |                                       |   | 2   |                                      |  | ≤2 >2 >12  |   |                                    |   |   |  |   |   |                                    |   |

Cohort month and year

Mother and child details (place of delivery, feeding practices, infant tests, prophylaxis)

Majibu ya Kipimo (18a & 25a)  
 P = Positive  
 N = Negative  
 Y = "Yanautata" (lab unable to run test)

Ufuatiliaji (MAMA)  
 CTN = Continue in care  
 MISSAP = Missed scheduled appointment this month  
 LTF = Lost to follow-up (not seen for 3 or more months since last appointment)

TI = Transferred in from another PMTCT facility  
 TO = Transferred out to another PMTCT facility  
 TP = Transferred to a new PMTCT cohort (new pregnancy)  
 DIED  
 EXIT to CTC (discharged from PMTCT)





# Other Key Tools-HEI Card

The HEI card is used to document longitudinal information on care provided to HIV-exposed infants

Divided into three main sections:

**i. The registration section**

*Captures important information about the mother and the infant at the time of the infant's birth*

**ii. The visit details section**

*Captures information during each of the infant's follow-up visits*

**iii. The outcome section**

*Captures information about the infant's final outcome*

The form is titled "United Republic of Tanzania, Ministry of Health, Community Development, Gender, Liberty and Children, Prevention of Mother to Child Transmission of HIV Program, HIV Exposed Infant Card". It includes fields for Facility, District, HIV exposed infant number (HEI number), Name of Child, Sex of Child, Name of Mother, Date of Birth (Infant), Birth Weight (kg), Mother on ART, Infant Prophylaxis at birth, and Infant feeding practice at birth. A table for "Visit details" has columns for Visit Date, Age, Weight (kg), and various clinical indicators like E2S, No. of Days, HIV, etc. At the bottom, there are sections for "Confirmed HIV status by Antibody test" and "Confirmed HIV status by DNA PCR test".

Infant's ID # is linked to mothers unique CTC ID #



# Electronic Systems



## Care and Treatment Database (CTC2)

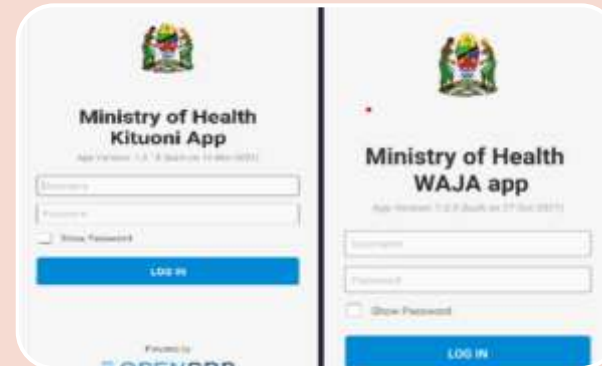
Electronic database captures information of all PLHIV and infants with perinatal HIV exposure, uses CTC2 and HEI cards as source of information

Generate care and treatment reports and VTP reports



## CTC3 Macro Database

Aggregate information from CTC2 database (national level)



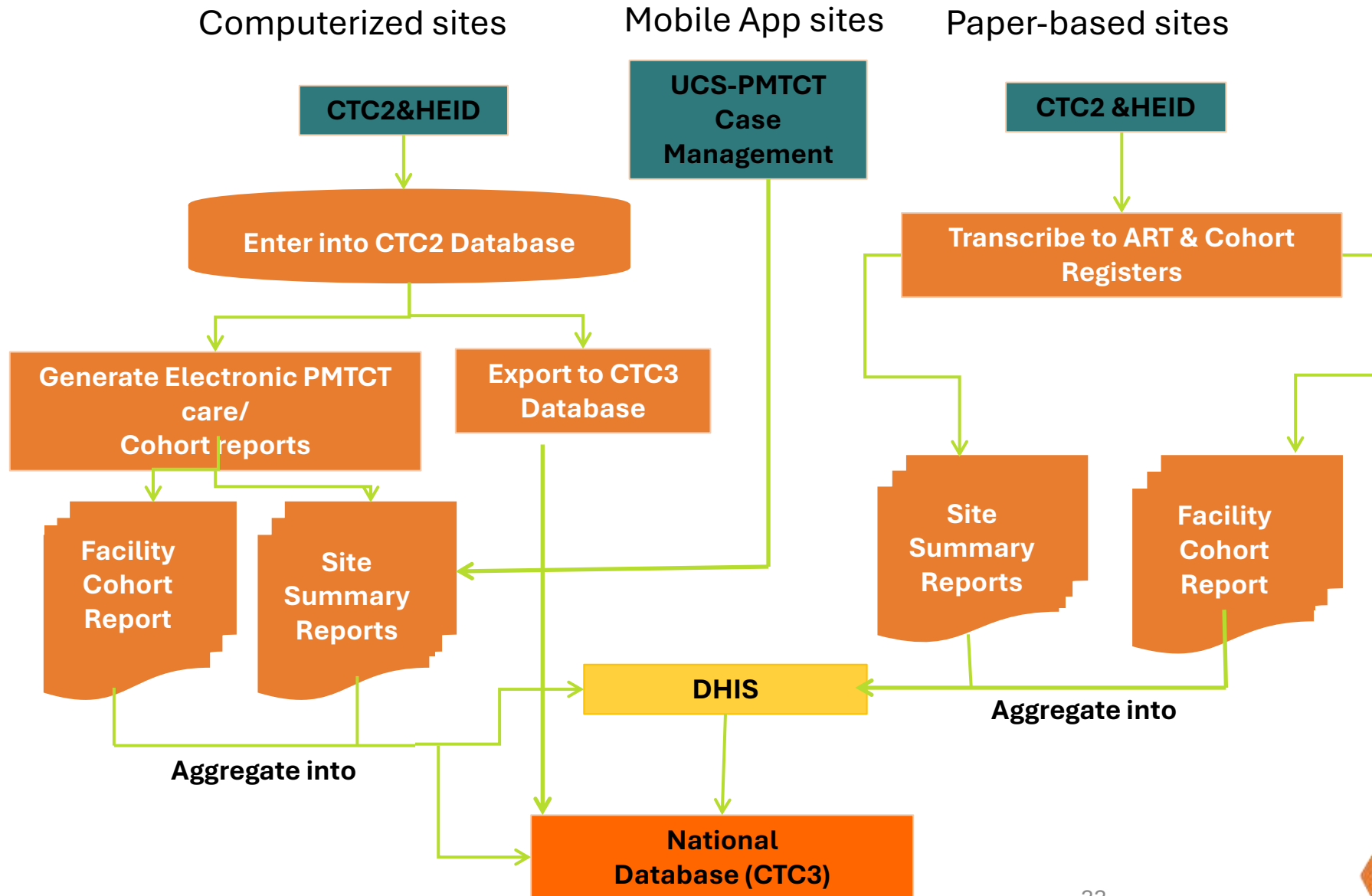
## Unified Community System (UCS)

An application that unifies and integrate the vertical programs (CBHS, ANC, PMTCT, L&D, HEI, PNC, HTS, PrEP, Malaria, TB)

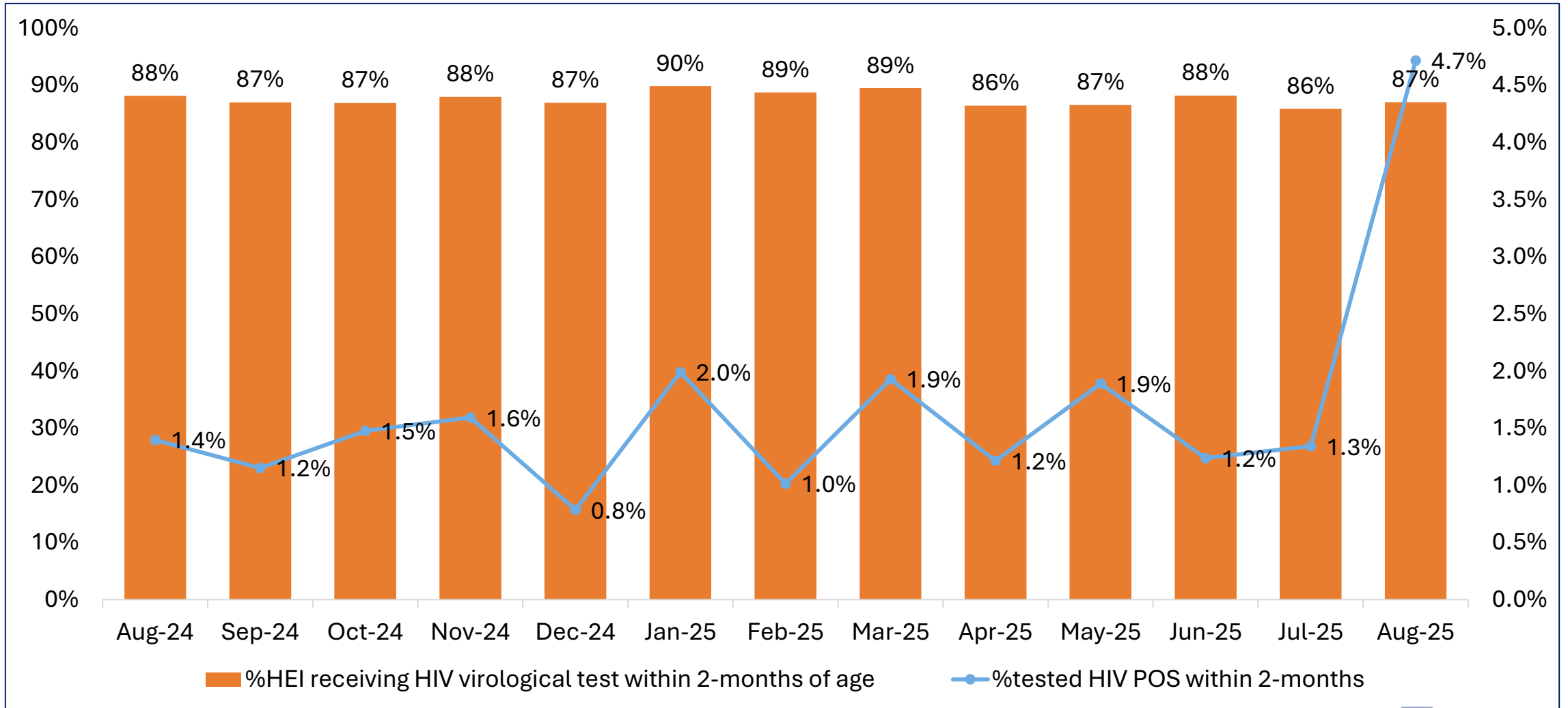
VTP case management

Facilitate bidirectional linkage of services between communities and facilities (tracking of missed appointments and lost follow-up to improve the continuum of care)

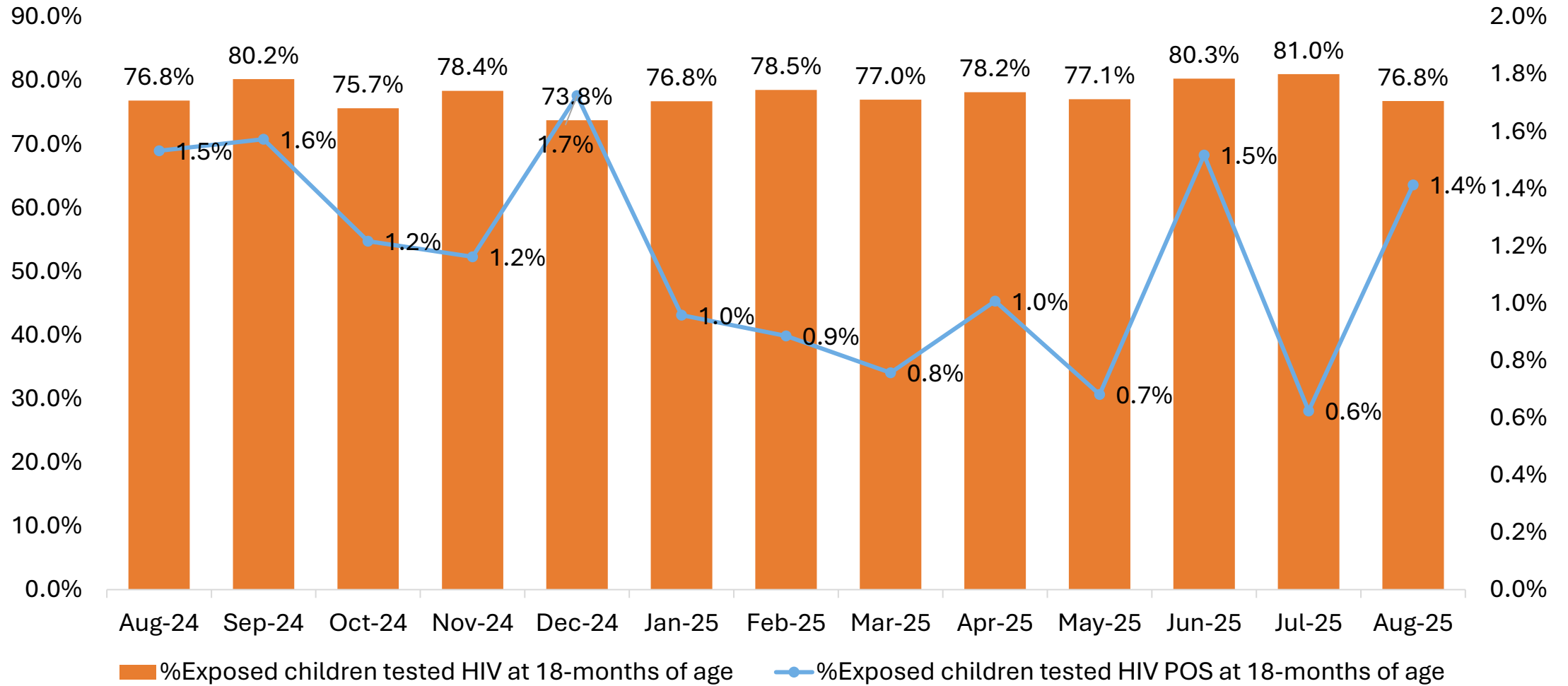
# Data Flow



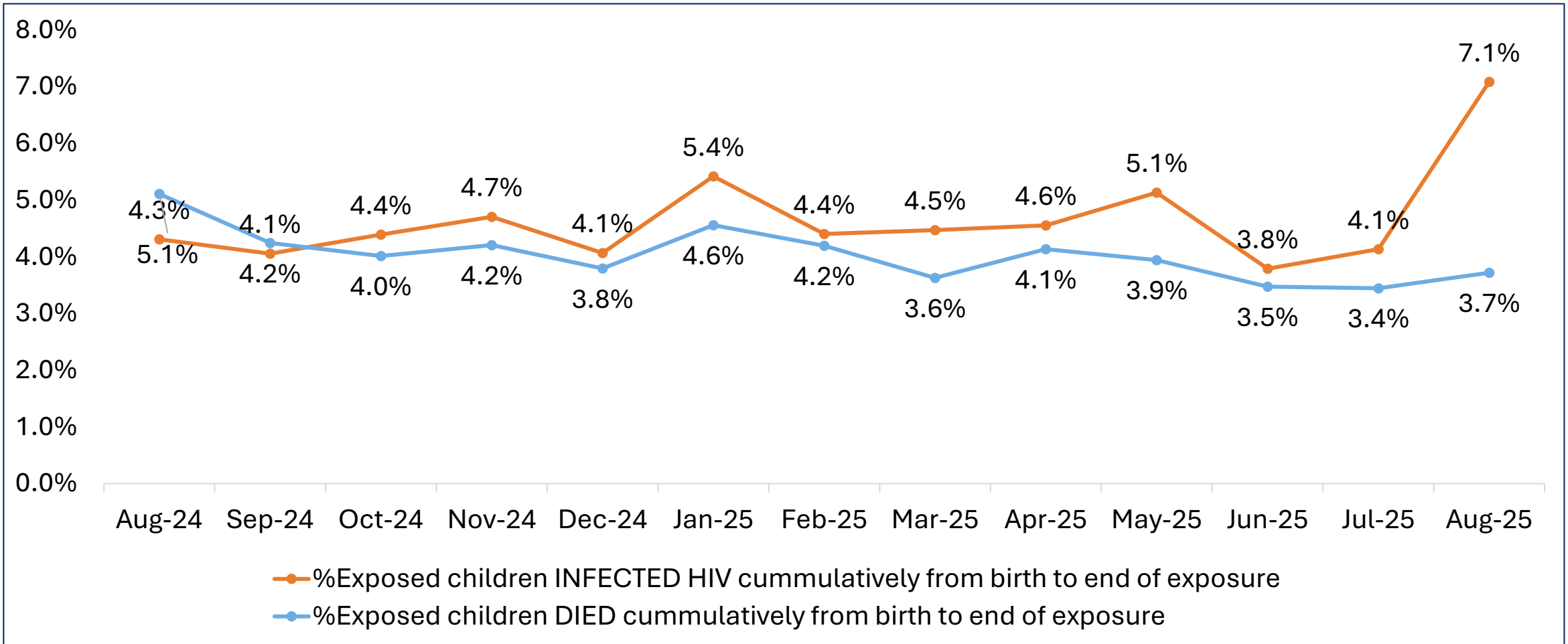
# EID Coverage: ≤ 2 months: Aug 2024 – Aug 2025



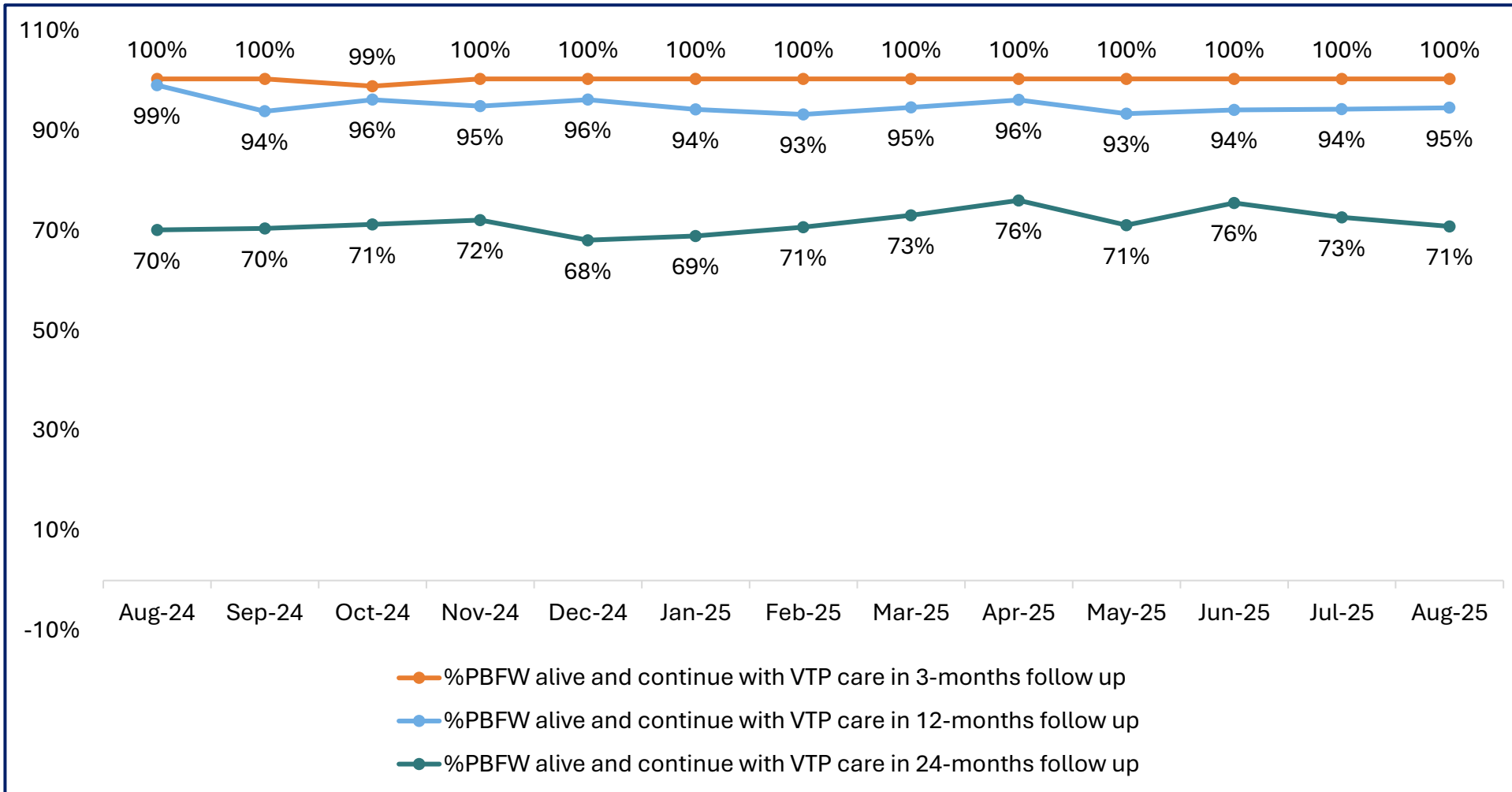
# Testing Coverage and Positivity at 18 Months of Age (August 2024 – August 2025)



# HIV-Exposed Infant Outcomes at the End of BF: Mortality and HIV Infection (Aug 2024-Aug 2025)



# 3, 12, and 24 Months VTP Retention Among PBFW (Aug 2024-Aug 2025)



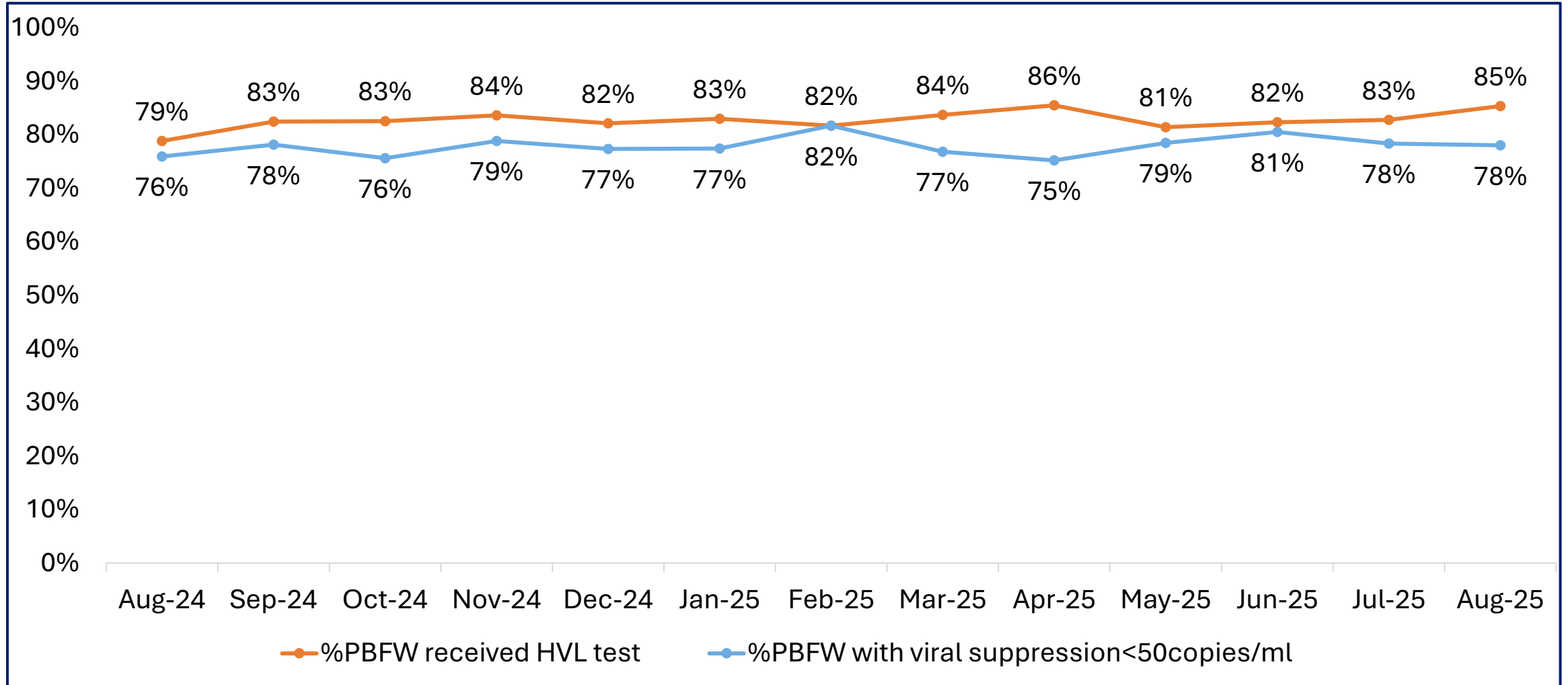
**Cohort of mothers - a group of women in a specific health facility,**

- HIV positive,
- accessing reproductive and child health care
- ***started PMTCT care in same month of a year***

**Include those**

- ART naïve (Testing HIV positive for the first time; pregnant or BF)
- Known Positive; ART experienced (Already on ARVs but become pregnant)

# Pregnant and Breastfeeding Women Viral Load Testing Coverage and Suppression (Aug 2024 – Aug 2025)



# Challenges and Opportunities

## Challenges

- Frequent data quality issues emanating from the data entry errors
- Limited resources for scale up of UCS and VTP Case Management System
  - Capacity building
  - Procurement of Tablets
- Inadequate data use and knowledge management at all levels

## Opportunities

- Community health workers program
  - *Opportunity for increased services utilization and community reporting*
- Availability of electronic recording systems
- Availability of HMIS focal persons at council and regional levels
- Integrated data systems

# Way Forward

- Scale-up UCS and VTP case management system
- Conduct regular DQAs at all levels
- Conduct survey to inform Path-To-Elimination (PTE) validation application
- Encourage data use and knowledge management

# Thank you.



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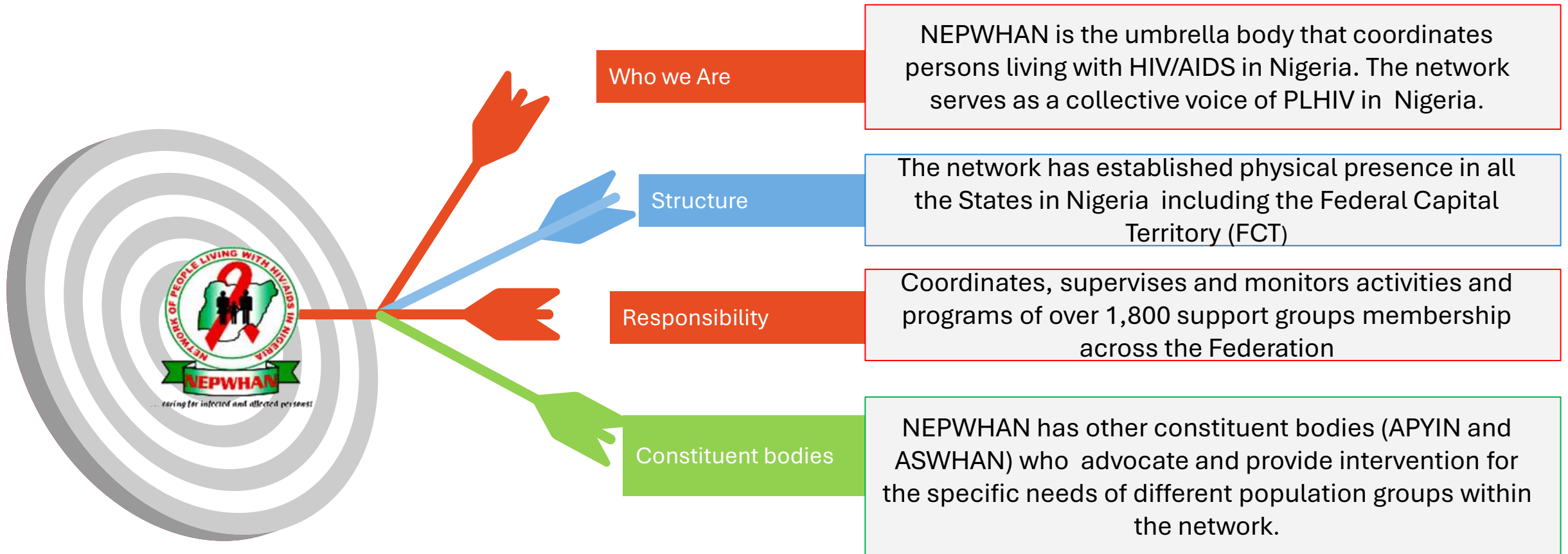


# Follow Up of Mothers and Infants: Successes and Challenges

**Nkechi Okoro**

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National Network of People Living  
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# Introduction: About NEPWHAN



# Vertical Transmission Prevention Interventions

Demand Creation and Mobilization of Pregnant Women for HTS, ANC and other prevention services in the community through the Community Mentor Mothers

Support Group Meetings and patient community gatherings to ensure Peer-to-Peer education, treatment adherence, service uptake, stigma reduction, differentiated care, referrals, and linkages to care.

Provide Gender and Human Rights (GHR) Support to PLHIV, KP throughout implementation cycle



Provide of essential support for treatment, C&S, tracking and adherence both at the facility and community levels

Put community at the center of implementation through CLM activities to identify and address service delivery barriers

# Approaches/Strategies for Mother and Infant Follow-Up

- Deployment of Mentor Mothers into supported health facilities and unconventional settings within GC7 grant.
  - Mentor Mothers provide peer counselling, disclosure support, adherence guidance, and emotional support to HIV-positive pregnant women.
  - They accompany mothers through the VTP cascade from ANC booking to infant final outcome testing.
  - They assist in early identification of LTFU cases for follow-up.
  - Conduct community-based defaulter tracking and follow-up: Track mothers and infants who miss appointments or default from ART or EID services and re-engage them in care.

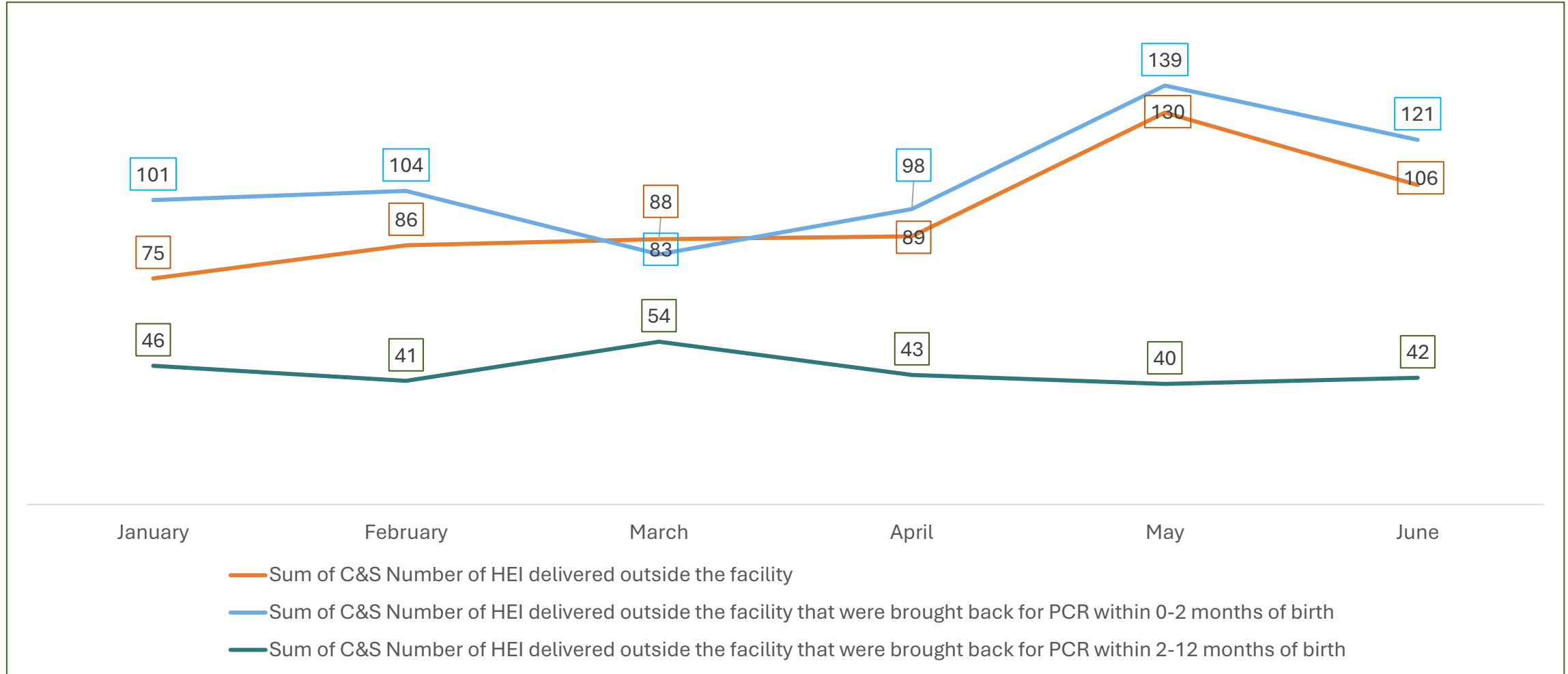
# Approaches/Strategies for Mother and Infant Follow-Up

- Integration with facility-based support systems to ensure smooth referral and linkage between the facility and community for mothers and infants. Through this effort, HIV-positive pregnant women identified in the community are linked to ANC and VTP services.
- Community sensitization and anti-stigma campaigns for community-level education to reduce stigma and discrimination, which are key barriers to follow-up for mothers and infants.
- Work with traditional birth attendants (TBAs) to refer women for VTP services.

# CLM for Vertical Transmission Prevention

- Within the VTP interventions, CLM has been effective in identifying and addressing service delivery barriers with a view to addressing such barriers for improved quality of care and positive outcomes.
- Across the continuum of care from ANC to postpartum and infant follow up, for VTP, CLM strategy has been found effective in documenting experiences of pregnant and breastfeeding women - monitoring client satisfaction at every point of care.

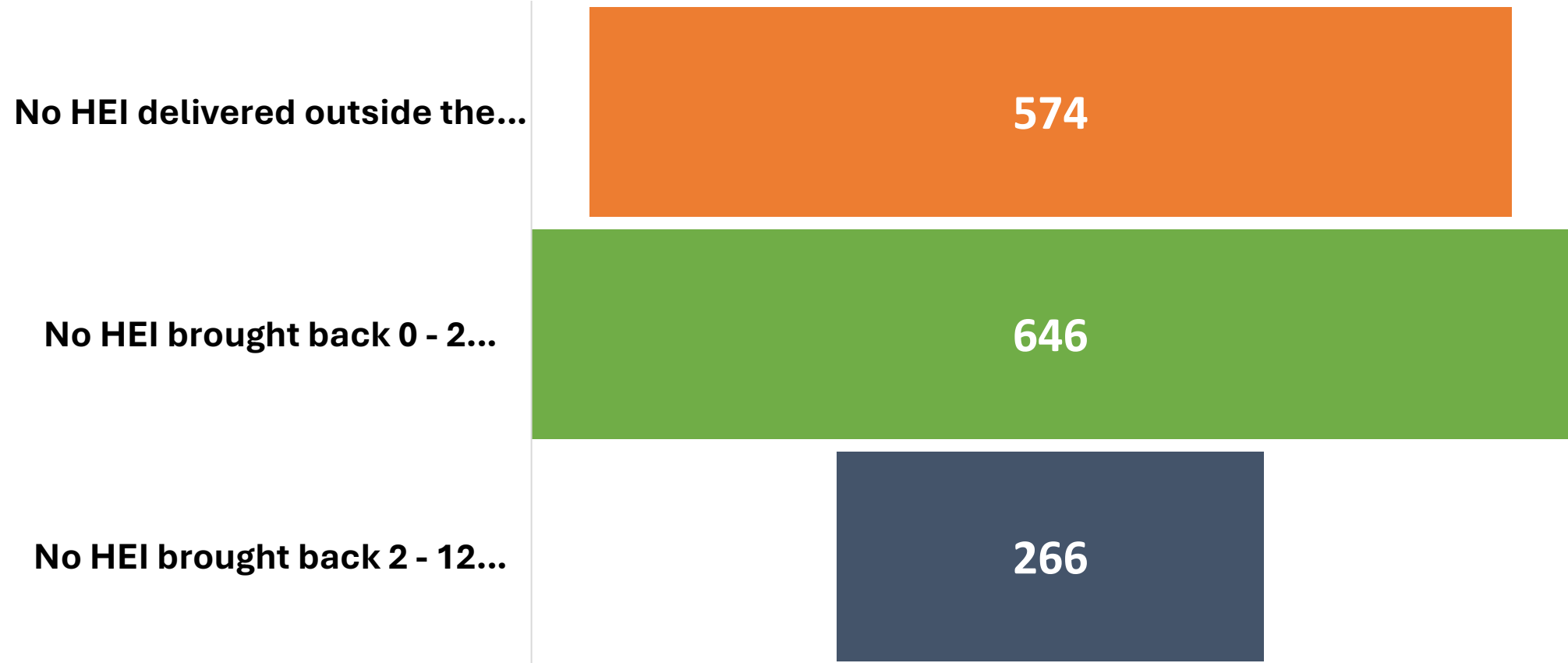
# Infants Delivered Outside Facilities Brought Back for PCR Test at Facilities (2025)



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# Infants delivered outside facilities brought back for PCR test at facilities (2025)



# Challenges

## ✓ Coverage issues due to funding threats:

- Mentor Mother coverage issue is mostly due to limited resource availability and funding threat.
- Within the GC7, NEPWHAN started with **3,805** Mentor Mothers but now trimmed down to **2,011** due to funding cut (**53% are retained**).
- These **2011** Mentor Mothers are deployed to **111** health facilities in the 4 intervention States; the gap is huge especially if we further drill down to look at the number of health facilities in those States. Despite a large pool of experienced mentor mothers who are willing to work, only a limited number have been deployed compared to the number of Local Government Areas (LGAs) and number of health facilities in coverage States.
- The implication for NEPWHAN is that, only selected health facilities have Mentor Mothers assigned to provide the needed care services for mothers and infants.

# Challenges



## Collaboration issues:

- This relates to poor collaboration in coordinating the implementation of community activities involving different entities.
- Although NEPWHAN's Mentor Mothers have remained effective (especially in the unconventional settings) different implementers still handle different aspects of care services that support HTS and follow up on mothers and infants - poor collaboration has remained a huge challenge.

# Way Forward

## ✓ Coverage:

- Improve coverage for the work that Mentor Mothers do to cover more health facilities and communities.
- Improve coverage for community sensitization working with various opinion leaders to sensitize more women.

## ✓ Collaboration issues:

- Improve collaboration with Traditional Birth Attendants to improve linkage since some women still prefer to deliver their babies at home.
- Improved collaboration with other implementers for improved coordination of activities at the community level.

# Thank you.



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# Q&A Discussion

## Moderators



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MOH, Zambia



**Maira Chanase**  
PMTCT Advisor  
MOH, Mozambique

## Panelists & Discussants



# Closing Remarks

**Maureen Syowai**

Program Director (CQUIN/HIVE)

ICAP in Kenya

Slides & recordings from this session are available on the HIVE Website

[hiveimpactnetwork.com](http://hiveimpactnetwork.com)

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# Thank you.



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