HIVE WEBINAR

Expanding HIV PrEP Coverage Through Integrated Postnatal Care

Thursday, June 18, 2026

Welcome and Introductions

Maureen Syowai

Program Director (CQUIN/HIVE)

ICAP in Kenya

HIV Impact Network *for* Vertical Transmission Elimination

Agenda

- **Welcome and Introductions –** Maureen Syowai, Program Director, CQUIN/HIVE, ICAP
- **Framing Remarks –** Liesl Page-Shipp, Senior Program Officer TB & HIV, Gates Foundation
- **Country Presentation:**
    - South Africa: Dr Jeannette Wessels, Research Center for Maternal, Fetal, Neonatal & Child Health Care Strategies – University of Pretoria
- **Reflections from Civil Society/Community**
    - Ndivhuwo Rambau, Project Coordinator, Ritshidze Program-South Africa
- **Panel Discussion/Q&A**
    - Moderators: Bernadeta Msongole, HIVE Regional Clinical Advisor**,** ICAP in Tanzania and Lulu Ndapatani, HIVE Regional Clinical Advisor, ICAP in Kenya
- **Closing –** Maureen Syowai, Program Director, CQUIN/HIVE, ICAP

HIV Impact Network for Vertical Transmission Elimination

Presenters

Liesl Page-Shipp
Senior Program Officer
TB & HIV
Gates Foundation

Jeannette Wessels
Research Center for Maternal,
Fetal, Neonatal & Child Health Care
Strategies- University of Pretoria
South Africa

Ndivhuwo Rambau
Project Coordinator
Ritshidze Program
South Africa

HIV Impact Network for Vertical Transmission Elimination

Framing Remarks

Integrating HIV Prevention into Postnatal Care and MCH Services: Opportunities for Continuity of Care

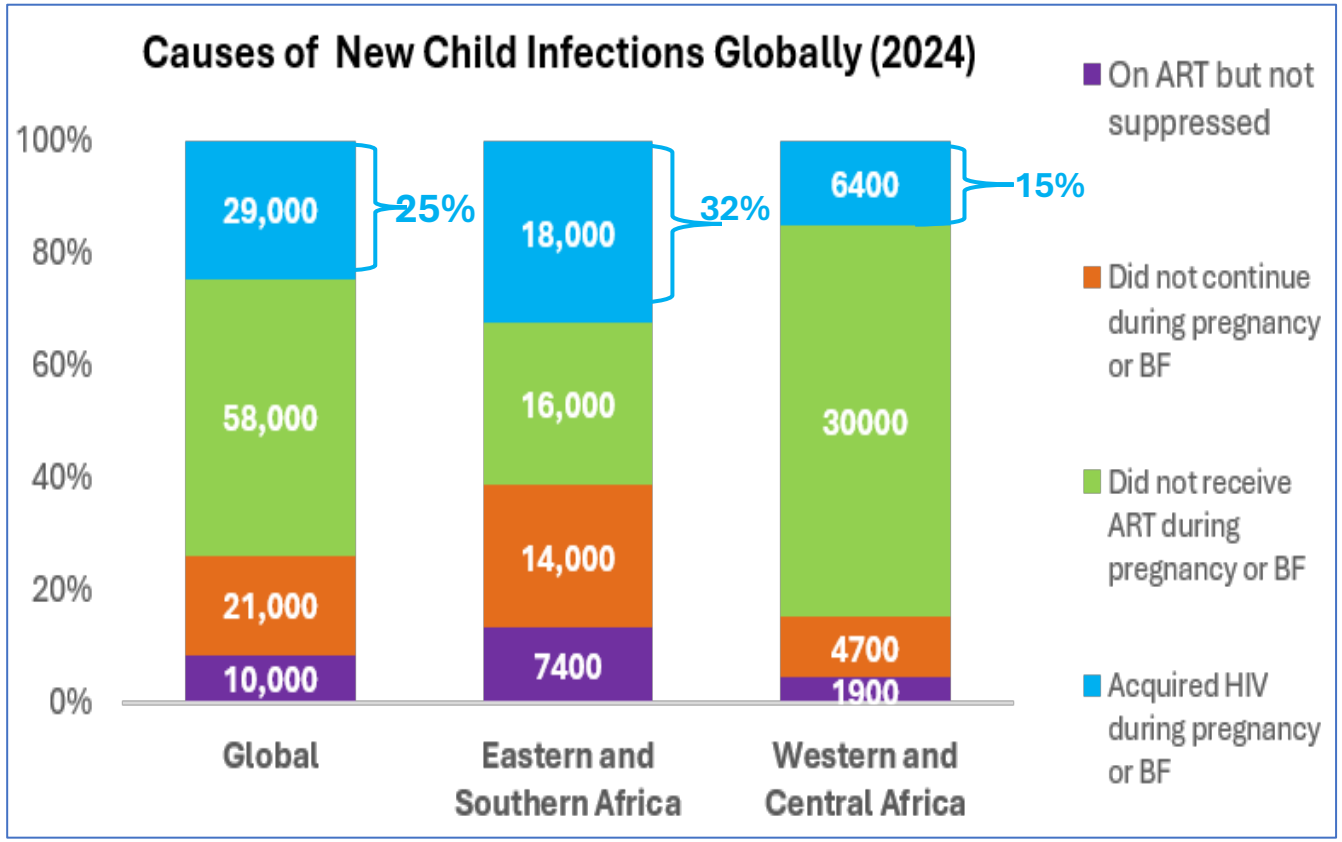
Liesl Page-Shipp

Senior Program Officer

TB & HIV, Gates Foundation

HIV Impact Network for Vertical Transmission Elimination

Globally, incident Infections in PBFW accounted for 25% of new pediatric infections in 2024



- Kenya 2 in 10
- Mozambique 3 in 10
- Nigeria 1 in 10
- South Africa 6 in 10
- Tanzania 3 in 10
- Zambia 4 in 10

Data from HIVE Meeting, April 2026

Source: UNAIDS 2025.

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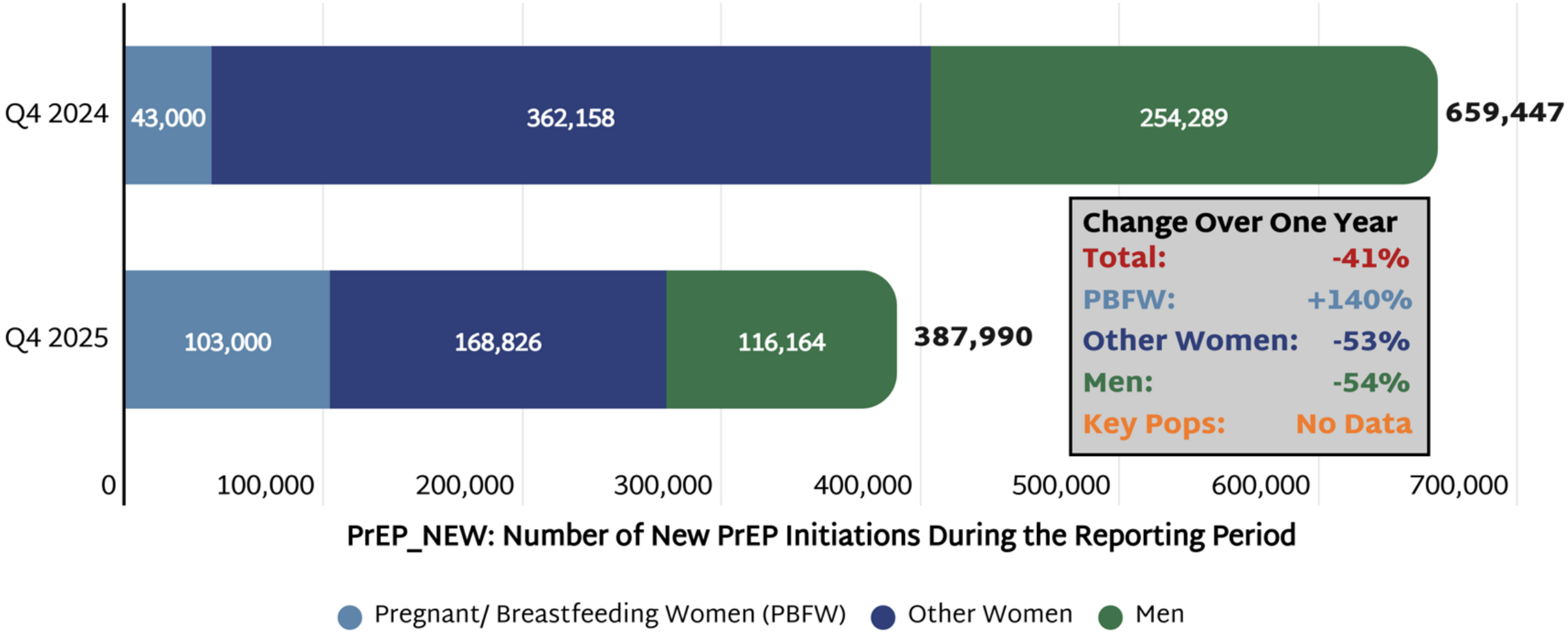
Steep decline in PEPFAR PrEP initiations in 2025; however, PrEP for PBFW increased



Source: AVAC, April 2026

Postnatal period is a critical window for HIV prevention

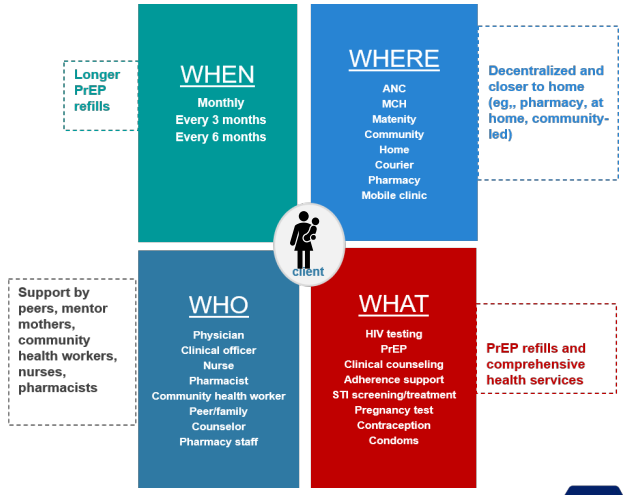
- **Breastfeeding women remain biologically and socially vulnerable to HIV acquisition, with risk influenced**
  - By partner HIV status,
  - Postpartum sexual practices, and
  - Reduced engagement with health services after delivery.
- **Reduced engagement with the health system during the postnatal period contributes to gaps in:-**
  - HIV retesting, risk assessment, and access to prevention services
- **Protecting HIV-negative breastfeeding women through primary prevention of HIV is a core pillar for eliminating vertical transmission**

Drake AL et al PLoS Med 2014, Thompson KA et al J Infect DIs 2018, WHO framework for Triple Elimination

HIV Impact Network for Vertical Transmission Elimination

Integrating PrEP in MCH programs provides unique opportunities

- Increase uptake of HIV testing
- Reduce fragmentation, missed opportunities, and promote continuity in care
- Improve outcomes for mother-infant pairs
- Enhance program efficiency and maximize resources
- Cost effective



Kinuthia J et al, Lancet HIV 2020 , Nelson A et al, BMC Global Health 2024, WHO Integrating HIV Viral Hepatitis and STI with PHC

HIV Impact Network for Vertical Transmission Elimination

Gaps in Postnatal HIV Prevention Identified by Countries

Several missed opportunities for HIV prevention, with critical gaps across services:

- Limited HIV retesting
- Challenges identifying clients who need PrEP
- Limited PrEP options in some countries
- Challenges monitoring initiation and continuation of PrEP
- Limited number of HF providing PrEP
- Asynchronous visit schedules for mother-infant pairs

HIV Impact Network for Vertical Transmission Elimination

Conclusion

- Every postnatal contact is an opportunity to prevent maternal HIV acquisition and protect infants from HIV infection
- Integrating PrEP into existing MCH services requires collaboration across HIV and community programs to ensure access to new PrEP products like Lenacapavir and Cabotegravir
- HIVE provides unique opportunity for shared learning to accelerate PrEP for PBFW

HIV Impact Network for Vertical Transmission Elimination

Thank you.

Country Presentation

Integrated Postnatal Care: A service delivery model for preventing vertical transmission in breastfeeding mothers in South Africa

Jeannette Wessels
Research Center for Maternal, Fetal, Neonatal & Child Health Care Strategies – University of Pretoria, South Africa

HIV Impact Network for Vertical Transmission Elimination

Integrated Postnatal Care

A service delivery model for preventing vertical transmission in breastfeeding mothers in South Africa

HIVE Webinar
18 June 2026

SIHAMBA KUNYE

We walk together

Side by Side

Dr Jeannette Wessels

Research Centre for Maternal, Fetal, Neonatal and Child Healthcare Strategies

University of Pretoria

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Research Centre for Maternal, Fetal, Newborn and Child Health Care Strategies

Sihamba Kunye Integrated Postnatal Care Study

Implementation Science Research to figure out the "How" of IPNC

International and national goals, policies and plans

The problem

Postnatal care for mom is **fragmented in the First 1000 days**

75% of **vertical HIV transmission** occurs during breastfeeding…

Towards the solution

Integrated Postnatal Care Model as a "one-stop shop" for all moms and babies, using a life-course approach

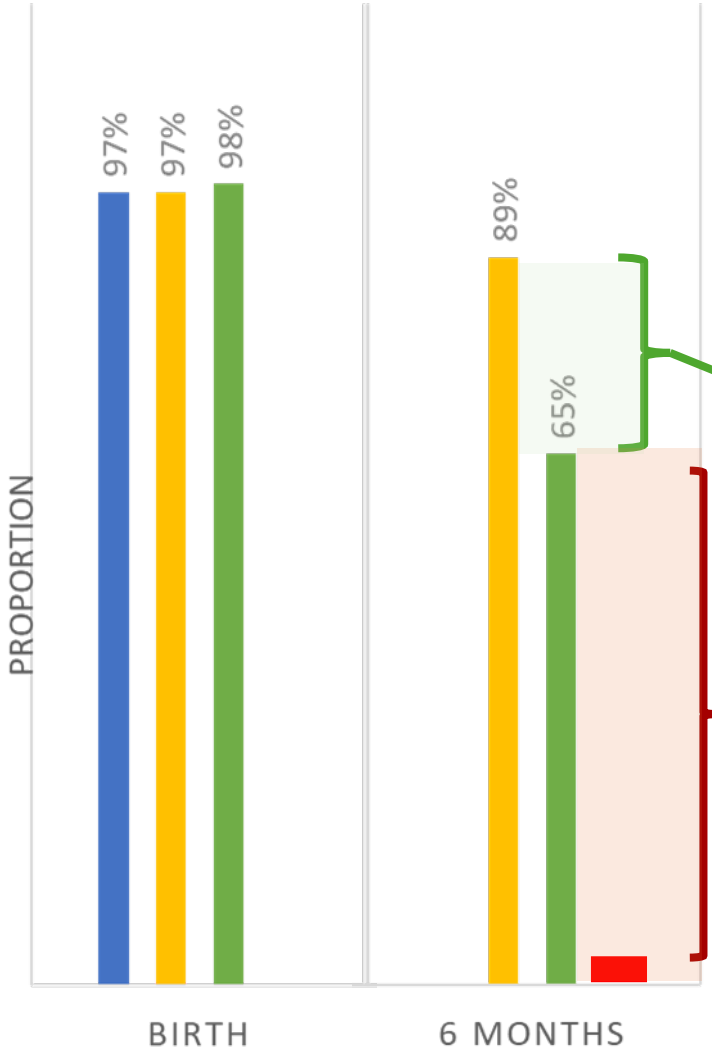
Improved Clinical Outcomes including decreased HIV Vertical Transmissions

Improve operational efficiencies

Increased convenience and reduced cost for mother

Sustainable, using existing resources

Evidence of missed opportunities



75% of vertical transmissions occurred in the **breastfeeding period**

1/3 of VTs during breastfeeding due to new maternal HIV infections

24% difference in the coverage of measles vaccine at 6 months *vs* the coverage of HIV-PCR testing at 6 months

! Significant missed opportunities

to provide an integrated package of care

Less than 0.1% of mothers receive a HIV VL 6 months after delivery

Lack of an enabling environment to provide care for breastfeeding mothers

Live births to WLHIV in a facility

Immunisation coverage (Hexa/Measles coverage)

HIV PCR coverage

VL 6/12s after delivery

What we need to do: The 4 Pillars of VTP

PILLAR 1

Primary prevention of HIV, especially among women of childbearing potential

PILLAR 2

Preventing unintended pregnancies among women living with HIV

PILLAR 3

Preventing HIV transmission from a woman living with HIV to her infant

PILLAR 4

Providing appropriate treatment, care, and support to women living with HIV, their children, partners and families

Pillar 1
HIV retesting and PrEP

Pillar 2
Contraception

Pillar 3 & 4
ART & Adherence support
Maternal VL monitoring
Screening for TB, STIs & Maternal mental health
Infant prophylaxis and EID
Breastfeeding support

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Examples of non-client-centric service delivery models that contribute to missed opportunities and disengagement from care

Scenario 1

Care for a mother and baby without visit coordination or integration

Scheduled visit	Well baby visit	HIV exposed infant	ART/HIV prevention mother	Mother's Family planning	Number of Visits
3-6 day visit	x	Birth PCR result Risk profile	Delivery VL result		1
6 weeks	x	stop NVP			1
8 weeks			ART	NET-EN	2
10 weeks	x	10-week PCR			1
12 weeks			HIV test	Depo/COCP	2
14 weeks	x				1
20 weeks			ART		1
6 months	x	6-month PCR	ART & VL test	x	2
					11

- Coordinate visits (lose visits at 8, 12 and 20 wks)
- Integrate care at each visit

8 weeks X

12 weeks X

20 weeks X

Scenario 2

Care for a mother-baby-pair with visit coordination and integration

Scheduled visit	Well baby visit	HIV exposed infant	ART/HIV prevention mother	Mother's Family planning	Number of Visits
3-6 day visit	x	Birth PCR result Risk profile	Delivery VL result		1
6 weeks	x	stop NVP	ART	NET-EN	1
10 weeks	x	10-week PCR	HIV test	Depo/COCP	1
14 weeks	x		ART		1
6 months	x	6-month PCR	ART & VL test	x	1
					5

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Sihamba Kunye: Figuring out the “How?”

Sihamba Kunye Side-by-Side

A 2-year funded Implementation Science Project
(July 2024 to June 2026)

Aim: To implement a structured and **integrated postnatal care package** (‘First 1000-day Roadmap’) for the mother after delivery, located **at the same service delivery point as care for her infant**

Tshwane Health District

Sub-districts 5, 6 and 7 in Tshwane District, Gauteng

- **8 sites in total**
- **Mix of rural (3) and urban (5)**
- **Mix of small, medium, and large ‘PHC under five headcount’**
- **6 facilities (provincial) and 2 facilities (City of Tshwane)**

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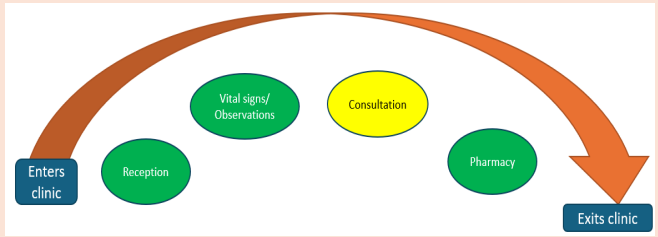
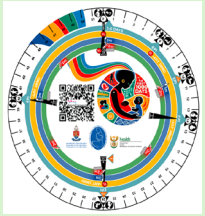
Sihamba Kunye tools to figure out the “How?”

Tools

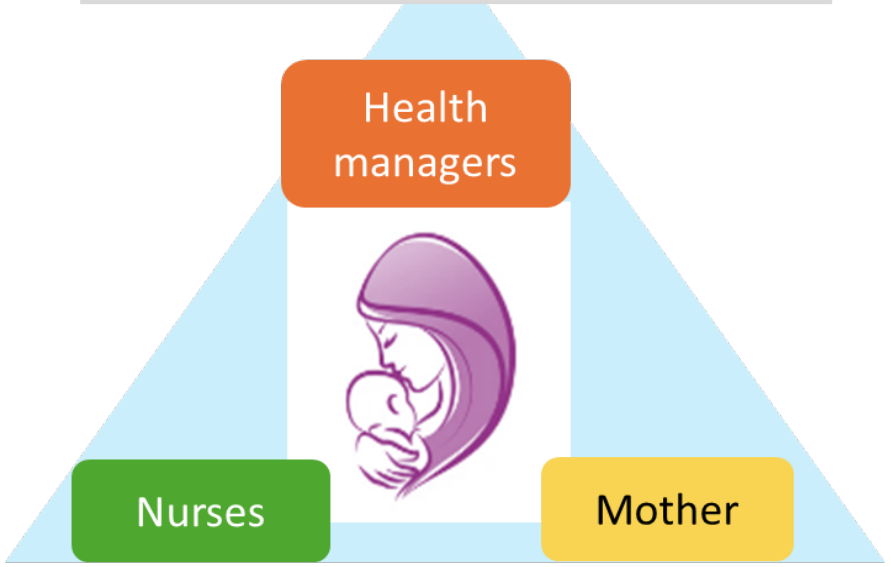


Time and Motion Studies

Tools



Roadmap & Integration wheel



One-stop-shop for mother-baby pair

Tools

Client interviews

To date we have conducted

8729

interviews with MIPs

What have we learned and what have we achieved by implementing a model of integrated postnatal care?

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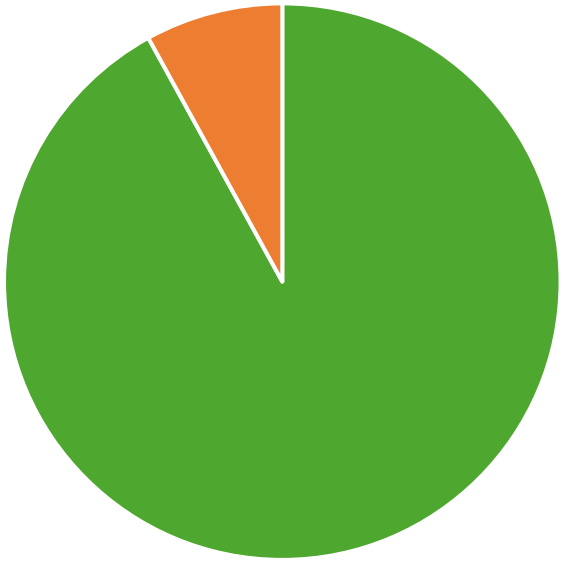
Good news!

- 93% (7708/8258) babies attended with their mothers



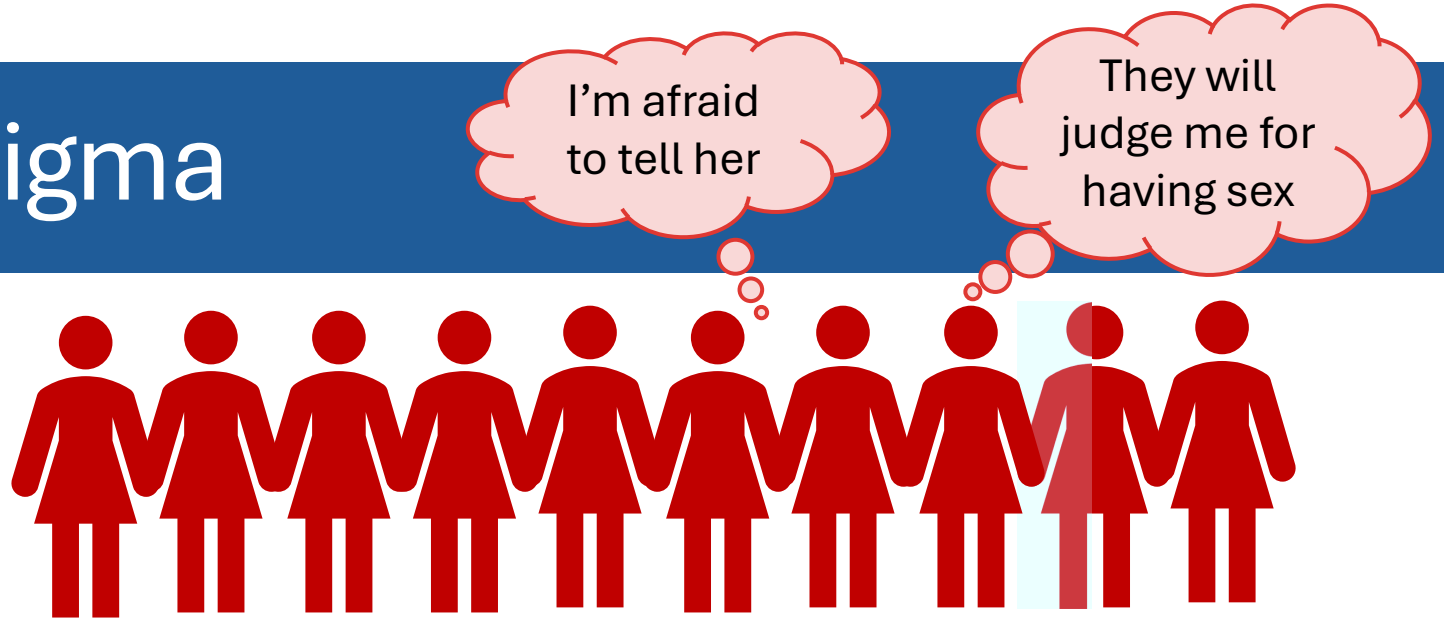
Opportunity to provide:

- **HIV testing** and **PrEP**
- **Family planning**.
- **ART** & 6-monthly **VL testing** to mothers during breastfeeding
- **HIV-PCR testing** with parental **consent**
- Support **breastfeeding**

Anticipated Stigma

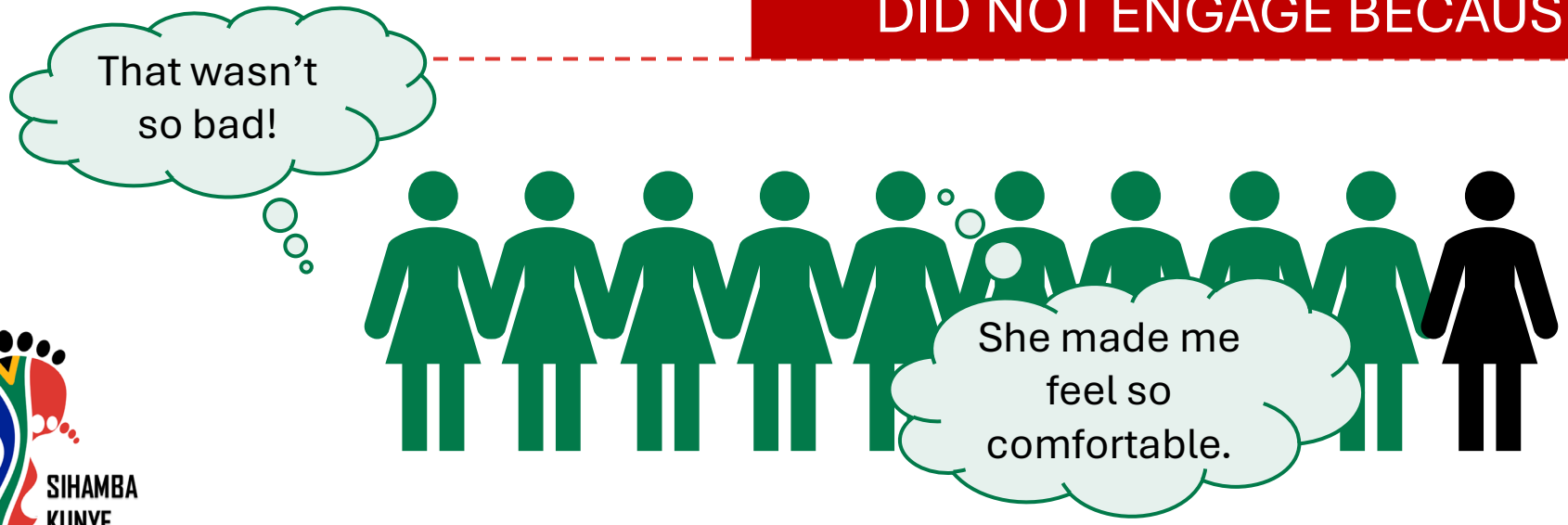
5291 women

"Do you think a HCW will disapprove of sex soon after delivery?"



41% of women

DID NOT ENGAGE BECAUSE OF THIS



But, of those who did engage about sex, almost 9 out of 10 ***did not*** actually experience stigma

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Women expect judgement!
They will not initiate conversations about sex and HIV risk

Most women will never ask for PrEP

How we start that conversation can be a deal breaker.
She will decide in the first 90 seconds if she feels safe

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What the first 90 seconds must do

- Normalise sex
- Normalise risk
- Explain protection is for mom and baby
- Offer choice

Every person is different.

But if we start here, the rest of the conversation becomes easier.

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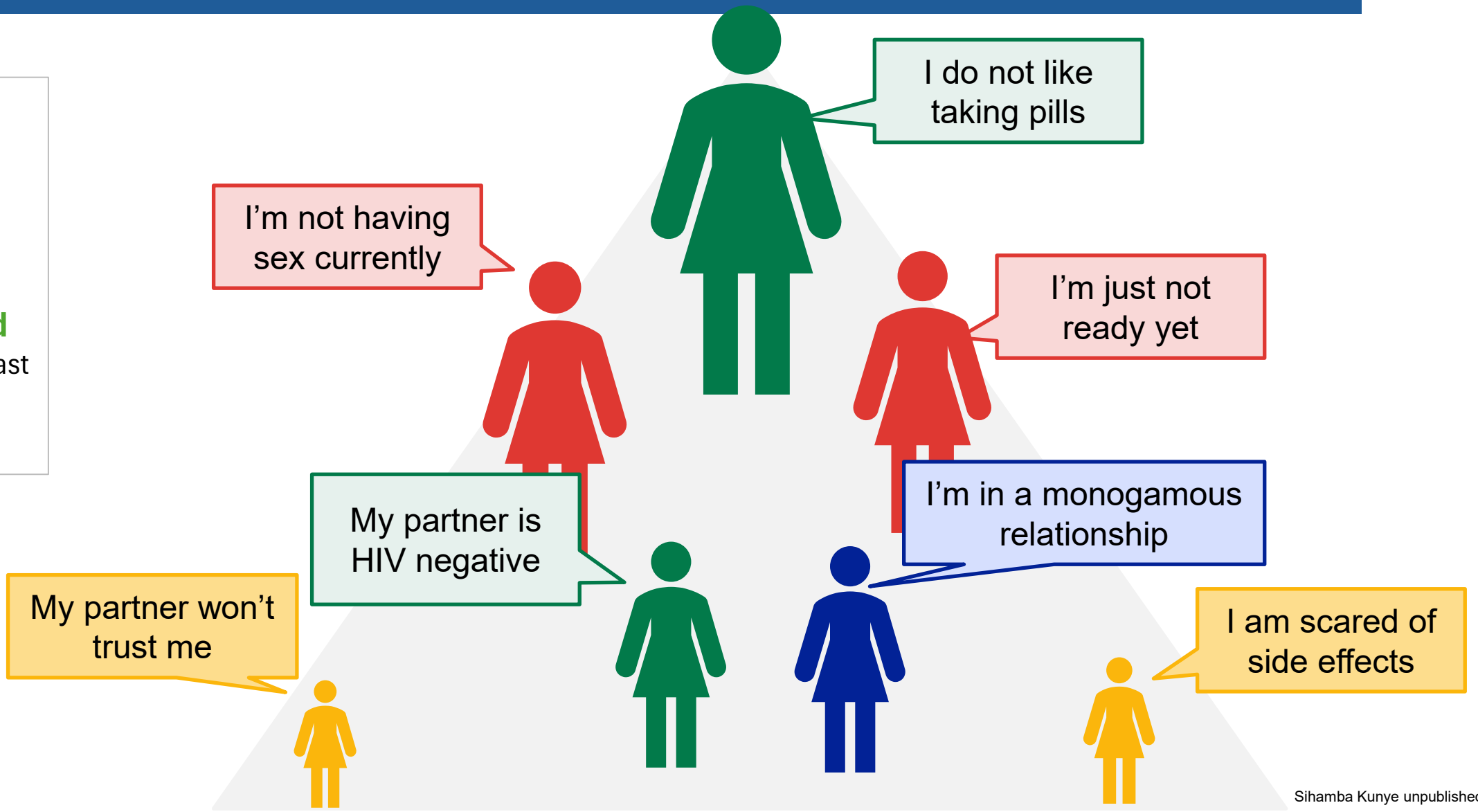
Reasons why women decline PrEP

%

Mothers with partners who **have tested** negative in the last 12 months



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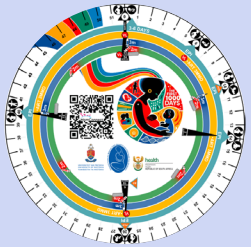
Essential Steps for Integrated Postnatal Care

Step 1

- Mom and baby need to be present at child health services

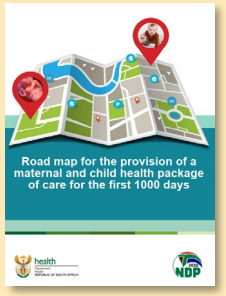
Step 2

- Drawing files for mom & baby
- Appointment alignment



Step 3

- Nurse clinical decision support tools



Step 4

- Nurse needs to have **TIME for longer clinical consultations**

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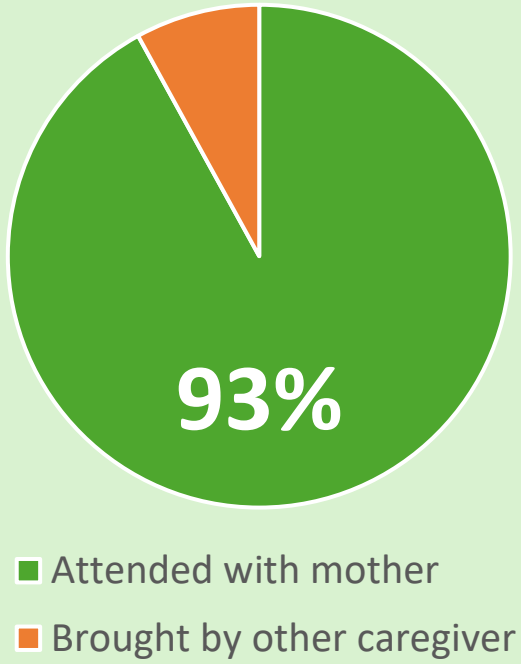
Step 1: Mothers must bring their babies to the clinic

In Tshwane, SA, 93% (7708/8258) of babies attended with their mothers



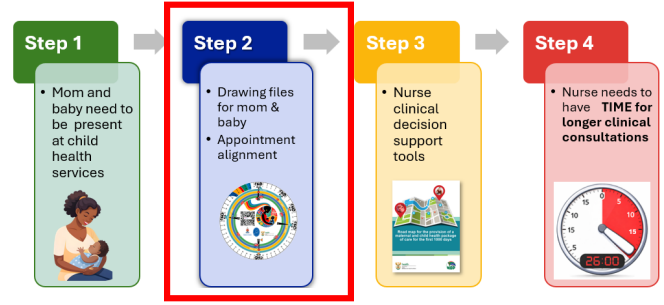
When mothers bring their babies to a health facility, we need to make every contact.

This is an opportunity to provide:

- **HIV testing** and **PrEP**
- **Family planning**.
- **ART** & 6-monthly **VL testing** to mothers during breastfeeding
- **HIV-PCR testing** with parental **consent**
- Support **breastfeeding**

Consider demand creation strategies
(social media, radio messaging, posters, etc.)
to inform mothers of services available as a one-stop shop.

Step 2: Practical steps for visit alignment



Mom needs to have her file for any maternal care or visit re-alignment to happen

This enables integrated service provision at the **current visit**

Mom and baby present at child health services

Draw mom's file for every mother bringing her baby to child health services

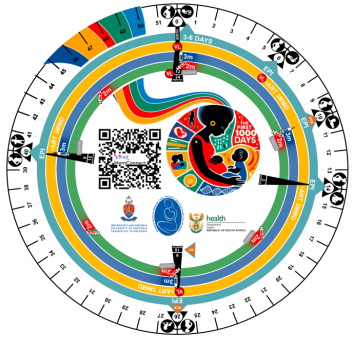
Other service points from where visits can be aligned:

Align mother and baby visits at **3–6-day visit**

Align mother/baby visits when mother comes to **Family planning**

Mom's return date needs to be aligned with her infant's return date from **Child Health Service Point**

This addresses visit alignment for the **next visit**



1. Draw the mother's file when she brings the baby
2. Give the next appointment that aligns with the baby's appointment schedule
3. Make sure she doesn't run out of treatment (ART/PrEP)
4. Make sure she doesn't run out of contraceptive coverage
5. The Integration wheel is a helpful tool to ensure points 2-4 above
6. Remember to check that your date doesn't fall on a weekend!

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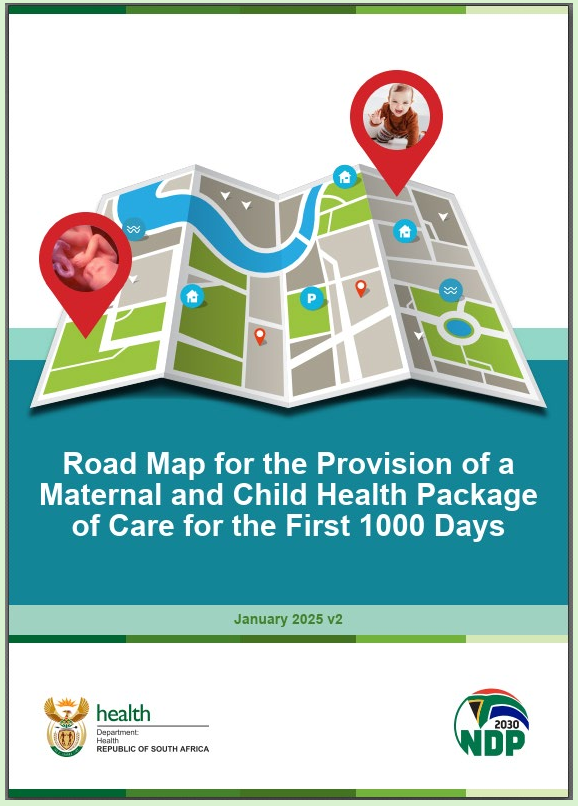
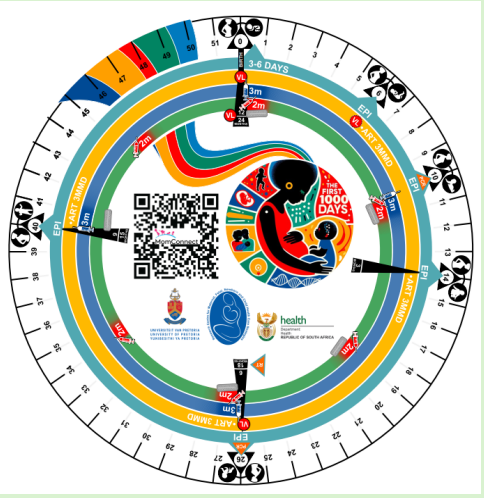
Step 3 Decision support tools for nurses

From a disease-specific orientation





From To a patient-centred and visit-focused orientation

POSTNATAL VISIT: MOTHER: 10 WEEKS

DURING THE CONSULTATION

Introduce yourself by name to the mother and build a rapport. Be empathetic and address any concerns.
Ask the mother: How are you feeling? How are you managing with your baby?

GENERAL HEALTH

• Ask the mother: Do you have any health concerns? • Assess the general well-being of the mother. • Measure blood pressure and heart rate. Check for pallor.	• Address any health concerns. • Take a history and clinical examination relevant to any complaints. Manage according to protocols.

NUTRITION

Measure weight and height. Check the mother's MUAC. Check for food insecurity. INFO 12.	Use MUAC to determine nutritional status and manage according to INFO 6.

VERTICAL TRANSMISSION PREVENTION

Retest the HIV-negative mother for HIV	If not known to be LHIV, offer a repeat HIV test today: • If HIV negative and not on PrEP, screen for and offer PrEP INFO 14. • Offer basic HIV prevention package. INFO 13 • If HIV positive, initiate ART. INFO 15
Check partner/husband's status	• Offer partner/couples testing if partner not tested in last year. • Manage discordant status according to VTP guidelines. • Offer PrEP for her HIV-negative partner.
Offer PrEP for the HIV-negative mother	• Check PrEP adherence. Provide PrEP for 3 DCs (3MMD)
Provide ART for the mother LHIV	• Check ART adherence. Confirm that she has ART supply to last till the 14 week visit.
Monitor and manage the mother's viral load	Review results of HIV-VL done at 6 wks (mother with HIV-VL ≥ 50 c/mL at delivery only). • If HIV-VL > 50 c/mL, manage mother as per INFO 16A. • Continue NVP for the infant until the mother's repeat HIV-VL is confirmed to be < 50 c/mL
Ask if she has other biological children?	Check that the HIV status of her other children is known

TUBERCULOSIS SCREENING FOR THE MOTHER

Screen for TB symptoms and TB exposure in all mothers at visit, and regardless of her HIV status. INFO 21.	• If asymptomatic and TB exposed, assess for TPT eligibility as per INFO 22. • If symptomatic, do or refer for TB investigations according to the National TB Guidelines. • If the mother has TB, be sure to evaluate the baby for either TB treatment or TPT.

SEXUALLY TRANSMITTED INFECTION SCREENING

Ask the mother: Do you have a vaginal discharge?	• Manage vaginal discharge as per INFO 25.
Ask the mother: Do you have any genital sores?	• Manage genital ulcers as per INFO 26.

MENTAL HEALTH SCREENING

Review when last the mother was screened for mental health conditions. If eligible, do mental health screening and manage according to guidelines. INFO 27

CERVICAL CANCER SCREENING

Screen the mother to determine if she is eligible for a cervical smear. INFO 11	If eligible, do a cervical smear today.

CONTRACEPTION

Ask the mother: What contraceptive method are you using?	• If the mother received either DMPA (Depo Provera®or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit. • If on the COCP, provide 3MMD today • If on DMPA or COCP, give next appointment to align with 6-month well-baby visit. • If on NET-EN, give next appointment at 4 months (18 weeks) for repeat NET-EN.

EXTRA CARE

Review the mother's age. If a teenager, ASK: are you having any problems, at home, school or work? Refer to social worker if there is abuse or violence. Refer to teenage support groups, if available. Advise against alcohol, smoking and recreational drugs.

- Explore social circumstances among all women. Identify any support needed and link to networks if necessary.
- Ensure the mother is linked to MomConnect and receiving postnatal messages.
- Ensure the mother and baby are linked to a CHW for home visits.

GIVE NEXT APPOINTMENT

- Give the mother an appointment date for the 14-week well-mother/child visit.
- Make sure the mother knows when and where she will get all her needed care, e.g., ART, contraception, etc.
- Advise mother to return if she or baby is sick, if she needs breastfeeding support or if she has any concerns.

POSTNATAL VISIT: BABY: 10 WEEKS

DURING THE CONSULTATION

Introduce yourself by name to the mother and build a rapport. Be empathetic and address any concerns.
Ask the mother: How are you managing with the baby? Can I please see your baby's RTHB?

HEALTH CARE

Ask the mother: Is the child sick today?	• If yes, manage according to IMCI guidelines.
Ask the mother: • Has the child been sick since the last clinic visit?	• If yes, review clinical notes in the RTHB and manage according to IMCI guidelines.

GROWTH MONITORING

Measure the baby's weight and length. • Plot the weight on the RTHB weight chart (p. 12 or 16). • Plot the length on the RTHB length chart (p. 15 or 19). • Plot the weight for height on the RTHB (p. 11 or 20).	• Manage according to IMCI guidelines INFO 11. • If weight for length is less than -3, refer urgently.
Check for bilateral pedal oedema.	• If present, review clinical notes in the RTHB and manage according to IMCI guidelines.

NUTRITION TO GROW

Ask the mother: • How is the feeding going? • How many times do you breastfeed in 24 hours? • Does your baby get any other food or fluids? - If yes, how often?	• Manage according to IMCI guidelines INFO 10. • Assist with any challenges and support mothers to exclusively breastfeed for 6 months INFO 8. • If planning to return to school or work, advise to express breast milk to give to the baby while away from the baby. • If no longer breastfeeding, counsel about possibility of re-establishing breastfeeding. • If no longer able to breastfeed, counsel about giving safe replacement feeds INFO 9.

VERTICAL TRANSMISSION PREVENTION

All HIV-exposed infants (HEI):	• Do 10-week HIV-PCR test today.
Low-risk HIV-exposed infant (HEI):	• Confirm that NVP was stopped at the 6 week visit.

Higher-risk HEI:
(mother's delivery HIV-VL was ≥ 50 c/mL)
	• Check if the mother's HIV-VL was repeated at 6 weeks. Review the results and manage the baby's HIV prophylaxis accordingly:
	  - If the repeat maternal HIV-VL at 6 weeks was < 50 c/mL, stop NVP after 12 weeks have been completed.
	  - If the maternal HIV-VL was still ≥ 50c/mL, ensure that the baby continues to take NVP prophylaxis until maternal HIV-VL suppression is confirmed or until 4 weeks after all breastfeeding has stopped. INFO 17A
	  - Check adherence to NVP.
	  - Check the supply of NVP and provide if necessary.

CONSIDER TB IN THE CHILD

Screen for TB symptoms and exposure in all children at every visit, regardless of the mother's HIV status.	• If asymptomatic and TB exposed, assess for TPT eligibility as per the latest TPT Guideline. • If symptomatic, do or refer for TB investigations, including induced sputum and CXR, according to INFO 24.

IMMUNISATIONS

Give the 10-week immunisations as per the EPI schedule. INFO 29A

DEVELOPMENT

Ask the mother: • Are you concerned about your baby's development? • Do you feel your baby is making eye contact with you? Check: does the baby respond to sound?	• Address any concern the mother has and refer if necessary.

LOVE, PLAY AND TALK

- Advise the mother to pay attention to her child's interests, emotions, likes and dislikes. Encourage mother to talk, sing and show love to her baby.
- Encourage father to participate in the child's care and development.

EXTRA CARE

- Advise the mother how to apply for a birth certificate.
- Advise the mother how to apply for a child support grant.
- Ensure the mother is linked to MomConnect and receiving postnatal messages.
- Ensure the mother and baby are linked to a CHW for home visits.

NEXT APPOINTMENT

- Advise the mother to return to the nearest clinic for a well-mother/child visit at 14-weeks.

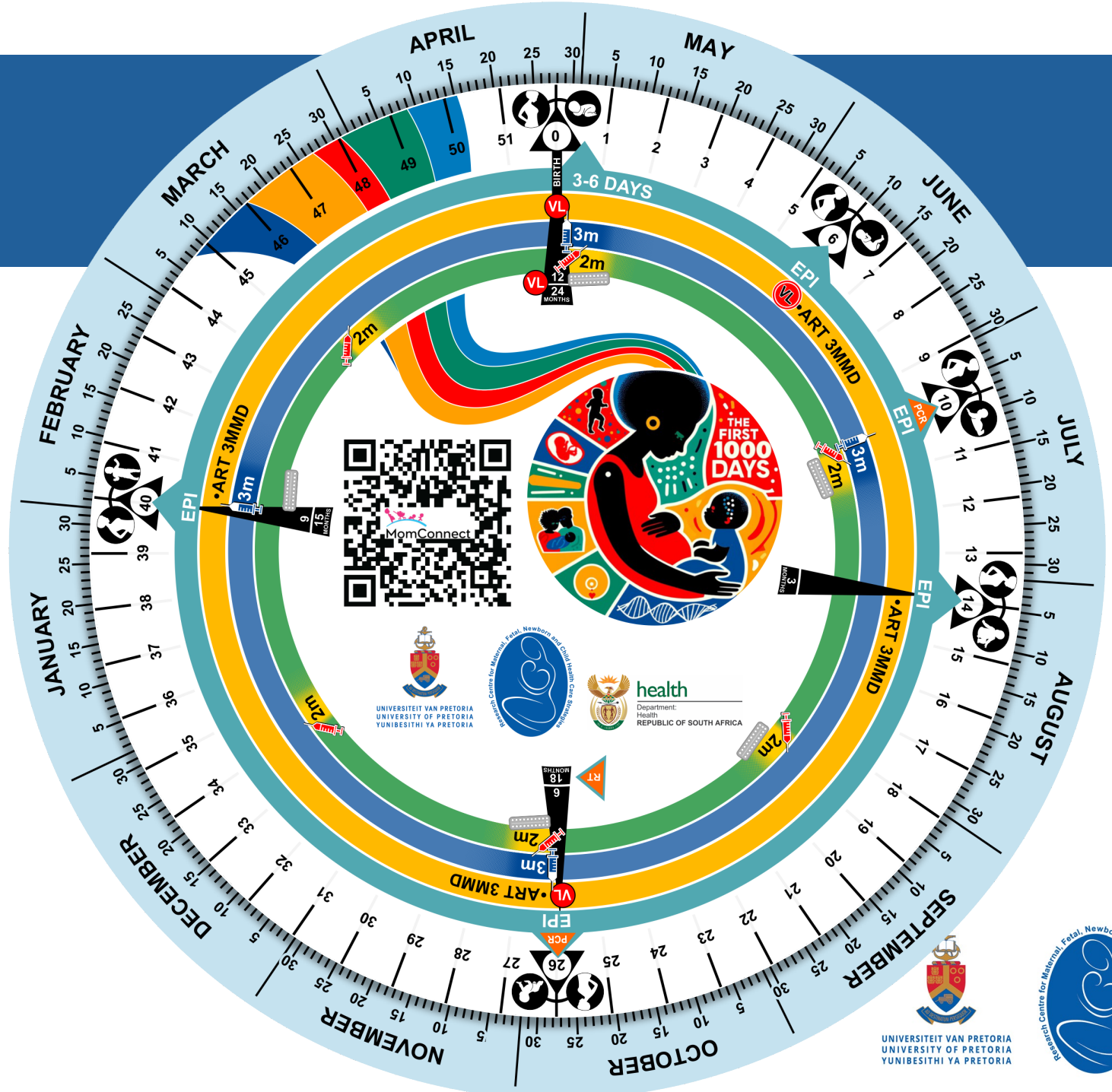
REMEMBER TO PROVIDE INTEGRATED POSTNATAL CARE FOR THE MOTHER AS DETAILED ON THE OPPOSITE PAGE.

Back Slider

Integration wheel guides:

What is the **‘next visit’** date for the MIP

‘How much’ to give to ensure mother doesn’t run out of treatment or contraceptive effectiveness



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Front Slider

Integration wheel guides:

'What to give' components of care requiring some kind of medication (ART, PrEP, FP)

'When to give' which visit needs which components

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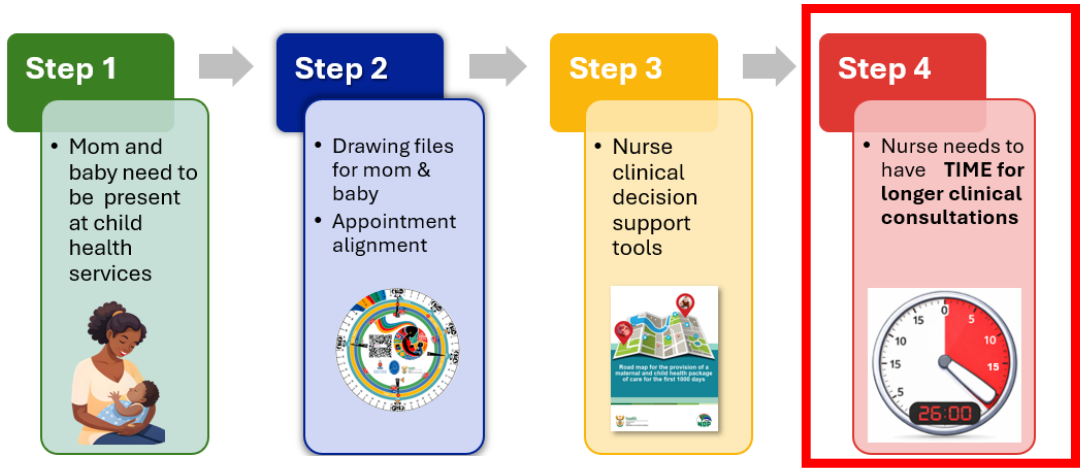
Step 4: Increasing the time available to nurses at child health services



How can we increase available nurse consultation time without employing more nurses?

A **Decrease process waste**

B **Task shifting**

C **Nurse workload redistribution**
If clients move,
nurses may need to move

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Integration Levels

Workload calculations can determine the amount of time remaining in a nurse's workday that is available for maternal consultations, over and above the time she needs to see her child consultations. This will determine the level of one-stop-shop integration that can be provided for the mother-baby pair. Integration options are illustrated below.

Individual

Mother and child

Level 1 integration:
Same-day visit alignment for an **individual**, different consultation rooms

Level 2 integration:
All care in one consultation room for an **individual**

Level 3 integration:
Same-day visit alignment for **mother & child**, but different consultation rooms

Level 3 / 4 Hybrid integration

For mother and child:

- Level 3 up to 6-month EPI visit; level 2 thereafter
- Level 3 for mothers LHIV

Level 4 Full "one-stop-shop" integration

Sufficient time is available to see **mother and child** on the same day, in the same consultation room, with the same nurse

Same-day appointments

Same consultation room

Three models have been observed

Small facilities
< 13 well-baby visits/day/nurse

Level 4 Integration feasible

Full 1-stop-shop IPNC

Medium facilities
14-26 well-baby visits/day/nurse

Level 3/4 Hybrid Integration

based on
- Infant age or
- HIV exposure status

Large facilities
> 26 well-baby visits/day/nurse

Level 3 Integration

Workload limits Level 3 feasibility
Workload re-distribution essential

Key lessons

- Integrated postnatal care produces rapid, measurable gains.
- Integration gaps are operational, rather than primarily clinical.
- Workflow and workload optimisation is the critical enabler of scale.
- Clinical Decision-support tools change practice.
- One size does not fit all facilities.

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IPNC Potential

- A vehicle to move IPCC policy into practice and reduce system-level fragmentation
- A vehicle to move us closer to VTP elimination targets
  - Prevent new infections in women through HTS and PrEP
  - Improved 95-95-95 for women of childbearing potential
  - Reduce HIV infections in children
- A vehicle to move us closer to SDG survive thrive targets for all women and children

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Let’s keep
mothers and babies
‘Walking Together’
Side By Side

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Thank you

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Research Centre for Maternal, Fetal, Newborn and Child Health Care Strategies

Reflections from Civil Society

Ndivhuwo Rambau
Project Coordinator
Ritshidze Program
South Africa

HIV Impact Network for Vertical Transmission Elimination

TAC
TREATMENT ACTION CAMPAIGN

KEY ISSUES
THAT NEED TO BE TACKLED

Limited awareness of HIV risk during breastfeeding.

Fear of side effects and concerns about infant safety.

Long waiting times and transport costs.

Stigma associated with HIV prevention and PrEP use.

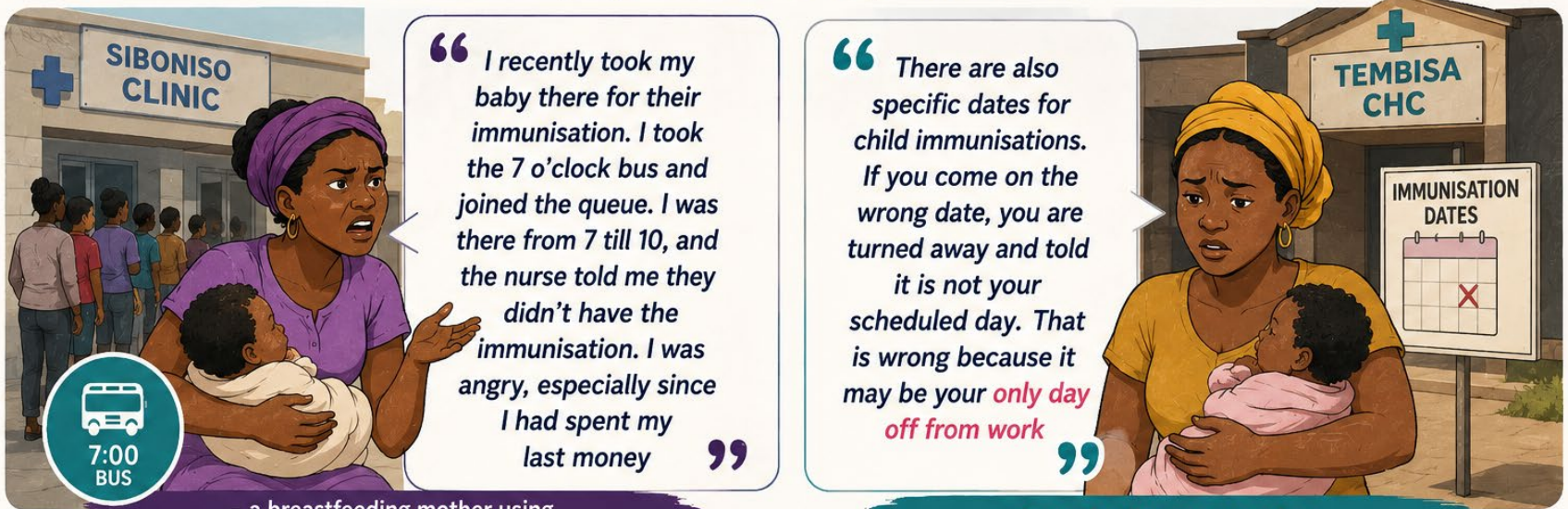
WHEN THESE BARRIERS ARE REMOVED,
MOTHERS CAN ACCESS THE CARE THEY NEED—AND DESERVE.

COMMUNITIES SPEAK. SYSTEMS LISTEN. TOGETHER, WE CAN CLOSE THE GAPS.

HIV Impact Network for Vertical Transmission Elimination

REAL VOICES. REAL BARRIERS. REAL CHANGE.

Mothers are trying their best. The system is letting them down.



- Long waiting times
- High transport costs
- Stock-outs of immunisations
- Rigid schedules and turned away
- Financial strain on families

No mother should be punished for trying to protect her child.

HEALTH SERVICES MUST BE RELIABLE, RESPECTFUL AND ACCESSIBLE—FOR EVERY MOTHER, EVERY TIME.

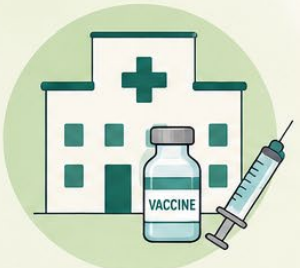
TAC
TREATMENT ACTION CAMPAIGN

NO MOTHER SHOULD FALL THROUGH THE CRACKS *after delivery.*

HIV prevention services must follow women throughout the entire postnatal journey.

Integrated HIV prevention services throughout the breastfeeding period, including routine HIV re-testing, risk assessments, access to PrEP, partner services, and adherence support.

Alignment of maternal and child health appointments so that mothers and infants receive services during the same visit.



Integration of HIV prevention into postnatal care, immunisation, and well-baby clinics to reduce missed opportunities for follow-up.

Use of community-generated evidence to identify barriers to continuity of care and hold health systems accountable for addressing service gaps.

No mother should fall through the cracks after delivery.
HIV prevention services must follow women throughout the entire postnatal journey.

EVERY WOMAN. EVERY VISIT. EVERY OPPORTUNITY. *No one left behind.*

HIV Impact Network for Vertical Transmission Elimination

Thank you.

Q&A Discussion

Moderators

Bernadeta Msongole
HIVE VTP Advisor,
ICAP Tanzania

Lulu Ndapatani
HIVE VTP Advisor,
ICAP Kenya

Panelists & Discussants

Liesl Page-Shipp
Senior Program Officer
TB & HIV
Gates Foundation

Jeannette Wessels
UP Research Center for
Maternal, Fetal, Newborn &
Child Health Care
Strategies, South Africa

Ndivhuwo Rambau
Project Coordinator
Ritshidze program
South Africa

HIV Impact Network for Vertical Transmission Elimination

Closing Remarks

Maureen Syowai
Program Director (CQUIN/HIVE)
ICAP in Kenya

HIV Impact Network for Vertical Transmission Elimination

Thank you.