PMTCT implementation in Eastern and Southern Africa
Case study: Mozambique MTCT program

Marilena Urso
06.02.17
CDC Mozambique
Outline

- Global Plan
- Global targets and Pillars
- Progress of the Global Plan
- Successes and Gaps in implementation of PMTCT cascade in Eastern Southern Africa
- Case study: Mozambique
- Questions & Answers
Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive

Goals:
- Reduce number of new HIV infections among children by 90% from 2009 baseline to <40,000 per year and transmission to <5%
- Reduce the number of HIV-related maternal deaths by 50%
Where?
22 High Priority Countries where in 2009 90% of Pregnant women HIV+ were in need of PMTCT

<table>
<thead>
<tr>
<th>Angola</th>
<th>Ghana</th>
<th>South Africa</th>
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<tbody>
<tr>
<td>Botswana</td>
<td>*India</td>
<td>Swaziland</td>
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<td>Ethiopia</td>
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Global Targets

Reduce number of new HIV infections among children by 90%
  • Reduce AIDS related infant deaths by > 50%
  • Provide ART to all children
Reduce number of AIDS related maternal deaths by 50%

AND CONTRIBUTES TO

Previous MDGs 3-6
(Gender Equity, Infant Mortality, Maternal Health, Infectious Diseases)
Goal: prevent new HIV infections among children

• Prevention of primary infection (all women and especially targeting adolescent young women and pregnant breastfeeding women)
• Early access to antenatal care and HIV testing for all pregnant women
• Identification of HIV+ pregnant women and male partners (Quality psychosocial support and Option B+ for mother, retention/ adherence in treatment)
• Identify treatment failures and correct
• Safe childbirth, efficient drugs for prophylaxis for infant
• Safe breastfeeding and infant feeding
• Early infant testing for HIV and early linkage to treatment
More Than 1/3 New HIV Infections Globally Occur Among Young Women in Africa

Subnational HIV incidence (%) among young women (aged 15–24 years), by age group, eastern and southern Africa, 2014–2015

Source: UNAIDS special analysis, 2016; for more details, see annex on methodology.
Pregnancy and the postpartum period are times of persistent HIV risk, at rates similar to “high risk” cohorts.

MTCT risk was significantly higher among women with incident versus chronic HIV infection in the postpartum period (OR 2.9, 95% CI 2.2–3.9) or in pregnancy/postpartum periods combined (OR 2.3, 95% CI 1.2–4.4). (Small sample)
In Mozambique...

High HIV incidence in the postpartum period sustains vertical transmission in settings with generalized epidemics: a cohort study in Southern Mozambique

Caroline De Schacht, Nélio Mabunda, Orlando C. Ferreira Jr., Nádia Ismael, Nuriel Calu, Isabel Santos, Heather J. Hoffman, Catharina Alôa, Laura Guay, and Ilesh V. Jani

957 women, median follow-up of 18.2 months.

The HIV incidence in postpartum women is estimated at 3.20/100 women-years (95% CI: 2.30–4.46), with the highest rate among 18- to 19-year-olds (4.92 per 100 women-years; 95% CI: 2.65–9.15).

Of the new infections, 14 (34%) were identified during the first six months postpartum, 11 (27%) between 6 and 12 months and 16 (39%) between 12 and 18 months postpartum.

- Risk factors for incident HIV infection include young age, low number of children, higher education level of the woman's partner and having had sex with someone other than one's partner.
- The vertical transmission was 21% (95% CI: 5–36) among newly infected women.
Modeling of % of MTCT due to maternal seroconversion during pregnancy & breastfeeding
(per courtesy of L. Johnson, South Africa)

In 2015 59% was the modeled fraction of MTCT attributable to maternal seroconversion during pregnancy and breastfeeding.
Partners’ HIV Counseling and Testing (CHTC) crucial to identify serodiscordant couples

- ANC and PMTCT setting important entry for couples C&T
- Evidence from HPTN 052: 96% decrease in transmission in serodiscordant couples

- High rates of serodiscordance in many settings (10-50%)
- In Mozambique 10% of serodiscordant couples
- Coverage of partners’ testing 50% with regional differences

- Provide ART, regardless of "eligibility" for the HIV+ partner in serodiscordant couple
Percent of ever-married or partnered women (aged 15–49 years) reporting experiences of physical and/or sexual violence by a former or current male intimate partner in the past 12 months, most recent data, 2010–2014

<table>
<thead>
<tr>
<th></th>
<th>20 – 40%</th>
<th>10 – 19%</th>
<th>0 – 9%</th>
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Sexual violence still plays a significant role in new HIV infections in eastern and Southern Africa.
Prevention of New Maternal HIV Infection

- Prevention of *incident infection* in uninfected pregnant and breastfeeding women (*esp. adolescent girls and young women*)
  - Repeat HIV testing during pregnancy/BF offers opportunity to protect women initially identified as uninfected (WHO 2016)
- Prevention of male primary infections (male engagement, male circumcision)
- Testing of male partners and linkage of infected partners to treatment may reduce transmission
- PrEP for HIV- woman (at least during high-risk period of pregnancy and breastfeeding)
All pregnant and breastfeeding women should know their HIV status (goal is 90%)

- Quality of testing is a challenge
- WHO 2016 guidelines recommend repeat testing (challenges for feasibility and costing)

Countries with low HIV testing coverage among pregnant women have many challenges in common:

- Lack of test kits due to poor procurement and supply chain systems
- Traditional beliefs, cultural practices, stigma and discrimination, lack of confidentiality within health-care settings and transportation challenges hinder access and contribute to underutilization of services
Beneficial impact of male involvement in programs to prevent the mother-to-child transmission of HIV to tackle new infections among infants

Morfaw et al. Systematic Reviews 2013, 2:5
http://www.systematicreviewsjournal.com/content/2/1/5

24 studies from peer-reviewed journals; 21 from sub-Saharan Africa

Barriers to male PMTCT involvement:

☑ At the level of the society: ANC and PMTCT as a woman’s activity

☑ The health system: long waiting times/ male unfriendliness of PMTCT services

☑ The Individual: the lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse’s HIV status was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce. Financial dependence of women was key to facilitating spousal involvement

Actions implemented.....

Partners’ invitation, afterhours attendance, prioritization
Pre-exposure prophylaxis for pregnant and breastfeeding women (PrEP) taken daily reduces by 90% risk of transmission

- Additional HIV prevention option for pregnant and breastfeeding women in settings with continuing high HIV incidence during this period of life.
- WHO recommends that women taking PrEP should continue taking PrEP when they become pregnant and during breastfeeding.
- PrEP should be an option for pregnant and breastfeeding women in high-prevalence settings in sub-Saharan Africa, and it recommended that mothers and infants should be monitored for potential adverse effects (WHO).
- Globally, pregnant and breastfeeding women within serodiscordant couples—where the male partner is living with HIV—should consider PrEP in addition to antiretroviral therapy for the male partner until viral suppression is achieved.
- Preventing HIV infection during pregnancy and breastfeeding has important implications for transmission to the child because women who seroconvert during pregnancy or breastfeeding are 18% and 27% likely to transmit the virus to their unborn child, respectively.
- **To be piloted in Mozambique in 2017, already being implemented in South Africa**
Goal: prevent new HIV infections among children

- Prevention of primary infection (all women and especially targeting adolescent young women and pregnant breastfeeding women)
- Early access to antenatal care and HIV testing for all pregnant women
- Identification of HIV+ pregnant women and male partners and initiation of ART (Quality psychosocial support and Option B+ for mother, retention/ adherence in treatment)
- Identify treatment failures and correct
- Safe childbirth, efficient drugs for prophylaxis for infant
- Safe breastfeeding and infant feeding
- Early infant testing for HIV and early linkage to treatment
Early access to ANC and Option B+ reduces MTCT (especially preconception and with achievement of viral suppression)

*Mandelbrot L et al. CROI 2015. Seattle, WA. Abs. 867

Delivery RNA and MTCT According to Time ART Initiation

- Started before conception: MTCT 0.2%
- Started 1st trimester: MTCT 0.4%
- Started 2nd trimester: MTCT 0.9%
- Started 3rd trimester: MTCT 2.2%

*threshold if assay LLD >50 c/mL
Goal: prevent new HIV infections among children

• Prevention of primary infection (all women and especially targeting adolescent young women and pregnant breastfeeding women)
• Early access to antenatal care and HIV testing for all pregnant women and partners
• Identification of HIV+ pregnant women and male partners, initiation of ART (Quality psychosocial support and Option B+ for mother, retention/ adherence in treatment), viral suppression
• Safe childbirth, efficient drugs for prophylaxis for infant
• Safe breastfeeding and infant feeding
• Early infant testing for HIV and early linkage to treatment
Option B+: evidence for implementation

OPTION B+
Lifelong ART for all pregnant and breastfeeding HIV + women

Implemented with introduction of
✓ TDF/3TC/EFV FDC 1 dose a day
✓ Task-shifting
✓ One stop model (differentiated service delivery model)

Reduces MTCT to less than 5% in countries with breastfeeding policy
Less than 2% non breastfeeding policy (Botswana)
What is Option B+?

<table>
<thead>
<tr>
<th>Table 1: Three Options for PMTCT</th>
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<tbody>
<tr>
<td><strong>WOMEN WITH CD4 COUNT ABOVE 350 CELLS/MM³</strong></td>
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<tr>
<td><strong>OPTION A</strong></td>
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<tr>
<td>During pregnancy: AZT starting as early as 14 weeks of pregnancy</td>
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<tr>
<td>At delivery: single-dose NVP and first dose of AZT/3TC</td>
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<tr>
<td>After delivery: daily AZT/3TC through 7 days postpartum</td>
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<tr>
<td><strong>OPTION B</strong></td>
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<tr>
<td><strong>Triple ARVs starting as early as 14 weeks of pregnancy continued through childbirth (if not breastfeeding) or until 1 week after all breastfeeding has finished</strong></td>
</tr>
<tr>
<td><strong>OPTION B+</strong></td>
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<tr>
<td><strong>Triple ARVs started as soon as diagnosed and continued for life</strong></td>
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</table>
Provision of lifelong ART to pregnant and breastfeeding women living with HIV, October 2016

Source: Global AIDS Response Progress Reporting (WHO/UNICEF/UNAIDS) and WHO HIV Country Intelligence Tool.
Goal: prevent new HIV infections among children

- Prevention of primary infection (all women and especially targeting adolescent young women and pregnant breastfeeding women)
- Early access to antenatal care and HIV testing for all pregnant women
- Identification of HIV+ pregnant women and male partners, initiation of ART (Quality psychosocial support and Option B+ for mother, retention/ adherence in treatment) and viral suppression
- Safe childbirth, efficient drugs for prophylaxis for infant
- Safe breastfeeding and infant feeding
- Early infant testing for HIV and early linkage to treatment
WHO recommends new prophylaxis’ regimen in high risk setting

High risk: recent infection, lack of viral suppression

• For “high risk” – use two drugs together in infants for 6 weeks after delivery
• For “high risk” – in breastfed infants continue prophylaxis (either 1 drug or 2) for 12 weeks until maternal ART drops the viral load
Global Plan Results

60% decline in new HIV infections among children 2009-2015

Figure 1
Number of new HIV infections among children in 21 Global Plan priority countries, 2000–2015

Source: UNAIDS/2016 estimates
### Percentage decline in new HIV pediatric infections by country

<table>
<thead>
<tr>
<th>&gt;66% decline</th>
<th>33%-66% decline</th>
<th>&lt;33% decline</th>
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<tbody>
<tr>
<td>Burundi (84%)</td>
<td>Botswana (63%)</td>
<td>Angola (24%)</td>
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<td>Malawi (71%)</td>
<td>Cameroon (49%)</td>
<td>Nigeria (21%)</td>
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<td>Mozambique (75%)</td>
<td>Chad (49%)</td>
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<td>Namibia (79%)</td>
<td>Côte d’Ivoire (36%)</td>
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<td>South Africa (84%)</td>
<td>Democratic Republic of the Congo (66%)</td>
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<td>Swaziland (80%)</td>
<td>Ghana (46%)</td>
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<td>Uganda (86%)</td>
<td>Kenya (55%)</td>
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<td>United Republic of Tanzania (69%)</td>
<td>Lesotho (44%)</td>
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<td>Zambia (69%)</td>
<td>Zimbabwe (65%)</td>
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</table>
Percentage of pregnant women living with HIV receiving antiretroviral medicines (either prophylaxis or lifelong therapy) to prevent mother-to-child transmission, by country, 2015

Source: UNAIDS 2016 estimates.
Percentage of currently married women with an unmet need for family planning, most recent household surveys, 2003–2015

*Denotes that the survey was a Multiple Indicator Cluster Survey (MICS). MICS are based on a slightly different definition of unmet need for family planning.
Six-week and final mother-to-child transmission rates, by country, 2015
AIDS related death among women of reproductive age (15-49 years)

AIDS-related deaths among women of reproductive age (15–49 years) in the 21 Global Plan priority countries, 2009–2015

Source: UNAIDS 2015 estimates.
PMTCT, new HIV pediatric infections and child mortality

The number of children aged 0–14 years on antiretroviral therapy globally has doubled over the past five years, reducing AIDS-related deaths among children by 44%.
Following the global plan...

UNAIDS New Targets for 2020: 90-90-90

- **Test**: 90%
  - 90% of HIV-infected patients know their status
- **Treat**: 90%
  - 90% of those initiated on treatment
- **Retain**: 90%
  - 90% of those achieve viral load suppression

ON THE FAST-TRACK TO END AIDS

A SUPER-FAST-TRACK FRAMEWORK FOR ENDING AIDS IN CHILDREN, ADOLESCENTS AND YOUNG WOMEN BY 2020
Case study: Mozambique

- Population **25 million** inhabitants
- Estimated number of PLHIV **1.4 million**
- **770,000 women**
- Prevalence of HIV (2009)
  - Pregnant women (National): **15.8 %**
- Fertility rate **5.3 %** IMASIDA 2015
- Coverage of first ANC **93%** (IMASIDA 2015)
- Coverage of 4 ANC **55%** (IMASIDA 2015)
- Institutional delivery rate **70%** (IMASIDA 2015)
Historical milestones of PMTCT program in Mozambique

- **2002**: PMTCT implementation starts in 8 HF;
- **2004**: Program integrated in nation health plan 2004-2008;
- **2006**: Integration of PMTCT in MCH services
- **2010**: Option A adopted by the country;
- **2011**: Endorsed Global EMTCT Plan 2012-2015
- **June 2013**: Starts implementation of Option B+
PMTCT in Mozambique

Important increase in coverage of Option B+

- **1437** HF offering PMTCT
- **1104** US Option B+ (72% HF PMTCT)
- **402** US Option A
- **93%** of HIV+ pregnant women on ARVs were receiving ART

**EID**

- **1346** HF (88% HF with PMTCT).
- MTCT rate = **6,2 (UNAIDS)**
- 5 Reference labs to process PCR DNA and Viral load
- SMS printers implementation in 526 HF (44% of HF with EID)
Maternal Infant Cascade: results from PEPFAR Annual report 2016

Gaps include PCR coverage (especially <2 months), return of results and linkage to ART
MoH PMTCT cascade

Cascata de PTV nove meses

1ª CPN: 1089829
MG com serostado conhecido: 923641
MG HIV+ na CPN: 75904
MG em PTV na CPN: 70909
TOTAL DE TARV: 67148
CE ao HIV na CCR: 59463
CE com 1º PCR colhido < 2 meses: 39380

85% 93% 88% 78% 66%
PMTCT implementation in Mozambique: summary of guidelines

- **Universal opt-out testing** to all pregnant women at 1st ANC and to all women with unknown status (> 3 months since last test). Generally repeated in 3rd trimester/delivery.

- **Option B+** in all 1104 ART clinics (Option A still implemented in remaining 240 non ART sites)

- **Viral load test** repeated after 3 months from ART initiation (1st ANC in DHS at around 20 weeks!)

- If patient identified as HIV+ ART initiated in all MCH entry points (ANC, maternity, post partum and HEI clinic) in MCH setting (same day initiation)

- **One stop model** in MCH setting (mother and infant pair followed together) and **task-shifting** (nurses prescribing ART and providing clinical care to mother-child pair)

- Both for breastfeeding and non breastfeeding exposed infant NVP 6 weeks prophylaxis

- **First PCR HIV test at 4-6 weeks**: coverage 66% at 4-6 wks (MOH data)

- **Discharge from MCH setting after end of breastfeeding** → testing for final diagnosis of child (50% of children still breastfeeding at 2 years of age, DHS 2011)
Growth in ART offer along the years (MOH data)

Evolução do PTV

Número de mulheres grávidas HIV + a receber TARV
Número de mulheres grávidas HIV + a receber buprofilaxia (AZT + NVP)
Cobertura populacional
# Pepfar annual program report 2016 (APR 16): Testing and ARVs

## PMTCT_STAT

<table>
<thead>
<tr>
<th></th>
<th>APR 2012 Result</th>
<th>APR 2013 Result</th>
<th>APR 2014 Result</th>
<th>APR 2015 Result</th>
<th>APR 2016 Result</th>
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<tbody>
<tr>
<td># unique women registered in ANC</td>
<td>991,951</td>
<td>1,023,581</td>
<td>1,169,291</td>
<td>1,233,463</td>
<td>1,019,249</td>
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<tr>
<td># pregnant and immediate post-partum women with known HIV - ANC</td>
<td>836,108</td>
<td>930,526</td>
<td>1,079,805</td>
<td>1,185,816</td>
<td>984,862</td>
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<tr>
<td>% of pregnant women with known HIV Status (ANC)</td>
<td>84%</td>
<td>91%</td>
<td>92%</td>
<td>96%</td>
<td>97%</td>
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## PMTCT_ARV

<table>
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<tr>
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<th>APR 2012 Result</th>
<th>APR 2013 Result</th>
<th>APR 2014 Result</th>
<th>APR 2015 Result</th>
<th>APR 2016 Result</th>
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<tr>
<td># HIV+ pregnant women identified in ANC</td>
<td>95,613</td>
<td>97,870</td>
<td>93,931</td>
<td>100,302</td>
<td>92,254</td>
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<tr>
<td># HIV+ pregnant women who received ARVs in ANC</td>
<td>87,635</td>
<td>88,512</td>
<td>84,297</td>
<td>94,221</td>
<td>90,153</td>
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<tr>
<td>% HIV+ pregnant women who received PMTCT in ANC</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
<td>94%</td>
<td>97%</td>
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APR 16 12 months retention (disaggregation by age and gender)

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<tr>
<th>Age Range</th>
<th>Female 2015 Q4</th>
<th>Female 2016 Q2</th>
<th>Female 2016 Q4</th>
<th>Male 2015 Q4</th>
<th>Male 2016 Q2</th>
<th>Male 2016 Q4</th>
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<tr>
<td>&lt;5</td>
<td>65%</td>
<td>67%</td>
<td>79%</td>
<td>69%</td>
<td>63%</td>
<td>74%</td>
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<td>5-14</td>
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<td>73%</td>
<td>79%</td>
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<td>15-19</td>
<td>69%</td>
<td>63%</td>
<td>74%</td>
<td>69%</td>
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<td>74%</td>
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<tr>
<td>20+</td>
<td>65%</td>
<td>67%</td>
<td>79%</td>
<td>69%</td>
<td>63%</td>
<td>74%</td>
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12 Month Retention (EPTS) Trends

- 2015 Q4
- 2016 Q2
- 2016 Q4
• At the individual-level, poor knowledge of HIV/ART/vertical transmission, lower maternal educational level and psychological issues following HIV diagnosis. Stigma and fear of status disclosure to partners, family or community members (community-level factors) were the most frequently cited barriers overall and across time.

• Weak engagement of family, community and partner

• Key health-systems issues included poor staff-client interactions, staff shortages, service accessibility and non-facility deliveries

IN SOME PROVINCES OF MOZAMBIQUE HIGH RATES OF REFUSAL (around 10% in Nampula and Zambesia)
15099 patients registered before 2014

**Subjects who were LTFU**

1. fewer days in care than retained subjects
2. longer duration of ART
3. higher baseline HIV viral loads and higher body mass indexes
4. live in urban settings
5. distance to the centre and cost of transportation were associated with LTFU as was absence of a maternal figure
Interventions implemented to improve retention...

**MENTOR MOTHERS**

Short-Term ANC retention in Gaza among women seen for 1st ANC in May

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<tr>
<th></th>
<th>ALL EPTS Health Facilities</th>
<th>HF with Mentor Mothers</th>
<th>HF without Mentor Mothers</th>
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<tbody>
<tr>
<td>One Month</td>
<td>79%</td>
<td>83%</td>
<td>70%</td>
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<tr>
<td>Two Month</td>
<td>69%</td>
<td>73%</td>
<td>60%</td>
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<tr>
<td>Three Month</td>
<td>67%</td>
<td>73%</td>
<td>55%</td>
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**FAMILY APPROACH**


8 countries in sub-Saharan Africa and southeast Asia; roughly 12,000 individuals

- Comprehensive HIV care program, along with their newborn infants, as well as HIV+ family and household members
- More than 2/3 of index women enrolled their HIV-exposed baby or an HIV-infected family member. Retention of participants was very high, with fewer than 600 adults leaving the program, including 190 reported deaths. More than 2000 infants, 90% of those who reached 18 months, were determined uninfected, and of the 761 infected children enrolled, 65% received highly active antiretroviral therapy (HAART)

12 Month ANC retention in Chokwe before & after expansion of Mentor Mothers

![Graph showing ANC retention in Chokwe before and after expansion of Mentor Mothers](image)
**Successes**

- **HIV testing >90%**.
  Retesting not implemented routinely
  Partners’ testing coverage: 50%
- **ARV coverage: >90%**.
  40% of PW already on ARVs at 1\textsuperscript{st} ANC
- Longitudinal registers (link mother and baby pair)

**Challenges**

- **Low adherence and retention:**
  retention on treatment at 6 and 12 months: 60% and 65%
  1\textsuperscript{st} ANC coverage is more than 90%
  but 4\textsuperscript{th} ANC 55%
- Institutional delivery 70%
- Viral suppression: preliminary data 60%
  Coverage of EID at 4-6 weeks: 63%
- **Data quality issues**
Questions & Answers
Muito Obrigada!
Grazie mille!
Thank you!
Kanimambo!