MINISTRY OF HEALTH

TOWARDS THE ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV AND KEEPING MOTHERS ALIVE

STRATEGIC FRAMEWORK

2012 - 2015

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
AOP	Annual Operational Plan
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CHW	Community Health Worker
CHEW	Community Health Extension Worker
DBS	Dry Blood Spot
DHMT	District Health Management Teams
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission
EMoNC	Emergency Maternal and Newborn Care
FANC	Focused Antenatal Care'
FP	Family Planning
HAART	Highly Active Anti-Retroviral Therapy
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HSSF	Health Sector Services Fund
IATT	Inter-Agency Task team (for PMTCT)
IYCF	Infant and Young Child Feeding
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey

KEPH	Kenya Essential Package for Health
KMA	Keeping Mothers Alive
KNASP	Kenya National AIDS Strategic Plan
M&E	Monitoring and Evaluation
MAMCH	Maternal and Child health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MTCT	Mother-to-Child transmission of HIV
NACC	National AIDS Control Council
NASCOP	National AIDS/STI Control Program
PLHIV	People living with HIV
PCR	Polymerase Chain Reaction
PNC	Postnatal Care
QI	Quality Improvement
SOP	Standard Operating Procedure
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

Translations

MAISHA	Life
KATA SHAURI	Make a decision

Foreword

The Ministries of Health (MoH) are committed to eliminating mother to child transmission of HIV. The Ministries have been supporting the development of the eMTCT framework whose goal is to eliminate new paediatric HIV infections and improve MNCH and survival in the context of HIV.

The eMTCT framework is an important part of the Government strategy to reduce MTCT and is in line with the National Health Sector Strategic Plan (NHSSP) and Kenya National AIDS Strategic Plan (KNASP), whose focus is prevention of new infections, improving quality of life of those infected and affected, and mitigation of social and economic impacts of the infection.

The framework sets clear targets and proposes a collective responsibility in working toward the elimination of MTCT. To achieve this, we will require Integrated delivery of health services and life-saving interventions to facilitate access for women and children, Stronger health systems with sufficient skilled human resources, Innovation in financing, product development and efficient delivery of health services, Promotion of human rights, equity and gender empowerment and Improved monitoring and evaluation to ensure accountability of all actors for resources and results.

"We can prevent mothers from dying and babies from becoming infected with HIV.
That is why I am calling for the virtual elimination of new HIV infections among children by 2015."

Michel Sidibe 21 May 2009

Through this strategy, we call all health care workers and Kenyans to commit to the task of achieving elimination of mother-to-child transmission and assuring HIV free survival of children in Kenya.

Dr. Francis Kimani
Director of Medical Services

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Director of Public Health and Sanitation

Acknowledgement

The Kenya eMTCT framework is a result of efforts by many individuals and organizations in the country led by The Technical Working Group on PMTCT and Paediatric HIV.

We wish to thank the following institutions for technical as well as financial support during the development of the framework; National AIDS and STDs Control Programme (NASCOP), the Division of Reproductive Health (DRH), Division of Child and Adolescent Health (DCAH), National AIDS Control Council (NACC), the joint UN agencies and the US government agencies (USGs).

It is not possible to mention all individuals and organizations that participated in this important exercise.

This work is inspired by all the women living with HIV.

To all of you, Asante Sana!

eMTCT Framework for Kenya

Introduction and Rationale

Elimination of MTCT has been achieved in many developed countries. In Africa, the eMTCT goal (MTCT rate of <5% among breast feeding populations or 90% reduction in mother to child HIV transmission rates by 2015) is now considered a realistic and achievable public health goal and an important contributor to achieving MDGs by 2015.

Kenya is among the 22 countries which collectively account for 90% of pregnant women living with HIV. The Kenyan eMTCT Framework is in line with the global eMTCT plan which focuses on strategies for the elimination of new HIV infections among children by 2015 and keeping mothers alive (KMA). The elimination agenda was inspired by near-zero MTCT rate achieved in high-income countries as a result of high access to effective interventions by all pregnant women (Global Plan for EMTCT, 2011-2015).

This plan signifies the government's commitment to maternal and child health and to achieving MDGs 4, 5 and 6. This Framework brings together a critical analysis of the current status of the program and the strategic direction towards elimination of MTCT by 2015.

Fig 1: New HIV infections attributable to MTCT in Kenya

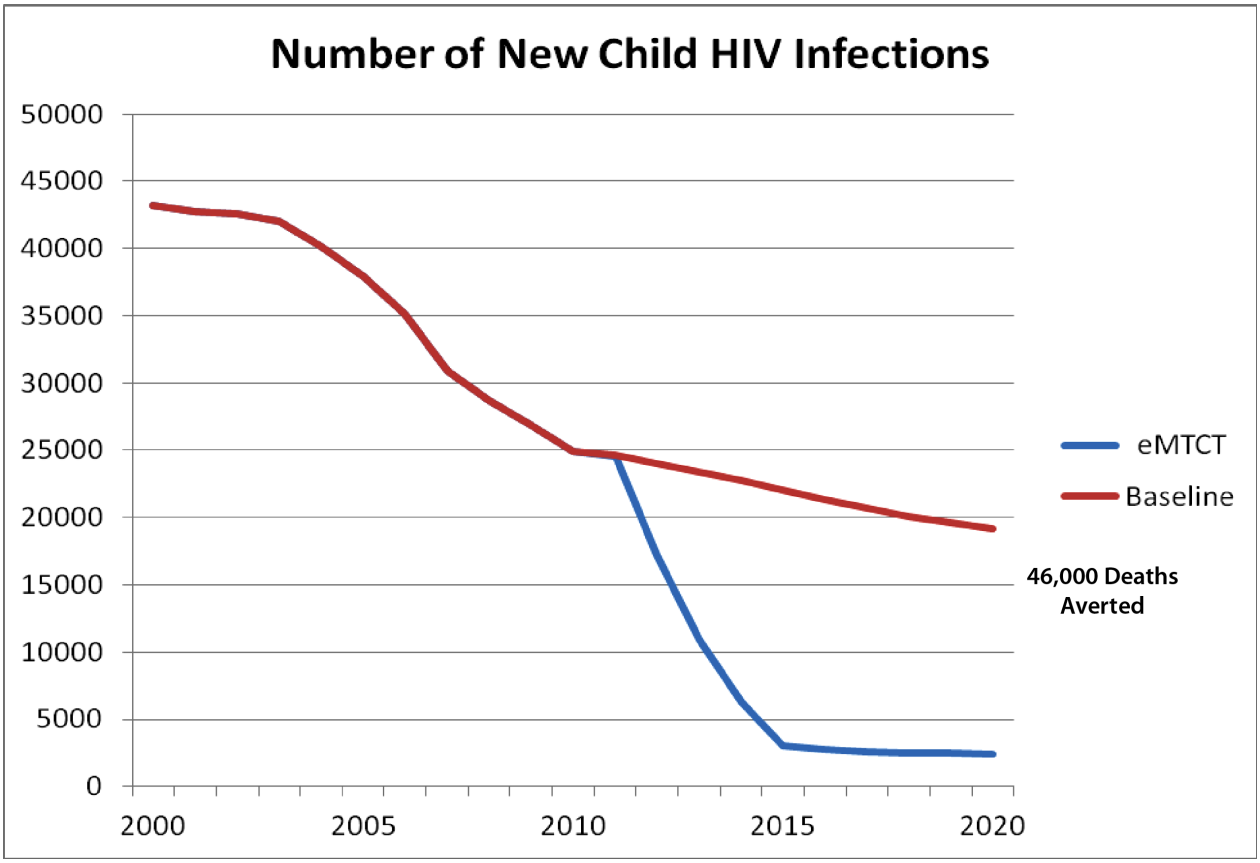


Figure 1 above illustrates modelling of two scenarios for PMTCT interventions in Kenya. Scenario 1 (Red line) shows the effectiveness of the current PMTCT interventions and their projected achievements while Scenario 2 (blue line) illustrates how accelerated efforts can achieve elimination by 2015. This intervention scenario would require a 50% reduction in HIV incidence among women of reproductive age, elimination of unmet need for family planning from the current 26% (or increasing the contraceptive prevalence to 76%) and provision of ARVs or ART to ≥90% of HIV positive pregnant women in need.

Background of PMTCT in Kenya

An estimated 1.4 million adults aged 15 – 64 are infected with HIV/AIDS with about 1 million rural and 400,000 urban residents infected (KDHS 2008/9). The HIV epidemic shows regional and sexual heterogeneity with HIV prevalence being higher among women (KAIS 2007). The estimated number of pregnancies every year is 1.5 million with an ANC prevalence of 6.2% which translates to 87,000 HIV positive pregnant women.

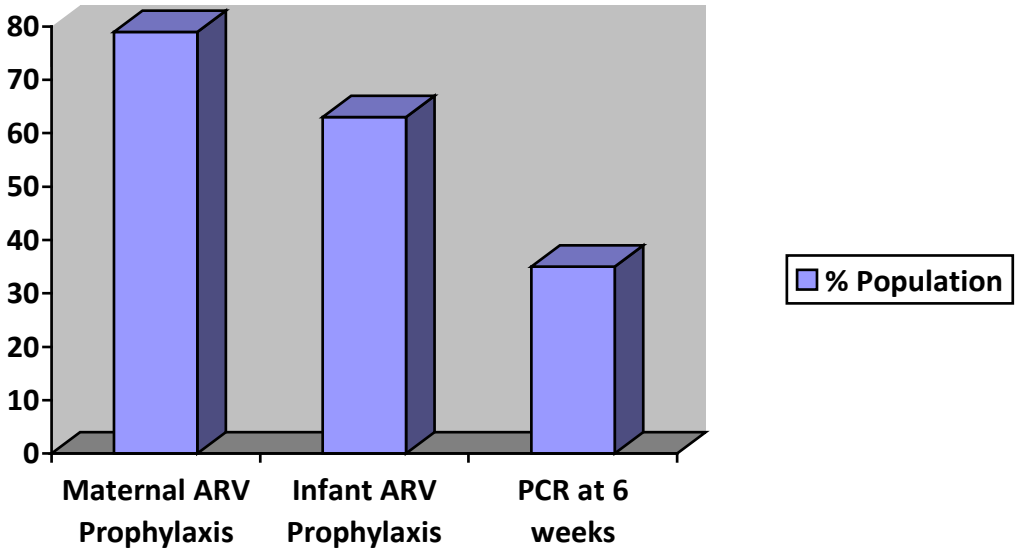
The national PMTCT Programme started in 2002, and since then over 60% of health facilities countrywide provide PMTCT services (Master Facility list. 2009). As a result, over 80% of pregnant women are counselled and tested for HIV and 79% of the HIV positive women receive anti-retrovirals (ARVs) for prophylaxis, (Annual Program Review, NASCOP 2011). However, 33% still receive single dose Nevirapine, a regimen being phased out in response to new WHO guidelines (Universal Access-UA Report, 2010).

Only 63% of exposed infants receive ARV prophylaxis (Figure 2) and only 35% of the exposed infants receive a PCR (Polymerase Chain Reaction) HIV test 6 weeks after birth (National PMTCT statistics, NASCOP 2011). Currently, many HIV exposed infants are falling through the cracks and cannot be accounted for by 18 months. By 2009, it was estimated that MTCT rate was 27% at 18 months. Transition to more efficacious regimens and provision of extended infant prophylaxis for the duration of breastfeeding is expected to drastically reduce the MTCT rates. Another area that still needs improvement is that of the unmet need for family planning for HIV positive women.

Kenya has been implementing the four-pronged approach to elimination of MTCT. This involves primary prevention among women of reproductive age, family planning for all HIV+ women who want to delay their next birth, ARV prophylaxis during pregnancy, delivery and breastfeeding, and care and treatment. Implementation has been through a phased scale-up system and the involvement of multiple stakeholders. Currently, about 60% of facilities are providing PMTCT services; however, only about 20% (KSPA 2011) provide comprehensive PMTCT package (i.e. the 4 prongs of PMTCT).

Following the release of WHO 2010 guidelines, Kenya adopted option A with provision to implement option B in areas that have capacity for initiation and monitoring systems. Subsequently, health care workers have been trained nationally to build capacity for adoption and roll-out of the new guidelines.

Fig 2: Cascade of PMTCT Services in Kenya (UNGASS 2010 report)



PMTCT Bottleneck Review

Despite the achievements, some of the challenges identified during recent PMTCT program reviews include:

Demand challenges	Supply challenges
Low PMTCT awareness	Slow adoption of new PMTCT guidelines
Weak health seeking behaviour	Commodity stock-out
Stigma and discrimination (Low disclosure)	Infrastructural and equipment challenges (integration)
Late first ANC attendance (15% first trimester attendance)	Data challenges - HR, tools, quality and utility
Weak PMTCT community-facility linkages	Missed opportunities for HEI –EID,ART initiation e.t.c.
Social cultural beliefs and practices	Mixed messaging on IYCF
Low skilled delivery	Transition to the county system (decentralisation)
Low male involvement (<30%)	Human resource gaps

N.B.
A cross-cutting challenge is that of high donor dependency for HIV financing (>80%) which threatens the sustainability of the HIV response.

[1] Formative research (2010), Joint Review Mission report (2011), Routine program reviews

Vision, Goal, Targets and Objectives

VISION

An HIV free society in Kenya

GOAL

To eliminate new HIV infections among children and to keep mothers alive through universal access to comprehensive PMTCT services.

OVERALL TARGETS

1. Reduction of mother-to-child transmission rate to less than 5% by 2015
2. Reduce the number of HIV related maternal mortality by 50%.

To achieve the above targets, Kenya needs to;

1. Reduce number of new child HIV infections by 90%
2. Reduce HIV incidence in Women of Reproductive Age (WRA) (15-49 yrs) by 50%
3. Eliminate unmet FP need among all women (especially HIV positive women)
4. Reduce HIV-related maternal deaths up to 12 months postpartum by 90%
5. Reduce HIV-attributable deaths among infants and children <5yrs by 50%

GUIDING PRINCIPLES

The eMTCT initiative is aligned to the National Health Policy, the Health Sector Strategic Plan and the Kenya National AIDS Strategic Plan (KNASP).

The eMTCT initiative will be implemented within the framework of MNCH services and the devolved county health service delivery structures. The framework will be based on the following principles;

- Universal coverage – expand access to equitable health services to all women
- Leveraging synergies, linkages and integration for improved sustainability
- Women living with HIV are at the centre of the design and implementation
- Respect for human rights
- Community ownership
- Shared responsibility and accountability
- Implementation of evidence-based interventions

STRATEGIC DIRECTIONS

The planning and implementation of the eMTCT Framework will be based on five critical strategic directions.

These are:

1. Leadership, Commitment and Advocacy.
2. Improving access and demand for PMTCT.
3. Integration of Services and Strengthening of Linkages.
4. Health systems strengthening.
5. Resource Mobilization for Sustainability/Sustainable financing

Strategic Direction 1:

Leadership, Commitment and Advocacy

To promote a sense of urgency, political advocacy and commitment for eMTCT and KMA, a national political campaign will be launched under the leadership of the Ministry of Health. The campaign will be anchored within the national political systems, devolved governance structures in the 47 counties right down to the community level.

Political leadership and championship of the eMTCT and KMA

The Ministry of Health will leverage existing partnerships to promote national, county and community championship in order to make eMTCT and KMA a political agenda. Commitment to deliver localized targets will be sought through influencing the political manifesto of political aspirants and political parties, by community groups such as women's groups, women living with HIV, youth, media, local authorities, trade unions, religious leaders and other associations that drive political processes in Kenya.

The eMTCT campaign will need responses that are non-generic and sensitive to local contexts. Strategic information generated through progress reports will be packaged to influence political accountability for regional differences in paediatric HIV incidences and performance within the cascade of PMTCT services.

The national and county level political commitment will be championed by a high level political office to strengthen accountability. A regular countdown on targets for each county will be provided and made public to exert political pressure for leadership, financing and commitment in all counties. The national champion will work closely with county level champions to ensure that eMTCT and KMA agenda remains prioritised throughout the country.

Community Leadership and accountability

Through the male circumcision campaign, Kenya has demonstrated that community leadership can be instrumental in creating awareness and understanding, therefore driving demand for HIV services. The Council of elders' and political leadership resulted in increased demand for HIV prevention driven male circumcision in a traditionally non-circumcising community.

The social norms that create unique and localized patterns of uptake of HIV, maternal and child health services will require community engagement and leadership in design and implementation. The community health strategy platform and Social groups that enable social change such as women groups, council of elders, religious leaders and other informal community fora will be engaged through functional community committees to create awareness and account for eMTCT and KMA results.

Engagement of Women Living with HIV (WLHIV) as primary advocates of eMTCT and KMA

Central to the success of this plan is the active engagement and advocacy role of women living with HIV to address HIV related stigma that impedes demand for comprehensive MCH services. They will champion the call to eliminate mother to child transmission at all levels and partner with the health facility, monitoring progress and exert pressure at both the community and health facilities level to achieve localised targets for eMTCT and KMA.

Strategic Direction 2:

Improving Access and Demand for Quality PMTCT Interventions

The government is committed to ensuring that all Kenyans have access to quality, evidence-informed PMTCT services and interventions with maximum public health impact. The Ministry of Health will facilitate timely formulation and adoption of policies which promote innovative approaches to health care delivery and which address barriers to access such as cost and distance.

The Ministry will also support operations research and documentation, dissemination and application of best practices to encourage innovation in overcoming implementation challenges. Quality across all dimensions of health care and at all levels from the national right down to the community will be emphasized through creation of an atmosphere of responsibility and accountability. Standards based management systems; continuing medical education and annual appraisals will all contain means to assess, enhance and reward quality. The ongoing roll out of electronic medical records; the review of services and adoption of citizen service charter as part of result based management; is aimed at institutionalizing quality assurance systems in health care delivery particularly in the public sector. The Ministry of Health has also developed and is rolling out quality improvement (QI) strategies such as Standard Based Management Recognition (SMBR) and HealthQual to ensure high standards of service delivery.

Policies and guidelines will be updated regularly for constant alignment to global standards and emerging evidence and these will be disseminated right down to the lowest levels for rapid adoption as practice. Ensuring a knowledgeable, empowered and responsive society to eliminate MTCT of HIV through increasing knowledge and awareness on eMTCT; increasing community action, ownership and partnership for eMTCT; and creating a socially, politically and programmatically enabling environment to achieve eMTCT. Increasing knowledge and awareness will be achieved through advocacy on eMTCT at national, county and community level; sensitization of various target groups; and use of eMTCT champions. Increasing community action, ownership and partnership for eMTCT will be achieved through community mobilization to increase access and utilization of care; enhancing partnerships within the community and between the community and the facility; and male engagement to increase access to healthcare and optimizing RH services. Creating a socially, politically and programmatically enabling environment for eMTCT will be achieved through communication for improvement of knowledge, attitude and communication skills among HCW; advocacy for health systems strengthening; and engagement of WLHA in advocacy.

Wide geographic coverage of health services including to marginalized areas will be ensured through rapid scale up of a minimum package of services that includes FANC (Focused Antenatal Care) during pregnancy, PMTCT package of care for HIV-infected pregnant women, safe delivery, postpartum care, family planning, newborn care and care for HIV-exposed infants (HEI).

- Specialized services such as diagnostics and obstetric care will be decentralized through transfer of skills; improvement of infrastructure and equipment; operationalization of task shifting; use of point of care diagnostics and/or networking of laboratories.

- Systems and clinical algorithms will be simplified through use of innovation and best practice models such as SMS technology for rapid results delivery and client follow up; and same day HIV and CD4 results, and initiation of pregnant HIV positive women on HAART.

Retention of mothers and their infants throughout the continuum of care will be ensured by strengthening psychosocial support systems such as the mentor mother program. Community support systems will be strengthened through rapid roll out of the community strategy which sets up community units and empowers community health workers. Functional facility-community health committees and health management boards will facilitate strong community facility linkages at the primary health care level. They will supervise and ensure that communities work with their facilities to identify and follow up mothers and babies in need of intervention and care.

Public private partnerships will be strengthened to ensure consistency across both sectors in policy and practice around standard of care and to leverage resources, opportunities and results towards the common goal of eliminating new HIV infections among children and keeping mothers alive through universal access to comprehensive PMTCT services.

Strategic Direction 3:

Integration of Services and Strengthening Linkages

Historically, PMTCT services have been offered parallel to maternal and child health services. However it has been recognized that to maximize efficiencies and leverage resources, integration of services and strengthening of linkages is of utmost importance. PMTCT forms a component of a wide spectrum of services including ante, intra and postpartum care, family planning, HIV testing and counseling, antiretroviral therapy, infant and young child feeding and child welfare services (growth monitoring and immunization). Retention in care of the mother-baby pair is critical to ensure adherence to interventions and documentation of outcomes.

Integration may take several forms: provision of a continuum of services at one service delivery point (either MCH/FP or Comprehensive Care Clinics); or within a facility but at different service delivery points; or requiring referral to a different facility. The latter two require effective referral mechanisms and linkages across referral points. In addition strong linkages between the facility and the community are essential to ensure uptake, retention and continuum of care.

This framework recognizes the increasing contribution of HIV infection as an indirect cause of maternal mortality. It is therefore envisaged that programmes will be put in place to ensure early antenatal attendance with at least four focused visits, initiation of efficacious ARV regimen, access to skilled birth attendance and targeted post natal care. Other programs will target reduction of unmet need for family planning among this population.

Strong health systems to support integration of HIV care services and MCH/FP are necessary in keeping mothers alive. Several opportunities exist to integrate services including increasing access to FP services within HIV services (e.g. Comprehensive Care Clinics); providing point of care diagnostics for HIV, CD4 and PCR testing and preventing missed opportunities to provide continuum of care such as postpartum and early infant diagnosis services during immunization.

This framework will seek and support opportunities to strengthen and scale up the 2009 National Reproductive Health and HIV and AIDS strategy.

Priority areas for integration are:

1. Provision of FP services within CCCs.
2. Provision of HIV services within FP clinics.
3. Provision of ART in MCH where feasible.
4. Provision of EID and Paediatric ART within Child Welfare services.
5. Provision of cervical cancer screening and gender based violence services in MCH

Strategic Direction 4:

Health Systems Strengthening

Attainment of the service coverage targets defined in this framework depends on the capacity of the health system to deliver PMTCT services.

Weakness in human resource capacity, (number, skill mix, distribution) lab infrastructure, supply chain, health information systems, financing and program management have hampered the attainment of health goals, including maternal and child health targets. To achieve the ambitious targets in this framework, the HIV program will promote and support ongoing health systems interventions to improve the delivery of HIV prevention, care and treatment services for women and children.

Recognizing the additional investments from Global Fund and PEPFAR in funding HIV commodities, specific efforts will be made to ensure commodity security through improving, forecasting and quantification, strengthening logistics information systems and improving efficiency in commodity procurement and distribution.

The implementation of the current HIV Prevention Care & Treatment guidelines requires availability of labs for diagnostics and patient monitoring. The existing CD4, DNA-PCR and biochemistry/haematology capacities will be reviewed to develop strategies for improving the lab services. Where feasible, new lab service delivery points will be opened and better and efficient diagnostics technologies introduced. Existing systems will be reviewed and lab results transmission systems (e.g. SMS based printer systems) expanded to strengthen the current lab networking for CD4/DNA-PCR..

The elimination strategy requires a robust health information system to track progress and to provide data for decision making at all levels. Data requirements for monitoring progress in implementation of this framework will be included in the ongoing roll out of District Health Information Systems and Electronic Medical Records. To support these efforts, tools for capturing service data and summaries will be rolled out in all health facilities.

To achieve the current policy goal of universal access to HIV services, efforts will be made to build the capacities of health workers at all levels to deliver quality and comprehensive services. Further, PMTCT service packages to be delivered by various cadres will be developed to support the implementation of the task shifting/task sharing framework.

Strategic Direction 5:

Resource Mobilization for Sustainability

To facilitate country ownership, Kenya will undertake various advocacy strategies to ensure the mobilization of adequate resources to support the priorities in the eMTCT framework. These strategies will include costing of the plans, increasing domestic and international investments, innovative financing mechanisms and leveraging existing resources.

To guarantee continued funding, Kenya continues to ensure a coordinated and efficient management of the current substantial funding under Global Funds and other funding mechanisms. Harmonization of donor funding to achieve economies of scale will also be undertaken.

Further mobilization of resources will be undertaken to tap into devolved funds under the new constitution.

Implementation Approach

This section outlines key components of eMTCT implementation and defines sector involvement at each level of the governance system. It also elaborates the various coordination mechanisms which will ensure successful implementation and attainment of the goals and targets of the framework.

Policies

Policy formulation and enactment are fundamental to ensuring a favorable policy environment that responds to the needs and rights of the population. Several policies are already firmly in place; however some issues such as the need to address barriers to health access caused by user fees remain outstanding. Another outstanding issue is the absence of modalities for staff retention in rural and hard to reach areas. Key responsibility for policy formulation and enactment will lie with NASCOP and DRH under the guidance of the Technical Working groups.

Public Private Partnerships

The private sector is a key player in maternal and child health service provision. Currently an estimated 16.4% of mothers obtain antenatal care services from the private medical sector (KDHS 2009). This percentage is even higher in urban areas at 25%. Existing public-private partnerships (PPPs) in service delivery and in harnessing necessary resources will be strengthened. This will be done through ensuring their membership and involvement in decision making processes in the TWGs and involvement in capacity building, assessment and monitoring activities.

PLHIV at the Centre of the Response

PLHIV and their networks are critical stakeholders in this framework and they will play a strategic role in its implementation. They will be engaged in the creation of demand for and provision of quality services. Communities will be mobilized to play an active role in the implementation of eMTCT especially in reducing stigma, stimulating behaviour change and increasing uptake and retention. They will also be equipped with skills to support service delivery and support to women diagnosed with HIV, particularly during the process of their entry into and retention along the continuum of care. Their participation in the eMTCT response will be coordinated at health facility level through formation of health centre committees.

Service Delivery

It will be ensured that facilities can competently deliver high quality comprehensive PMTCT services. A priority action will be the dissemination of this eMTCT Framework as well as the new PMTCT Guidelines right down to the lowest level. The understanding and internalization of these technical guidance documents will be enhanced by production and distribution of wall charts and other job aids for the health facilities. Identification of training needs and capacity building through training and mentorship will be done constantly. Supportive supervision will be conducted at scheduled frequency in an integrated fashion and must always include systematic feedback including action points to address identified bottlenecks. Annual appraisal of health workers and health managers will factor in their prioritization of eMTCT. Those heading the facilities will provide leadership in using their data for regular self-assessment and ensure corrective actions are taken when needed.

Coordination of implementing partners

The coordination of implementing partners to ensure efficient use of resources will need to be done at both national and regional levels. Health management teams are responsible for ensuring that partners are responding to their priority health needs, are working within the norms and standards of the health system and are sharing data and reporting in a timely manner. This is in the spirit of leveraging resources and results towards a common goal. Fora such as stakeholder meetings should provide a regular opportunity to continually assess and strengthen the effectiveness of the partnership response.

Program reviews

Regular program reviews present an opportunity to share data and experiences regarding bottlenecks and best practices. The reviews should take place at national and sub-national levels to enhance the learning process and ensure that each level remains target and goal oriented. To this end, analysis of sub-national data will help in the design of interventions that are responsive to each context.

Phased Implementation

The Framework implementation will give priority to high burden counties to help achieve higher national targets. These are areas where the need is urgent and action is needed immediately. In addition, the framework will prioritize hard to reach and marginalized regions and persons to increase equity. Pilot implementation of Maisha Zones strategy has provided evidence that eMTCT is possible. This strategy will be evaluated to document lessons learned which will then be rolled out to other regions and sites.

Leadership and Coordination Mechanisms

The Ministry of Health will provide overall leadership for implementation of the framework through coordinating planning, implementation and performance monitoring processes of EMTCT. This implementation framework together with recently revised national guidelines on PMTCT and IYCF form the necessary basis for national coordination of efforts of all implementing partners by the Ministry of Health.

Coordination for eMTCT will happen both at national and sub national levels. It will entail different decision making organs and the leadership required to actualise eMTCT. At decentralised level, regional and local health management teams will coordinate programming and implementation through the incorporation of eMTCT explicit targets and interventions in Annual Operational Plans (AOPs). At the county level a focal eMTCT coordinator will be appointed to lead the implementation of the framework.

The lead body for coordination of policy and strategic planning of the eMTCT initiative will be the National EMTCT Steering Committee. This committee will be formed during the roll out of the framework and will have a wide membership comprising political leaders, personnel in relevant ministries, civil society and the development partners.

The steering committee's specific objectives will be:

- To monitor performance and ensure effective accountability of elimination of MTCT
- To strengthen coordination and harmonization among partners and stakeholders providing interventions in the country.
- To mobilize resources for eMTCT including human resource
- To contribute to the development and review of policies, guidelines and strategies on eMTCT interventions.
- Advocate for financial and political support of the eMTCT framework
- Provide linkage with the global steering committee

County steering committees comprising technical experts will be formed, and they will report to the national steering committee. They will be chaired by the County Health coordinator and all health facilities will be accountable to this committee for performance on their EMTCT targets.

The Technical Working Group (TWG) for PMTCT and Paediatric HIV will provide technical leadership and guidance on the eMTCT strategy. The TWG will develop and review PMTCT guidelines; regularly monitor implementation; review progress and develop innovative ways to enhance PMTCT outcomes. Whenever necessary, ad hoc sub-committees of the TWG may be formed to address specific programmatic challenges or achieve specific deliverables. The TWG is the main fora for coordination of and ensuring of accountability by implementing partners at a national level. This will ensure a harmonised and effective response.

Tracking Progress

Successful implementation of the eMTCT framework will require continuous monitoring and adjustment of the implementation process. National indicators and targets (Annex 2) have been developed and will be used for on-going performance tracking of the implementation of this framework. These indicators will feed into global eMTCT monitoring indicators.

Counties, sub counties and facilities will be expected to set own targets in line with national targets. Data collection and reporting on the eMTCT indicators will in part be through routine monitoring, sentinel cohort monitoring, operations research, programme reviews and population level surveys.

In keeping with the 2009 National Guidelines for PMTCT, the following minimum core indicator set has been adopted for monitoring of the eMTCT Initiative at target districts and health facilities:

Outcome indicators

a. Reduced new Paediatric HIV infections
b. Reduced Maternal HIV related mortality

Process Indicators

a. Number of pregnant women with known HIV status
b. Percentage of pregnant women whose male partners were tested for HIV in the PMTCT setting
c. Proportion of HIV positive women assessed for ART eligibility (by WHO staging or CD4) at first ANC visit
d. Number of HIV positive pregnant women who received antiretroviral medicines to reduce the risk of mother to child transmission
e. Percentage of HIV Exposed Infants initiated on cotrimoxazole (CTX) within two months of birth.
f. Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth
g. Percentage of HIV exposed Infants by feeding type
h. Percentage of HIV-exposed children confirmed positive through a confirmatory test
i. Proportion of HIV infected women who received family planning services at first post-natal visits
j. Proportion of mother baby pair on Care or treatment by 18 months after delivery.

During the implementation phase the process indicators will be measured through

Routine monitoring

- Health Management Information System (HMIS) – HMIS is used to collect health services delivery data. Currently such data is relayed from facility to regional level using the monthly paper based system where it is subsequently entered into a web-based HMIS portal. Through the eMTCT rollout, support will be provided to targeted subcounties and facilities to strengthen the HMIS system including its decentralization to facility level.

- The EMTCT/MCH Dashboard (Annex 5) - will be important tools to assist districts and health facilities maintain up-to-date statistics for monitoring progress. Innovative measures to improve program data management will be used. The ANC Longitudinal register will be reviewed and scaled out to eMTCT implementing facilities, electronic medical recording and smart card system

- Logistics Management Information System (LMIS) – LMIS is used to collect commodities ordering, supply and utilization information from health facilities. Health facilities or district stores compile and submit monthly reports to the District Pharmacist who forwards consolidated district reports and supply requests to the central Logistics Management Unit. Through the eMTCT rollout, support will be provided to targeted districts and facilities to strengthen the LMIS system including the planned consolidation in KEMSA (Kenya Medical Supplies Agency).

- Community-based Health Information System (CBHIS) – CBHIS is used to collect routine health interventions data at community level. This data is collected by CHWs and village health committees on their activities using a paper-based system. Data collected is passed on to Community Health Extension Worker (CHEW) who reviews, consolidates and submits aggregate reports to DHMT (District Health Management Teams). Through the eMTCT rollout, NASCOP will collaborate with the community services division to have the tools revised and accommodate some of the eMTCT elements.

- Early Infant Diagnosis for HIV Reporting (EIDR) – A web based data base for the 5 DNA - PCR testing laboratories (KEMRI) - Nairobi, Walter Reed - Kericho, KEMRI – Kisumu, KEMRI - ALUPE and AMPATH). The five labs are currently networked to the server at NASCOP where results produced are transmitted real time. The server has SMS gateway which can receive queries from the field and notifies sites when results are ready for collection. Sites can also log into the web based system and check their results.

Outcome monitoring

1. Paper based cohort monitoring

Facilities will be encouraged to use the recently revised HIV Exposed infant register which is a cohort register for HIV exposed infants. The register allows facilities to determine children outcomes based on their birth cohorts. Using this register the facilities can determine the proportion of infants who have had their 6wk PCR tests, their results, infant feeding practise and ARV coverage during breastfeeding. Ultimately the transmission rates at 6 weeks, one year and 18 months can be determined. In addition the survival and retention of HEIs need to be determined at set points, 9 months, one year and 18 months.

2. Sentinel cohort monitoring

Representative PMTCT service delivery sites will be selected and strengthened for collection of additional EMTCT data collection (prospective cohort data) to assess

- HIV vertical transmission
- HIV-free survival of children
- Mother and child survival

This will be complemented by retrospective cohort studies that link ANC, PMTCT and postnatal outcomes including loss to follow up.

3. Cohort monitoring using EMRs

Sites with EMR systems following up mother baby pair will be approached to share data sets on mother-infant pairs that will then be compiled nationally to determine maternal and childhood outcomes at set time points. Efforts shall be made to increase these sites so that more data on mother-baby pair is available.

Programme reviews

On-going programme reviews will compliment data collected through existing routine monitoring systems and will encompass:

- Supportive supervision & mentorship.
- Quarterly PMTCT data review meetings.
- Annual assessments and data quality audits.
- Baseline, mid-term (2013) and end-term (2015) programme assessments.

These are therefore planned as part of the eMTCT initiative rollout. However, the initiative will also support on-going implementation of sector-wide assessments conducted by the ministries of health every year such as the national clinical audit and user satisfaction survey.

Operations research

Research can help develop policy, design programs, analyze barriers, develop and evaluate solutions for these barriers, improve program performance (including logistics, access, quality and impact), and facilitate scale up and sustainability. The purpose of research within the eliminating mother-to-child transmission (eMTCT) framework is to work within eMTCT programs to develop and test program strategies that will optimize eMTCT program performance. By embedding implementation research as well as social-behavioral and anthropological research into eMTCT programs we can help generate lessons learned, optimize program performance, and inform other countries faced with similar challenges. Within the four prongs of PMTCT, there are various opportunities to conduct both qualitative, quantitative and cost-effectiveness research. Priority research questions for each prong of PMTCT are outlined in a table in the annex 6.

Population based surveys

To evaluate the eMTCT Initiative NASCOP will leverage various different national surveys including the KAIS in 2012, KDHS in 2013/2014, the MICS in 2014 and Demographic Surveillance Sites, adding specific indicators and questions for eMTCT.

Data use, dissemination and capacity building

On-going consolidation of collected data, including the use of modelling software such as spectrum will be undertaken. Derived information will regularly be shared with national and international stakeholders as well as for adjustments to the eMTCT framework and PMTCT interventions being implemented.

This will involve holding regular stakeholders meetings that include policy makers, development partners, programme managers, service providers and community leaders and community members. For the international stakeholders, national progress reports will be submitted through the UN system and specific funding initiatives e.g. PEPFAR and GFATM.

To enable all this, service providers will be trained on M&E, M&E tools including SOPs will be provided, feedback reports/bulletin to the service delivery will be introduced and facilities, districts and counties will be supported to prepare and update their EMTCT dashboards and score-cards (annex 5) monthly.

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ANNEXES

ANNEX 1: ACTIVITIES IN THE STRATEGIC DIRECTIONS

STRATEGIC DIRECTION 1:
TO STRENGTHEN POLITICAL COMMITMENT AND LEADERSHIP TO ACHIEVE EMTCT AND KMA TARGETS

Element	Activities
Objective 1: To make EMTCT and KMA a prioritized political agenda.	• Launch and dissemination of the Kenya eMTCT framework. • Lobby and publicize political declaration committing country to elimination • Identify, orient and motivate members (12) of the national EMTCT steering committee to provide political leadership and track progress • Identify, orient and facilitate 50 county level and national champions on EMTCT and KMA advocacy • Conduct national multi media campaign to disseminate Strategic information, create awareness to pressurize political commitment and funding for EMTCT and KMA
Objective 2: To build leadership and community ownership to promote behavior and social change	• To conduct county level sensitization and information exchange meetings with religious leaders, women leaders and traditional leaders (Use the community dialogue days forum for advocacy within community members). • Conduct county level advocacy meetings with leaders of women living with HIV to mobilize members , advocate for funding
Objective 3: To promote political, technical and administrative accountability	• Conduct a national EMTCT conference preceding the annual prevention summit to review the county score card and influence annual planning • Advocate for formation of a sub-committee on EMTCT within the Parliamentary health committees, trade unions, Local authorities Governors, Kenya National Union of teachers • Sensitization foras for the local administrative units and advocate their role as community accounting officers in 20 high burden counties • Design for dissemination in the leadership forums simplified county, village, wards facts sheets on access across PMTCT cascade, MTCT tracking progress • Support programme management support cost of EMTCT for NASCOP, including national steering committees, sub-committees, EMTCT secretariats and focal managers. (5 EMTCT focal persons)

STRATEGIC DIRECTION 2:

IMPROVING ACCESS AND DEMAND TO PMTCT INTERVENTIONS/EXPANDING ACCESS AND QUALITY OF PMTCT SERVICES WITH OPTIMAL IMPACT

Element	Activities
Objective 1: Support community initiatives to create demand for PMTCT interventions.	• Supporting the establishment and operationalization of community units and empowering community health workers, awareness creation and referral of PMTCT clients in 20 high MTCT burden counties and conduct defaulter tracing and refferal • Establish peer support groups, train and support to provider follow up counselling, defaulter tracing and retrieval, link clients to other social services using the Kenya mentor mothers approach in 20 high MTCT burden counties • Conduct Rapid Results Initiatives for couples counseling and testing in 20 counties. • Conduct a mass media and social mobilization campaign on exclusively breastfeeding for six months, Early ANC attendance, Delivery under skilled personnel and Family planning annually during the breast feeding week.
Objective 2: Strengthen the capacity of all facilities providing MCH services to deliver integrated PMTCT interventions	• Conduct outreach clinics to provide MCH services in 20 high burden counties. • Conduct in-service training in QI for health facility managers, support managers to provide facilitative supervision/mentorship , provide tools and hold annual review meetings to increase retention of mother baby pair in the PMTCT cascade. • Conduct mapping, training, facilitative supervision, and provide commodities e.g., ARVs for PMTCT,HIV test kits, EID supplies, support them on routine facility based service Monitoring data for private facilities (92 facilities per county for 20 counties)

STRATEGIC DIRECTION 3:
INTEGRATION OF SERVICES AND STRENGTHENING LINKAGES

Element	Activities
Objective 1: To Strengthen Integration of Reproductive, Child and HIV Health Services	• Build skills capacity for provision of FP within CCCs through long term and permanent FP methods training and mentorship • Scale up operationalization of the National Reproductive Health and HIV and AIDS integration Strategy (through policy review, tools adaptation, training, and mentorship/supervision) • Scale up EmONC services in 4000 PMTCT sites through, procuring equipment, training, mentorship and supervision. • Increase the number of sites providing ART within MCH
Objective 2: To Strengthen linkages between facilities and communities	• Scale up of peer support mechanisms to enhance retention in care of mother baby pairs • Training of community midwives to promote skilled birth attendances by identification and early referral of pregnant women in the community; and also to promote family planning uptake through FP counseling community based contraceptive distribution and referral to health facilities. • Support the strengthening and scale up of the community strategy through training of CHWs, support, mentoring and supervision • Support the strengthening and scale up of the community information system by printing of integrated data collecting tools, training of CHWs in information management.

STRATEGIC DIRECTION 4:

HEALTH SYSTEMS STRENGTHENING TO IMPLEMENT INTERVENTIONS ADDRESSING EMTCT

Element	Activities
Objective 1: Strengthen the infrastructure of all facilities providing MCH services to deliver PMTCT interventions	• Renovate/refurbish all MCH facilities where necessary to enable delivery of MCH services. • Quantify and procure furniture and equipment required for delivery of MCH services that fully integrates PMTCT such as the emergency obstetrics and neonatal care kits. • Carry out facility assessments to identify what will strengthen the capacity of respective facilities to deliver MCH services that fully integrates PMTCT.
Objective 2: Provide essential commodities and equipment for eMTCT and strengthen their management systems.	• Avail OI drugs, ARVs (for HAART and prophylaxis), EID DBS collection materials, CTX, INH and other commodities at MCH and Maternity • Provide logistics support to counties/districts for distribution of commodities and equipment to facilities (including stock sharing) • Provide laboratory equipment(such as point of care testing equipment and supplies, test kits for HIV testing, CD4 testing, HB estimation and urinalysis), reagents and supplies to all facilities conducting onsite lab testing for PMTCT lab tests. • Link all PMTCT facilities (including private facilities) to the national supply chain for PMTCT commodities and equipment
Objective 3: Build the capacity of all MCH service providers to include PMTCT interventions	• Train health service providers (at levels 2 to 6) on revised PMTCT guidelines and integrated MCH services. • Train ,mentor and supervise private practitioners on PMTCT services • Support implementation of task shifting to other cadres of health service providers. • Hire and deploy adequate service providers to all facilities providing MCH services with capacity to offer PMTCT services in line with established staffing norms.

STRATEGIC DIRECTION 5:
RESOURCE MOBILIZATION TOWARDS SUSTAINABILITY

Element	Activities
Objective 1: To mobilize resources for implementing eMTCT and leverage national plans and opportunities to create synergies within existing programmes.	• Lobby and advocate for funds to implement the eMTCT plan • Create database for tracking resources going into PMTCT

MONITORING PROGRESS OF THE EMTCT FRAMEWORK

Element	Activities
Objective 1: Strengthen existing service delivery, monitoring systems, and make information available for eMTCT progress monitoring	• Capacity building of service providers in DHIS and M&E- training • Sensitise health facilities on use of the eMTCT tracking tools (dash board, tracking progress tool). • Establish Sentinel sites for cohort monitoring in eMTCT.
Objective 2:	• Build capacity of PMTCT sites to conduct longitudinal cohort monitoring • Develop operation research agenda for eMTCT and support resource mobilization and implementation of identified research studies.
Objective 3: Strengthen M & E capacity and monitor eMTCT framework implementation	• Building capacity of national level programme managers to provide leadership in eMTCT monitoring • Support collection and synthesis of eMTCT M & E data from different sources for national and international reporting: • Support integrated supervision of eMTCT service delivery sites and providers County supervision • Support annual site assessment and data quality audit to collect non-routine transmitted data and to assess its quality: • Baseline assessment of eMTCT sites • Support preparation of annual eMTCT implementation progress report and review summits:

ANNEX 2: Indicator targets and manual

Areas to Monitor	2009	2010	2011	2012	2013	2014	2015	
	Baseline						Target	
Number of HIV+ women delivering*	87,000	75,738	65,934	57,399	49,968	43,500	43,500	Half maternal HIV infection
New paediatric HIV infections	22,564	14,236	8,982	5,667	3,576	2,256	2,256	Reduce to < 10%
HIV-associated maternal deaths	1,210	1,089	968	847	726	605	605	Reduce by 50%
New HIV infections in women age 15-49	45,331	40,798	36,265	31,732	27,199	22,666	22,666	Half all maternal HIV infections
Unmet FP Need	26	26	21	16	10	5	0	Reduce unmet need to zero
Mother-to-child transmission	26	23	19	16	12	9	5	Reduce to <5%
Maternal ARV (prophylaxis and ART) coverage	78	80	82	84	86	88	90	Increase to 90%
Breastfeeding ARV coverage								
ART coverage among pregnant women								HAART coverage for pregnant women
Under 5 deaths due to HIV	4,450	4,079	3,708	3,338	2,967	2,596	2,225	Spectrum
ART coverage among children	24	37	49	62	75	87	100	

Annex 3: PROGRAM DATA BY REGION

2010 Baseline DATA

Province	Estimated Pregnant women	Program Estimate	SS Prev	WLHIV 2011 Data	Distribution of PLHIV Spectrum-2011
Coast	130383		4.4	5737	5195
ES	148108		4.1	6072	5498
EN	40662		4.1	1667	1510
Central	95000		3.4	3230	2925
Nairobi	157624		8.2	12925	11703
NEP	71961		0.9	648	586
North Rift	202500		4.6	9315	8435
Nyanza	221534		15.5	34338	31092
Srift	275000		4.6	12650	11454
Western	190000		5	9500	8602
	1532772			96082	87000

Annex 4: Table of Partners

NO.	PARTNERS	ROLES AND RESPONSIBILITIES
1	Ministry of Medical Services, Ministry of Public Health and Sanitation	• Oversee and facilitate the implementation of the eMTCT initiative
2	NASCOP, DRH, DCAH	• Complete, disseminate and operationalise the eMTCT implementation framework • Regular review meetings at national and provincial levels to monitor progress in implementation of the eMTCT framework • Define and implement an integration package for each level of health care system to ensure all the four PMTCT prongs are implemented within MCH and RH services • Streamline and strengthen supply chain management of HIV/PMTCT commodities, laboratory support • Develop policies and strategies for task shifting for ART with appropriate supervision and support mechanism to ensure quality, safety and equity.[10]
3	Community health Strategy, Department of Health Promotions, CBOs	• Standardise and harmonise the scope of work for CHWs and other lay cadres, including link to facilities and inclusion of NGOs/CBOs to support PMTCT. • Roll out communication strategy for PMTCT in high prevalence areas.
4	NACC	• Resource mobilisation • Advocacy • Preparation of information use plans • Monitoring of the implementation

5	Other Ministries: • Planning and National Development • Finance • Public Service • Education • Youth and Sports • Information and Communication • Gender • Office of the President • Housing • Works • Roads • Home Affairs • Agriculture • Water • Special programmes	• Policy • Advocacy • Resource Mobilisation • Human Resource Development • Infrastructure
6	Development Partners: The Joint UN Team, Global Fund to fight HIV/AIDs, TB and malaria, USG	• Provide Technical oversight to the eMTCT initiative • Financial support to the eMTCT activities • Monitoring and evaluation of the eMTCT initiative
7	Implementing partners	• Support implementation of the eMTCT initiative at different levels-national, subnational and at health facilities • Monitoring progress of the eMTCT intiative
8	Civil Society Organizations	• Advocacy • Demand creation • Resource mobilisation • Monitoring impact of the program

9	People Living With HIV especially women	• Advocacy • Demand creation • Service provision • Feedback • Programme Development Input • Resource mobilisation
10	Training Institutions and referral facilities	• Research and Evidence-Based Interventions • Pre-service and In-service training of HCW in eMTCT and improved service Delivery
11	FBOs, Private facilities and organisations	• Implementation of eMTCT interventions • Public-Private partnership
12	Media	• Advocacy • Awareness and Demand creation

Annex 5: EMTCT Dashboard

	MCH DASHBOARD																
	County				**District**				**Facility**				**Year**				**Production**
		Q1			**Q2**				**Q3**				**Q4**				**Grand Total**
		J	**F**	**M**	**Total Q1**	**A**	**M**	**J**	**Total Q2**	**J**	**A**	**S**	**Total Q3**	**O**	**N**	**D**	**Total Q4**
	Indicator																
1	Expected ANC Clients (% preg women x catchment popn/12)																
2	% New ANC clients seen																
3	% New clients tested																
4	% HIV positivity rate (New and the known positives)																
5	% HIV+ clients tested for CD4 and received results																
6	% of HIV+ clients started on ARV prophylaxis at ANC																
7	% of clients whose male partners were tested in MCH																
8	% Clients who finished 4 ANC visits																
9	% skilled delivery																
10	% HIV exposed infants issued with ARV prophylaxis at ANC																
11	% HIV exposed infants issued with ARV prophylaxis at maternity																
12	HIV positivity rate(%) at 18 months																

ANNEX 6
PRIORITY RESEARCH QUESTIONS

PRONGS	TARGET	RESEARCH QUESTIONS
Prong 1: Primary prevention of HIV infection in WRA	Reduce HIV incidence in WRA by 50%	• What are innovative strategies to determine incidence of HIV in this population? • How can we use cohort studies in high and low prevalence regions to identify risk factors for HIV acquisition among relatively 'low risk populations'? • How can we intervene to reduce risk in polygamous relationships? • Why do women with better access to information and resources continue to be at higher risk of HIV infection? • What are the myths around HIV infection status and continued engagement in high risk sexual activity? • How can we reach pregnant and lactating women who test negative with effective prevention strategies for themselves and their partners including behavior change, condoms, PrEP, male circumcision, early initiation of ART (i.e. Option B+)? • What are the most effective interventions for the very high risk adolescent (aged 15-17 years and sexually active)? • How can we ethically conduct research in the high risk adolescent group? • What are the perceptions of risk and interventions among late pregnancy and postpartum sero-converters? (qualitative studies) • New testing algorithms: Through unlinked, de-identified (anonymous) testing of blood provided in ANC, what proportion of women who test negative with current testing algorithms are truly HIV negative? • How does HIV spread through sexual networks? • What interventions improve male participation in HIV testing and counseling and other maternal services? • How can interventions to prevent intimate partner violence contribute to prevention of HIV in women? • How can CHCT be increased among pregnant women and their partners (important for female-positive/male-negative and female-positive and male-negative discordant couples)?

Prong 2: Prevention of unintended pregnancies among HIV-positive women	Eliminate unmet FP need among all HIV positive women	• What are the commonly held myths around FP and use of ARV drugs? • How can healthcare providers better provide for the FP needs of post-partum HIV-positive women? • What is the role of FP/HIV/ANC service integration in meeting the FP needs of post-partum HIV-infected women? • How can, and which methods of safer conception be successfully rolled out to affected communities? • What are the optimal models for increasing health worker productivity, performance, ownership, and motivation for FP service delivery that can be adopted in the public, private and faith-based health system sectors? • What are the most acceptable FP methods for HIV-positive women in this setting? • How does stigma associated with use of FP and HIV-related stigma interact to serve as barriers to FP use for HIV-positive women?

Prong 3: Interventions to reduce transmission from HIV infected pregnant women to their children	Reduce number of new child HIV infections by 90%	• Why do women accessing ANC and testing HIV positive not take ARV's? • How do we position HIV assessment (CD4 and WHO staging) to avoid it becoming a barrier to care? • What impact does implementation of HIV assessment (CD4 and WHO staging) have on important clinical outcomes (e.g., number of women receiving appropriate treatment, time to initiation of appropriate treatment, number of women lost-to-follow-up in the diagnostic pathway)? • What is the impact of point-of-care CD4 testing on time of treatment initiation? • How can technology (such as mobile phones) be used to optimize care for the mother-baby pairs? • How can women be retained in HIV care after delivery? • What are the operational challenges, impact, and cost of implementing option B+? • How can long-term adherence to ARVs be strengthened among pregnant and postpartum women? • How does PMTCT ARV prophylaxis and subsequent treatment affect outcomes of HIV exposed infected infants including HIVDR levels and long term side effects of ARVs at 12 and 18 months? • What are the best strategies to improve identification of discordant couples in PMTCT settings and ensure that the infected partner is initiated and retained on treatment to reduce the risk of HIV transmission? • What is the link between Vitamin A and mortality in HIV positive, HIV negative and HIV exposed infants? • What is the impact of integrating stigma-reduction and violence prevention strategies into ANC/MNCH and PMTCT programs? • What are the best methods for facilitating disclosure of HIV status within couples to support family engagement in HIV care?

	Reduce HIV-attributable deaths among infants and children <5yrs by 50%	• What is the mortality rate of HIV infected ARV exposed infants? • What are the barriers to infant testing? • What is the cause of death in HIV exposed uninfected children and what interventions will reduce their mortality? • What interventions ensure early enrollment and retention into HIV care and treatment programs after testing HIV positive? • What minimal elements are needed in a nutritional package for HEI and how should the package differ for HIV positive, HIV negative and HIV exposed infants? • What interventions can help reduce early mortality of infants and children initiated on ART? • What are the long-term treatment outcomes (rates and causes of mortality, treatment failure, and common opportunistic infections, as well as developmental outcomes, etc) of children and how can they be improved? • What is the prevalence and pattern of HIVDR among children exposed to the recommended PMTCT regimens?
Prong 4: Care and support for women, children and families infected by HIV and AIDS	Reduce HIV-related maternal deaths up to 12 months postpartum by 90%	• What is the impact on health service delivery and patient care of integrating PMTCT into maternal, newborn, and child health services? • What are the most effective health service delivery models and systems for integrating maternal and child survival programs? • What is the impact of PMTCT on non-HIV services? • How can skilled delivery attendance be increased among all women, including HIV-positive women? • What interventions ensure early enrollment and retention into HIV care and treatment programs after testing HIV positive and beyond delivery? • How can mobile phones be used to improve retention in HIV care? • What are the most effective and cost-effective strategies to retain pregnant and postpartum women in pre-ART and ART care? • What innovative strategies can be feasibly implemented to conduct reliable pediatric HIV surveillance? • What innovative strategies can be feasibly implemented to reliably monitor mortality (all cause, cause-specific, age-specific and sex-specific mortality) and to evaluate the impact of HIV?

ANNEX 7

RESOURCE REQUIREMENTS FOR THE EMTCT IMPLEMENTATION FRAMEWORK

Estimated Costs of EMTCT Plan by Strategic Direction

	Million US$					Million KES				
Strategic objectives	2012	2013	2014	2015	Y1-Y4	2012	2013	2014	2015	Y1-Y4
Strategic direction 1	1.4	1.7	1.6	1.2	5.8	111.1	124.2	111.0	86.2	432.4
Strategic direction 2	6.0	6.0	5.9	5.9	23.8	480.7	448.7	419.4	419.2	1,767.9
Strategic direction 3	7.8	7.8	7.8	7.8	31.1	622.5	583.3	551.8	551.8	2,309.4
Strategic direction 4	28.3	24.2	19.1	19.1	90.7	2,260.8	1,813.7	1,357.7	1,357.7	6,789.9
Strategic direction 5	0.1	0.1	-	-	0.1	4.7	4.4	-	-	9.2
Strategic direction 6	3.5	3.3	2.6	2.7	12.0	277.7	249.5	184.3	188.6	900.1
Magt & supervision (3%) of total cost	1.4	1.3	1.1	1.1	5.0	115.8	97.1	79.0	78.4	370.4
Total	48.4	44.3	38.1	37.8	168.5	3,873.4	3,320.7	2,703.2	2,681.9	12,579.2

Estimated resource requirement by objective

The table above presents the total resource requirement by strategic objective and the key activities in each objective. The activities are based on the revised eMTCT framework. In the Strategic direction 1, objective 1 on making eMTCT and KMA a prioritized political agenda accounts for the largest share of resources in this objective (KES 339 million or US$ 4.24 million), followed by objective 2 (US$ 1.21 million). In Strategic direction 2, objective 2 on the strengthening of the capacity of all facilities providing MCH services to deliver integrated PMTCT interventions takes the largest share of the estimated resources (US$ 20.25 million for the 4 years) while in strategic direction 3 on integration of services and strengthening linkages, objective 1 on strengthening integration of Reproductive, Child and HIV Health Services accounts for approximately US$ 19.72 million over the 4 year period.

A detailed costing of the eMTCT initiative is available from NASCOP on request.

TOWARDS THE ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND KEEPING MOTHERS ALIVE IN KENYA

A STRATEGIC FRAMEWORK

2012 - 2015

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Ministry of Health
World Health Organization
Elizabeth Glaser Pediatric AIDS Foundation
UNFPA
Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK
unicef
unite for children