	Reference Documents
1	Version 9 Global-Alliance-to-End-AIDS-in-Children-Landmark 270112023
2	KASF
3	Kenya Framework for Elimination of Mother to Child Transmission of HIV, Syphillis & Hep B 2022-2026
4	Modular Framework Handbook Allocation Perios 2023-2025

Module	Intervention	Gaps identified	Activities to address the gaps
EMCT of HIV, Syphillis, Hep B	1. Integrated Testing of Pregnant Women for HIV, Syphillis and Hep B	Commodity Insecurity: RTKs, DUO, HepBsAg	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
			Introduction of trio-test kit to include HIV.Syphillis. HepB
			Prioritizing and ring fencing funding for PMTCT commodities
		No guidelines for Hep B Testing and management	Develop guidelines for Hep B testing and management
		Suboptimal adherence to testing guidelines	HCW continuous capacity building on fidelity to guideline implementation
			Develop an indicator for retesting within the current MoH reporting tools
		Missed opportunity for testing because of legal interpretation of skills requirement for HIV testing	Review MOH task shifting policy to include HIV testing services
		Suboptimal linkage of diagnosed PMTCT clients	Scale up PMTCT sites to include all HTS only sites
			Scale up use of case management (mentor mothers, peer champions, expert mothers) for psychosocial support of newly diagnosed clients
		Gaps in ANC uptake- worse at ANC 4 and skilled delivery	Incentivize mothers to improve ANC uptake (mama gift packs, transport reimbursement)
			Community involvement and political championing through structured engagement packages
			Incentivize TBAs to be referal agents
			Multi-stakeholder collaborations to enhance security for access of health facilities in areas with insecurity
			Conduct targeted outreaches and scale up use of CHEWs to increase coverage in line with UHC, CHS.
			Advocate for community ANC services delivery model using CHEWs, Family physicians for those with access challenges
		Lack of structured engagement packages	Develop packages/ guidelines for engaging non-health stakeholders in PMTCT e.g politicians, males, community gate keepers, influencers
		Inadequate private sector engagement and collaboration	Capacity build private sector HCWs to offer PMTCT services
			Provide appropriate tools to promote quality reporting
			Provide regular support supervision and mentorships to improve service provision
		Inadequate data capture due to lack of data element provisions in exisiting tools- Hep B	Review of tools to incorpote relevant data elements
	2. Prevention of incident HIV among pregnant and breastfeeding women	Poor Prep uptake in MCH	Incorporate Risk assessment (RAST) in MCH for all MCH client
			Expand options to include new formualtions of Prep in the market e.g vaginal ring, injectable prep
			Friendly packaging of prep to distinguish it from ARVs: improve labelling, resolve rattling sound
			Incorporate prep within MCH reporting tools
			Continuous Capacity building of HCWs on Prep
			Increase community awareness on prep through social marketing, integration into other service delivery points
		Inadequate Partner involvement	Adopt and scale up use of service package of care for male partner involvement at MCH
			Adopt model of care that incorporates male champions
		Lack of community awareness on HIV prevention strategies especially among adolescents and young people	Provision of HIV information at MCH through various modalities e.g Health talks, TV adverts
			Community advocacy through community gatekeepers and community forums e.g political leaders, chief barazas, CHVs, religious leaders
			Develop a engagement package for Education sector stakeholders
		Negative cultural beliefs and practices e.g cultures that encourage extramarital affairs hence exposing the MCH mother	Engage opinion leaders to support community advocacy against negative cultural practices

		Lack of guidelines on special and/or vulnerable groups in PMTCT e.g AYP, KPs, PWUDs, PLWDs	Develop guidelines on PMTCT for special and/or vulnerable
			Develop differentiated service delivery models for special/ vulnerable groups in PMTCT e.g outreaches to schools for pregnant AYPs
	3. Post-natal infant prophylaxis	HCW knowledge gap	Capacity build HCWs on PMTCT guidelines
		Commodity insecurity: ARV Prophylaxis	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
		Non-disclosure among PMTCT clients	Capacity build HCWs, peers on supporting disclosure
	4. Early infant diagnosis and follow-up HIV testing for exposed infants	Long turn around time for results	Scale up POC for EID
		EID Commodity insecurity: catridges, filter papers, sample bottles	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
			Prioritizing and ring fencing funding for PMTCT commodities
		Infant testing after 2 months	Strengthen appointment management in MCH e.g Ushauri
			Capacity build to adhere guidelines, address HCW attitudes
			Awareness creation among PMTCT clients/ couples on importance EID
			Disclosure and psychosocial support for PMTCT clients
	5. Retention support for pregnant and breastfeeding women (facility and community)	Unflexible guideline on alternative infant feeding for non-suppressed clients	Review guidelines to allow for alternative infant feeding for non-suppressed clients e.g formula, breast milk bank donations etc
			Provide alternative infant feeding for non-suppressed mothers
		Non-disclosure among PMTCT clients	Scale up PSSG
		Inadequate knowledge and skills to support disclosure and stigma reduction	Continuous capacity building of service provider: training and mentorship
			Scale up use of peers for PSS
		Long intervals for VL monitoring	Reduce VL monitoring interval from 6 to 3 monthly
		Poor retention among PMTCT clients especially amongst special/ vulnerable groups e.g AYPs, KPs, PWUD, PLWDs	Adopt innovative approaches e.g use ofchampions, influencers, social media platforms (whatsapp groups)
			Strengthen appointment management in MCH using technologies e.g Ushauri
		Limited access to other PMTCT related services like radiological and lab investigations where indicated	Promote NHIF enrollment beyond Linda Mama initiative among PMTCT clients.
		Lack of intergration on PMTCT services with CHS	Continuous supervision and mentorship to CHVs on PMTCT
			Leveraging on sensitized and mentored CHVs to trace PMTCT defaulters
			Advocate for peers, mentor mothers to be incorporated in the CHS
		Food security issues at household level	Multi-stakeholder engagement towards sustainable food security strategies e.g reintroduction of kitchen gardens and IGAs among PMTCT mothers
		Weak longitudinal mother-baby pair follow up	Adopt and scale up longitudinal case based surveillance for PMTCT clients
		Increase in incidences of GBV/ IPV in communities	Increase community awareness and advocacy against gender based violence/ intimate partner violence and strenghten response and refererral systems for the same
		Lack of comprehensive PMTCT service provision	Full integration of PMTCT service provision with other MCH services-
	Crosscutting	Inadequate capacity amongst various service providers: interns, newly posted staff, rotating staff	Provision of job AIDs
			Adoption/ development of simplified, interactive orientation packages for different service provision points
		Challenges and technicalities in using innovative approaches such as engaging social influencers, lobbying with politicians	Flexible budgeting models to accommodate innovative approaches
		Inadequate program leadership and coordination	Operationalize/ strenghthen PMTCT TWGs

			Institutionalize facility level PMTCT champions
			Counties to develop last mile strategic plan to guide EMTCT implementation
			Engage non-health partners to support PMTCT agenda. E.g companies, banks, local businesses through corporate social responsibility
		Over-reliance on partner support for PMTCT	Advocate for increased county government allocation for PMTCT activities
			Advocate for county HRH to support PMTCT service provision
		Multiple data collection systems with increased workload	Harmonization of data collection systems and alignments with data protection laws and policies
			Scale up use of PMTCT module in Kenya EMR