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SOP Title: STANDARD OPERATING PROCEDURES for INTEGRATED PMTCT-OVC PROGRAMMING AT THE FACILITY AND COMMUNITY LEVELS.	
Version Number:	
Effective Date:	Next revision date:

Introduction

Prevention of mother to child transmission of HIV (PMTCT) services are critical to achieve national and global targets of 90% ART coverage in PMTCT, and mother to child transmission rates less than 5%. Missed opportunities exist at both facility and community level, including the late and/or missed ANC visits; testing and ART initiation in PMTCT; late EID enrolments and testing for HEI; IITs along PMTCT cascade and poor follow-up with increased risk for HIV acquisition as well as poor adherence to ARVs and recommended infant feeding practices. Case management is recommended for all high risk PMTCT clients. Community-based programs for orphans and vulnerable children (OVC) are important links for families to health and social services through case management and preventive approaches. This platform ensures that caregivers are able to meet the needs of children, that at risk children are identified early, tested for HIV, and the HIV-positive children access and adhere to ARV treatment, and that adolescent girls stay safe through preventive evidence-based programs and they're in school, and on track to reach their potential. Pregnant and breastfeeding women are also supported to access recommended clinic services and PMTCT mothers adhere to treatment and follow up services. Therefore, intentional collaboration and integration of the PMTCT and OVC programs will result in better and sustained outcomes and wellbeing.

Purpose

This SOP is to be used as a guidance document by both the clinical and the OVC partners for integrated PMTCT and OVC programming at the facility and community levels. The clinical partner will provide guidance to the facility/clinical staff while the OVC partner will provide guidance to the caseworkers on the implementation of this SOP. It is vital that the clinical staff and the OVC caseworkers are aware of the procedures in this SOP to ensure seamless linkage of the pregnant and breastfeeding adolescents, and mother-baby pairs to appropriate services. They will work collaboratively in implementation of this SOP and ensure timely and accurate collection of the required data on a monthly and quarterly basis as needed.

The objectives of this SOP are to:

1. Create linkages between PMTCT and OVC programs at the facility and community levels in an effort to reduce high MTCT rates.
2. Ensure that eligible pregnant and breastfeeding adolescents regardless of HIV status are line-listed for follow-up at the community level.
3. Ensure that Breastfeeding women and HIV exposed infants (HEI) are line-listed for follow up at the community level.

4. Monitor and document progress towards the uptake and outcomes of interventions for mothers and children

RATIONALE

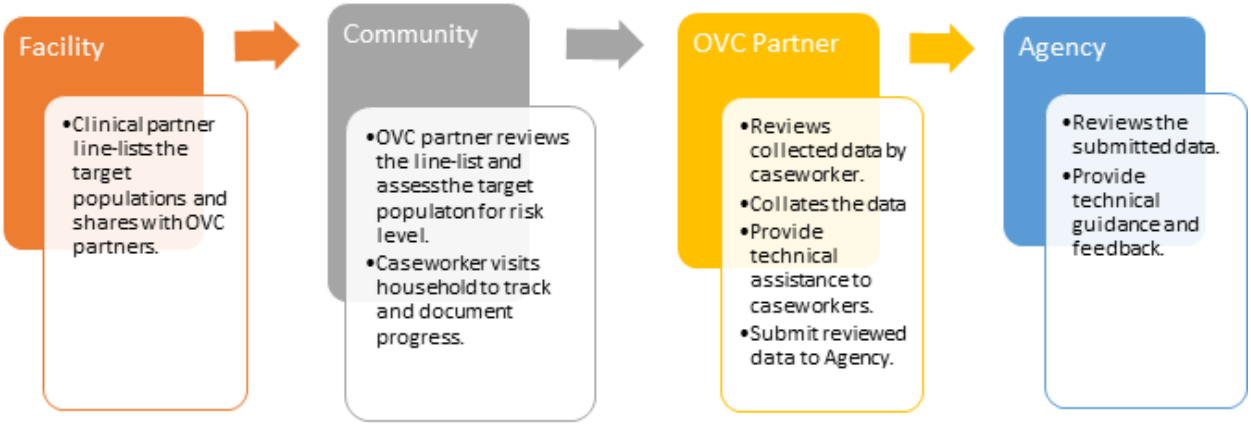
Despite the progress made in reducing MTCT rates, there remains several challenges in achieving the elimination of mother to child transmission. Some of the challenges identified include but not limited to; a) high MTCT rates; b) adolescents not identified and linked to early interventions; c) high rates of disengagement from care; d) late HEI PCR testing to ascertain status; and e) increased risk of HIV acquisition and high risk of pregnancy among adolescents (both HIV positive and negative).

This SOP aims to elaborate how OVC partners, in close coordination with clinical partners, ensure that pregnant and breastfeeding women and adolescents and their infants are closely followed up in the community to improve their health outcomes. This will be achieved through:

- Working with clinical partners to line-list and enroll pregnant and breastfeeding HIV positive and **eligible** HIV negative adolescents, **eligible** breastfeeding HIV positive women and their HIV exposed infants.
- Tracking clients in the community, support adherence/retention, and prevent LTFU through the initiation of prompt interventions in collaboration with health facilities.
- Monitoring the indicators outlined in the reporting tool and report the status of the clients on a monthly basis at implementing partner's level and at USG level on a quarterly basis.

IMPLEMENTATION

The PMTCT-OVC integrated program will be implemented by different stakeholders with different responsibilities as summarised below:



Step 1: At Facility level - define and identify who should be line listed

➔ On a daily basis the facility staff with assistance from the clinical implementing partner will screen antenatal and postnatal clients (see flow chart below) and populate 3 types of line lists:

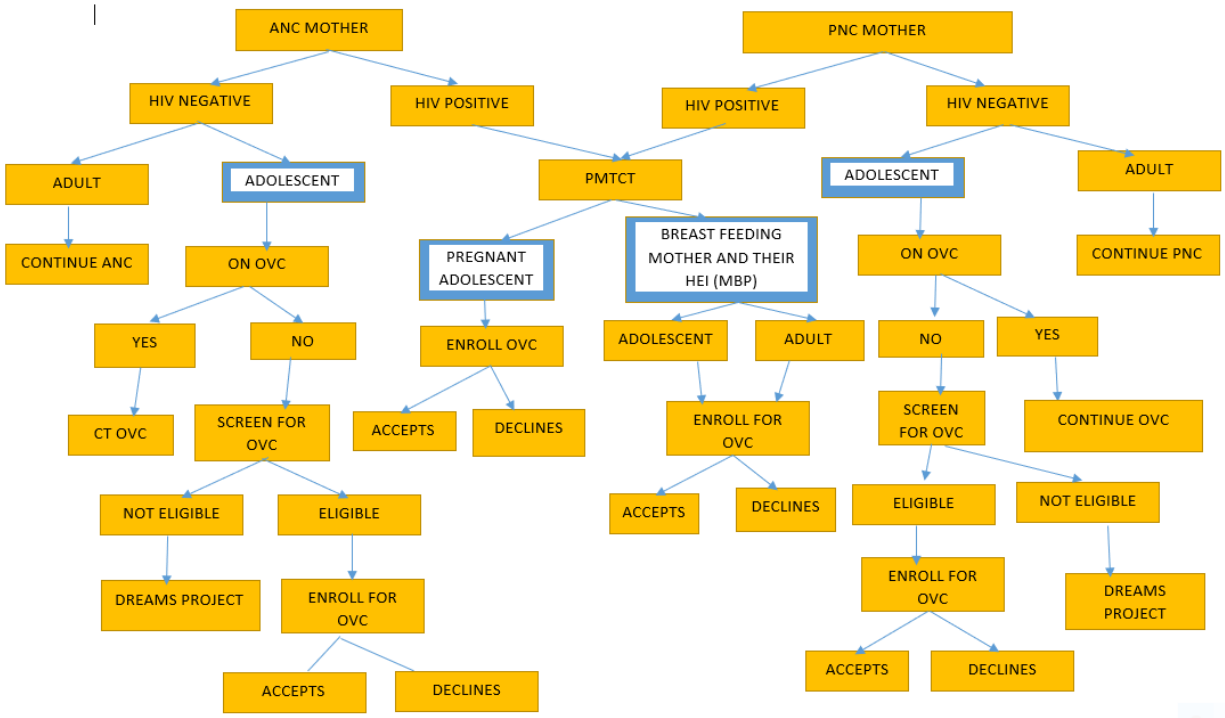
1. All HIV positive pregnant adolescents

2. **Eligible** HIV negative pregnant and breastfeeding adolescents
3. All HIV exposed infants and their mothers(mother-baby pair) including adolescent mothers.

➔ Facility staff should work closely with clinical partners to clear the backlog of all the current/existing ANC and PNC/MBP clients within the shortest time possible before embarking on routine daily screening.

➔ The facility staff will be responsible for completing all the columns on the 3 line lists except the column on "Enrolled in OVC program" which will be completed by the OVC partner upon receipt of the line lists from the clinical partner.

Screening Flow Chart by Clinical Partner



➔ HCW/ Facility team will screen all the negative pregnant adolescents, HIV Positive pregnant adolescents and HIV mother baby pairs and identify all high risk mothers i.e., IITs, Late ANC attendance, newly HIV diagnosed who will be line listed

➔ After line listing, the HCW(facility staff) facilitated by clinical partner will inform the clinical partner to initiate screening for OVC eligibility and enrolment.

➔ Thereafter, the HCW and clinical partner will ensure the enrolled clients continue to receive clinical services according to recommended guidelines.

Step 2: Community level - after line listing and referral to community

➔ Once the line-list has been generated by the clinical partner, the OVC partner will screen the clients for OVC enrolment using the OVC screening tool.

- ➔ The OVC partner will then work with the caseworkers to screen and follow up the line-listed adolescents, mothers and HEI in the community. The diagram below shows the flow of activities.
- ➔ The OVC Partner will map and allocate the enrolled clients to each case worker depending on their area/location of coverage.

Screening Flow chart by OVC teams

NOTE: It is recommended that enrolments can also be done from community settings such as Safe spaces, Churches, Households etc. The OVC case workers should ensure that referrals and linkage to Health Facility teams is done appropriately.

FOLLOW UP OF PREGNANT AND BREASTFEEDING WOMEN BY OVC CASE MANAGERS

1. **HIV negative pregnant and breastfeeding adolescents**

- ➔ Once the HIV negative pregnant and breastfeeding adolescents of below 18 years, has been identified from the line list, the CHV/caseworker will follow up and **conduct home visits** to ensure the following;

Case management for HIV negative adolescents by OVC case worker

-Screen the HIV negative adolescent using OVC HIV Risk Screening tool
-Enroll all the adolescents categorized as Most at risk for HIV infection.Explain the reasons/importance for the required close follow up and obtain consent before enrolment.
-Establish/initiate Health Education sessions with the enrolled pregnant adolescents with a focus on:

1. **Reduction of identified risks;** including FP use
2. **HIV Retesting**: Check Mother Child Handbook and ensure retesting at 3rd Trimester, maternity, Postnatal(6wks), 6 months, 1 yr then 6 monthly thereafter.
3. **Adherence to clinic visits(ANC,PNC,Immunization)**: Check Mother Child Handbook and ensure mother attends all indicated return visits.

-Refer(use referral note/escort) back to the Health facility all those clients with missed appointments/services or due for relevant services.
-Link all adolescents testing HIV positive to the health facility comprehensive care clinic for ART initiation

- ➔ Retested adolescents who maintain a HIV negative status should be referred to a HIV prevention program such as, Retesting, DREAMS, PrEP, Social Services etc.
- ➔ Adolescents found **not at risk** will be provided with HIV prevention information and referred to appropriate prevention services & Social services either at facility or community level. **Note: Low risk adolescents will not be enrolled in the OVC program.**

2. HIV positive pregnant adolescents and Breastfeeding mothers(MBP)

➔ Once the HIV positive pregnant adolescent and all the breastfeeding mothers(MBP) have been listed from the facility, they are **enrolled** into the OVC program for enhanced follow up that also ensures that they adhere to ANC ,PNC and overall PMTCT clinic visits and services.

Case management for HIV positive Pregnant adolescents and Breastfeeding mothers(MBP) by OVC case worker

-Explain the reasons/importance for the required close follow up and obtain consent
-Enroll all HIV positive Pregnant adolescents and all Breastfeeding mothers(MBP) for follow up
-Conduct a minimum of monthly follow up home visits
-Establish/initiate Health Education sessions and monitoring with a focus on:

1. **Adherence to clinic visits(ANC,PNC, CCC/PMTCT)**: Check mother child booklet and CCC appointment card to ensure mother attended all indicated return visits.
2. **Viral load**: All clients should have updated VL. Ask the mother her latest viral load date and results/suppression status and help her understand what her results means.
3. **Viral suppression**:For clients with VL > 1,000 copies/ml, explore possible reasons for non suppression and client solutions. Explain the importance of suppression and help define possible support systems.
4. **Disclosure:** Establish if clients have disclosed their status to someone close to them. Discuss the importance of disclosure. Support them address barriers to disclosure.
5. **Final outcomes**: Explain importance of good final outcomes for the mother and baby: HIV negative baby, Healthy Mother & Baby, Viral suppression, Exit from OVC program

-Refer(use referral note/escort client) back to the Health facility all those clients with missed appointments or due for relevant services.

➔ The HIV positive pregnant adolescent and breastfeeding HIV positive mothers will receive the same support services from the OVC Case manager.

3. HIV Exposed Infant (HEI)

➔ Once an HIV exposed infant has been enrolled into the OVC program, the CHV/case worker will follow up to ensure that the child remains on follow up till final outcomes are determined at 18-24months depending on breastfeeding status.

Case management for HIV Exposed Infants by OVC case worker

-All HEI will be enrolled with their mothers as Mother Baby pairs(MBP)
-Explain to the mother the reasons/importance for the required close follow up and obtain consent
-Enroll all mothers(MBP) for follow up
-Conduct a minimum of monthly follow up home visits
-Establish/initiate Health Education sessions and monitoring with a focus on:

1. **Immunization:** Explain the importance of immunization. Check the child's immunization status from Mother Child Handbook pages 32,33 and 34. Any missed opportunities?
2. **HIV/PCR Testing:** Confirm the child's age and check the Mother Child Handbook page 35 if the child has been done at Birth, 6wks, 6 months, 12 months and 18 months. Check if results are indicated. Explain importance.
3. **Breastfeeding:** Confirm the child's age and current feeding options she/he is on.Infant is on exclusive feeding option exclusive breast feeding(EBF) up to 6 months.Explain importance of EBF if applicable. Explore feeding patterns and type of food for babies more than 6 months
4. **Adherence to clinic visits(EID and growth monitoring)**: Check mother child booklet and CCC to ensure the child attended all EID and growth monitoring visits. Check the graph according to sex and provide health eudctaiona s necessary.
5. **Final outcomes**: Explain importance of good final outcomes for the mother and baby: HIV negative baby, Healthy Mother & Baby, Viral suppression. Document the outcome of the antibody test done at 18 or 24 months and exit the infant from PMTCT related follow up if the test is negative. *Deliberate their Exit from OVC program with OVC and clinical partners.*

-Refer(use referral note/escort client) back to the Health facility all those HEIs with missed appointments or due for relevant services.

-Link all HEIs testing HIV positive to the health facility comprehensive care clinic for ART initiation

Step 3: Partner level - Cycle of continuous monitoring

➔ The Clinical and OVC partner will observe the following steps for Quality Assurance/ Quality Control and for continuous monitoring of the program.

1. Review the line list register/tool regularly and ensure the information in summary tools meet all the data quality standards.
2. Review the submitted checklist by the CHVs/ caseworkers - at all levels ensure the following data quality standards are adhered to: **Validity of the information collected, Completeness, Accuracy, Consistency , Timely submission.**
3. Collation of the submitted checklist into the tracker by the case manager.
4. Generate the quarterly summary tool from the line list register/tool and tracker and ensure timely submission to the Agency. Online updating is encouraged.
5. Agency reviews the submitted information and provides both programmatic and M&E related feedback.

➔ The following indicators will be monitored by both Clinical and OVC partners together with Agency level

- Number of AGYW who have gone back to school, vocational training or linked to IGA
- % retention among clients enrolled
- % VL suppression among clients enrolled
- % Coverage and uptake of initial PCR at 6weeks

Step 4: Agency - Data Review and provision of technical guidance/assistance

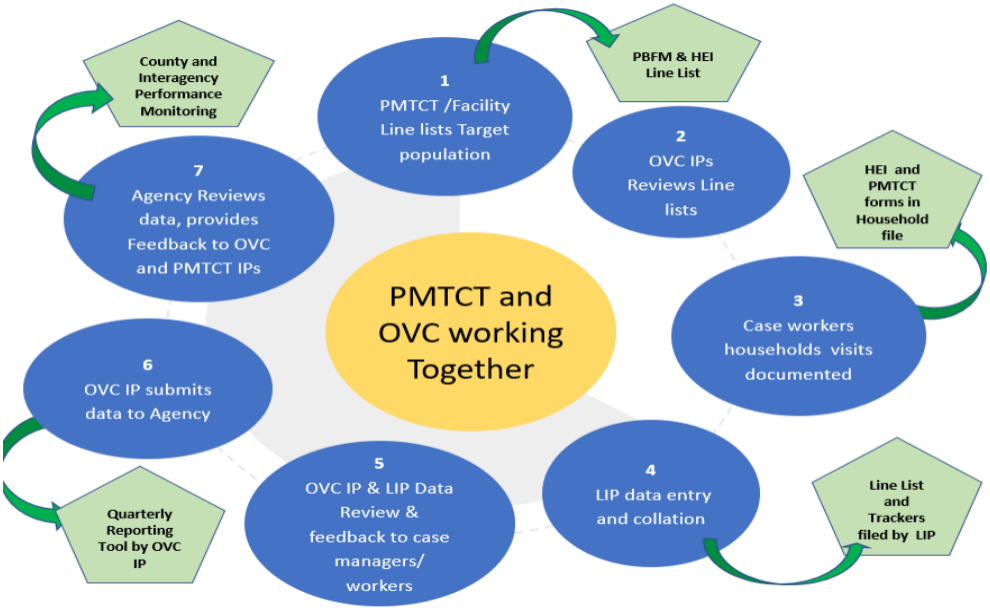
On a quarterly basis, the PMTCT and OVC interagency technical teams (ITT) will jointly be reviewing the data submitted by implementing partners.

- This information will be triangulated with the data submitted in DATIM of teenage mothers and HEIs identified and tested vis-a-vis those line-listed and offered the opportunity for enrollment into the OVC program.
- The interagency teams will have a better understanding of the extent of coverage and service delivery to the young teenage mothers within the counties PEPFAR is offering support.
- The PMTCT and OVC ITTs will further provide technical guidance to implementing partners on areas for focus based on coverage, gaps identified, impact and good practices.
- The outcome will be an inclusive, coordinated and integrated ITT that can engage with national and county governments and stakeholders to design and implement programs that would support young teenage mothers.

Consent, Confidentiality and Privacy of beneficiary information

Safeguarding beneficiary/client data and information is a requirement in PMTCT and OVC programming. Data and information entrusted to the program must be treated with utmost integrity and security. Partners must ensure that the clients' files are in a lockable and safe cabinet with only authorized access. Additionally, partners must uphold integrity as well as ensure retribution measures and systems are in place to address breaches of confidentiality. Individuals that access client data and information require adequate training including periodic refresher sessions. Partners must ensure that only trained and authorized staff can record required information in the client's file.

Annex I - PMTCT and OVC Working Together



Annex 2: Package of Services

PMTCT-OVC INTEGRATED PACKAGE OF SERVICES

Age group	OVC Services/Interventions	PMTCT/Pediatric and OVC Integrated services/Interventions	Who From Facility
0-9 Years	Birth certificates	(i) Community mobilization: sensitize on the need for regular clinic attendance and hospital delivery -this facilitates birth notification documents. Confirm form Mother Child Handbook. (ii) Sensitize and share information to PBF Adolescents on the need to have these documents.	Nurses, MCH staff
	Nutritional assessment/counseling/linkage to food supplementation	(i) Provide nutrition education and counseling; includes Care Givers with Malnourished children (ii) Provide nutritional supplements (Food by Prescription). (iii) Therapeutic food provided for children with Severe and Moderate Acute Malnutrition (iv) MUAC and weight progress (v) Linkage with other interventions and social safety nets for Chronic Malnutrition	The Nurses, Nutritionist, social worker and case manager
	School age CLHIV: Educational subsidies to promote regular attendance	(i) Routine assessment for developmental milestones, physical, emotional and mental assessment (ii) Deworming (iii) Immunization (iv) Prioritize education of young PBF Adolescents involvement in child development and monitoring	The Nurses,
10-14 Years	Parenting and violence prevention: Sinovuyo or FMP 2	(i) Screening for case finding management and referral of Physical, emotional, and sexual violence during clinical encounters (ii) Train on service providers to offer 1st line response to violence (iii) Linkage with community GBV support structures, committees. Conduct Sensitizations/Health Education	
	HIV prevention: Healthy Choices for a Better Future and FMP2	(i) HCW can initiate referrals and linkage of eligible clients to CHVs, Peer Educators and mentor mothers. (ii) Train CHVs, mentor mothers and peer educators as facilitators of parenting care intervention (iii) Organize for these sessions under school health program	Support from the IPs and the MCH staff
	Community mobilization & norms change: SASA!	(i) Revive community units and encourage community dialogue sessions challenging harmful norms (ii) To be done through community-based organizations that support prevention of SGBV. (iii) Use of radio spots and in person meetings	
	Educational subsidies, attendance and progression monitoring prioritizing CLHIV	(i) Routine assessment for developmental milestones, physical, emotional, and mental assessment during clinical encounters (ii) Referrals and Linkages to available education bursaries/subsidies e.g., CDF, (iii) School Outreach program discussing SRH, FP, HIV, Adherence, GBV (iv) Sensitizations on importance of OTZ clubs	
15-17 Years	Parenting Support: Sinovuyo, FMP 2	(i) Same as 10 -14 (ii) During health talks discuss and encourage on return to School after delivery (iii) Sensitizations on importance of OTZ clubs (iv) Under school health programs	nurse, CHV
	Educational subsidies prioritizing ALHIV	(i) Same as 10 -14 (ii) Counsel on re-entry back to school (iii) Routine assessment for developmental milestones, physical, emotional, and mental assessment during clinical encounters	
	School-based HIV Prevention: My Health My Choice	(i) Organize for these sessions under school health program	
Across Age bands	Case management (including HIV risk assessment, HIV treatment literacy,	(i) Risk assessment (ii) HTS services (iii) ART (iv) Referrals for those identified as HIV Positive	Nurses, mentor mothers, case-based

	disclosure support); graduation monitoring	(v) Treatment Literacy training (vi) Disclosure support and adherence, and stigma reduction, OTZ	managers/ peer mentors.
	Household economic strengthening: WORTH+ savings groups (household money management, parenting, GBV & gender norms); linkage to TASAF social protection	(i) SGBV screening, (ii) Case management and referrals (iii) Linkage to social protection (iv) Revive community units and encourage community dialogue sessions challenging harmful norms (v) Sensitize on importance of joining "chama" - VSLA and table banking for economic strengthening (vi) Referrals to available opportunities (e.g., Youth fund, Women Enterprise Fund in the respective counties	
	CALHIV: Adherence Support	(i) Risk assessment (ii) HTS services (iii) ART (iv) Referrals for those identified as HIV Positive (v) Treatment Literacy training, Disclosure support and adherence, and stigma reduction, OTZ	Nurses mentor mothers CCC in charge, OVC case worker
	CALHIV: Home visits, psychosocial support groups, escorted referrals	(i) Risk assessment (ii) HTS services (iii) ART (iv) Referrals for those identified as HIV Positive (v) Treatment Literacy training (vi) Disclosure support and adherence, and stigma reduction, OTZ (vii) Formation of support groups for caregivers, CALHIV	mentor mothers /Nurse/case worker Treatment buddy, peer mentors
	C/ALHIV support: transport to appointments & peer support groups mtgs	(i) Identify CALHIV with challenges in meeting clinic appointments and discuss with facility social worker for possible support from facility funds. (ii) Linkage of caregivers to other social safety nets from the County and constituency	Nurse/peer educators
	VAC/SGBV Screening & referral and linkage for support	(i) Ensure screening for VAC and SGBV is done at all service delivery points and ensure linkage with law enforcement is done. (ii) Linkage with community GBV support structures, committees	Support from the IPs for the MCH staff, Nurse, clinicians
	PrEP Provision (18 - 24 years AGYW)	(i) Linkage for Biomedical services (e.g., HIV risk screening and linkage to PrEP (ii) MCH-PrEP integration	Nurses
	Contraceptive Mix Provision OR active Referrals (18 - 24 years AGYW)	(i) Ensure assessment for FP need especially for emancipated minors at clinical encounter and provide linkage and referrals to available FP methods (ii) Condom Education and provision, and contraceptive method mix (iii) Promote FP uptake	Nurses
	Reducing risk male sex partners (link to Condoms, HTS, VMMC, HIV Treatment)	(i) Sensitize on importance of male partners involvement and access to required biomedical services e.g., HTS, VMMC (ii) Advocacy for male involvement and referral for interventions (iii) Ensure partners of emancipated minors have access or referral to these services	Nurses