Ministry of Health

NATIONAL GUIDELINES FOR PMTCT PEER EDUCATION AND PSYCHOSOCIAL SUPPORT IN KENYA

The Kenya Mentor Mother Program

First Edition

2012

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National AIDS and STI Control Program (NASCOP)
Ministry of Health, Kenya
PO Box 19361-00202
Nairobi, Kenya
Tel: +254.20.272.9549 or 272.9502
Email: head@nascop.or.ke

List of Contributors/Reviewers

Ambrose Juma	_	NASCOP
Antony Mutura	_	MOH / Moyale
Claris Ojwang	_	AMPATH
Daniel Gitau	_	PACT-PMH
Dr. Agatha Olago.	_	NASCOP
Dr. Charles Muga	_	FACES
Dr. David E. Bukusi	_	KNH, CBTS
Dr. Davies Kimanga	_	NASCOP
Dr. Lynn Kanyuuru	_	JPHIEGO
Dr. Mary Kariuki	_	PATHFINDER
Dr. Mildred Mudany	_	CDC
Dr. Nakato Jumba	_	DRH
Dr. Sirengo Martin	_	NASCOP
Dr. Isabella Yonga	_	USAID
Dr. Judy Maye	_	m2m
Elizabeth Ndegwa	_	NASCOP
Grace M. Njoroge	_	m2m
Ibrahim Wabuge	_	CARE
Jane Muringi	_	PACT/COE/PMHC
Janet Nzai	_	PACT UMB
Judith Maua	_	DRH
Judith Njumwah	_	m2m
Linda Beyer	_	UNICEF
Luiza Adhiambo	_	m2m
Lulu Ndapatani	_	CHS
Mary Maina	_	MOH
Mary Nungari	_	PACT-CDC KNH
Milker Simba	_	m2m
Mwikali Kyulo	_	EGPAF
Nicole Fulton	_	m2m
Pam Akhaabi	_	AMPATH
Rachael Muinde	_	NASCOP
Rogers Simiyu	_	EGPAF
Rosebelle Oketch	_	BOMU HOSPITAL
Ruth Ngechu	_	MOPHS/DCHS
Teresia Mutuku	_	JHPIEGO
Teresia Njeri	_	m2m
Teresia Njoki	_	WOFAK
Thomas O. Ondimu	_	FHI 360
Valerie Ndege	_	FACES
William Sugut	_	DOD – SRV

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Acknowledgments

The first edition of the *National Guidelines for PMTCT Peer Education and Psychosocial Support in Kenya: The Kenya Mentor Mother Program* has been developed through the collaborative efforts of many individuals and organizations. I take this opportunity to acknowledge the PMTCT Technical Working Group subcommittee that took a leadership role in coordinating the development of the guidelines and the contributors and reviewers of the document: the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the United Nations Children's Fund (UNICEF), the University of Nairobi, Moi University-AMPATH, Columbia University-ICAP, Doctors Without Borders-Belgium, Doctors Without Borders-France, FHI360, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Johns Hopkins University-JHPIEGO, the University of Maryland-IHV, the University of California San Francisco-FACES, Women Fighting AIDS in Kenya (WOFAK), and Pathfinder International, among others.

Specific acknowledgement goes to the National AIDS and STI Control Program (NASCOP) and the Division of Reproductive Health (DRH) for championing the Kenya Mentor Mother Program, and to USAID and UNICEF for technical and financial support. Special thanks and recognition is due to **mothers2mothers**, upon whose model the Kenya Mentor Mother Program is based, and who provided technical support to develop the *Guidelines*.

To all of you, we say thank you!

Dr. Sirengo Martin

PMTCT Program Manager
National AIDS and STI Control Program

Foreword

The Ministries of Health (MOH) welcome the new *National Guidelines for PMTCT Peer Education and Psychosocial Support in Kenya: The Kenya Mentor Mother Program,* which will provide guidance for the standardization and integration of peer education and psychosocial support services within the Kenyan national PMTCT program. These guidelines are an important part of the government's strategy to reduce mother to child transmission of HIV (MTCT) to less than 5% through the national eMTCT Framework, aligned with the National Health Strategic Plan (NHSSPII), and Kenya National AIDS Strategic Plan (KNASP III 2009-13) Pillar III, which focuses on strengthening community capacity to contribute to universal access and social transformation.

Despite the increasing availability of clinical services in Kenya to prevent pediatric HIV infection and promote maternal health, many women still do not access, uptake or fully adhere to the care recommended for themselves and their babies. The reasons for this are complex and multi-faceted.
Quality approaches to peer education and psychosocial support can help overcome obstacles such as stigma, discrimination and denial; lack of accurate knowledge and information; skepticism about the possibility of living positively with HIV and having an HIV-negative baby; lack of male involvement in and support for MNCH; preference for traditional birth attendants; perceptions of poor service quality; and others, as evidenced by the Joint Review Mission and the National Formative Research reports on PMTCT and pediatric HIV programming.

As a signatory to the *Global Plan* on eMTCT, the Government of Kenya supports the principle that women living with HIV must be at the center of the response to the epidemic. Community engagement is critical in generating demand for maternal, newborn and child health and PMTCT services. The Government of Kenya also recognizes that Mentor Mothers play a critical role in task-shifting to promote health service quality improvement as well as uptake of, adherence to and retention in care.

These guidelines, coordinated through the Ministries of Health and in collaboration with implementing partners, will support the elimination of mother-to-child transmission through all four prongs at both the facility and community level, promote maternal and infant health and empower women. The PMTCT Technical Working Group led the process of development of the guidelines and was informed by recent program evidence, best practice findings and recommendations from national and global guidelines.

Guided and inspired by previous success stories and milestones, we are confident that the comprehensive implementation of these guidelines will reduce the devastating effects of stigma and discrimination, promote maternal and child health and improve the lives of Kenyans.

Dr. S.K. Shariff
Director of Public Health and Sanitation

Dr. F. Kimani
Director of Medical Services

Abbreviations and Acronyms

AFASS	_	Acceptable, Feasible, Affordable, Sustainable and Safe (infant feeding criteria)
AIDS	_	Acquired Immune Deficiency Syndrome
AN	_	Antenatal
ANC	_	Antenatal Care
ART	_	Antiretroviral Therapy
ARV	_	Antiretroviral Drug
BCC	_	Behavior Change Communication
CCC	_	Comprehensive Care Center, for patients living with HIV/AIDS
CHEW	_	Community Health Extension Worker
CHW	_	Community Health Worker
DASCO	_	District AIDS/STI Coordinator
DHIS	_	District Health Information System
DHRIO	_	District Health Records and Information Officers
DRH	_	Division of Reproductive Health
EBF	_	Exclusive Breastfeeding
EID	_	Early Infant Diagnosis of HIV
EMR	_	Electronic Medical Record
eMTCT	_	Elimination of Mother to Child Transmission of HIV
FANC	_	Focused Antenatal Care
FP	_	Family Planning
HEI	_	HIV-Exposed Infant
HIV	_	Human Immunodeficiency Syndrome
HMT	_	Hospital Management Team
IEC	_	Information, Education and Communication Activities
KePMS	_	Kenya HIV/AIDS Program Monitoring System
KMMP	_	Kenya Mentor Mother Program
LIP	_	Local Implementing Partner
M&E	_	Monitoring and Evaluation
MIPA	_	Meaningful Involvement of People Living with HIV/AIDS
MM	_	Mentor Mother
MMTL	_	Mentor Mother Team Leader
MNCH	_	Maternal, Newborn and Child Health

MOH	_	Ministry of Health
MTCT	_	Mother to Child Transmission of HIV
NASCOP	_	National AIDS and STI Control Program
NGO	_	Non-Governmental Organization
PLHIV	_	People Living with HIV
PMTCT	_	Prevention of Mother to Child Transmission of HIV
PN	_	Postnatal
PNC	_	Postnatal Care
PSS	_	Psychosocial Support
PSSG	_	Psychosocial Support Group
SG	_	Support Group
STI	_	Sexually Transmitted Infection
TB	_	Tuberculosis

Executive Summary

The *National Guidelines* for the Kenya Mentor Mother Program (KMMP) integrates and standardizes peer education and psychosocial support for the prevention of mother-to-child transmission of HIV (PMTCT) programs. The guidelines were developed through a participatory and consultative process, drawing on expert opinions from public health institutions, NGOS, academic institutions and development partners. While numerous strategies have been implemented in high HIV-prevalence settings to increase PMTCT uptake, the absence of a standardized peer approach remains a significant gap in current HIV programming in general, and PMTCT programming in particular. Achieving the elimination of mother-to-child-transmission (eMTCT) will require the provision of quality peer education and psychosocial support services for people living with HIV/AIDS, and a much greater commitment to placing women living with HIV at the center of the response.

Evidence indicates that stigma and discrimination, lack of comprehensive knowledge and information, low male involvement, and lack of support systems all act as barriers to the uptake of and adherence to PMTCT services. These issues can be addressed through a peer education and psychosocial support approach that integrates women living with HIV into the health delivery team as ***Mentor Mothers***. Linked with Community Health Workers, Mentor Mothers draw from their own experiences as former PMTCT clients to inspire behavior change in their peers.

The process to develop these guidelines incorporated best practice approaches from PMTCT implementers across the country to inform the Kenya Mentor Mother Model. For use by PMTCT implementers, these guidelines will enhance the capacity of providers to utilize standardized peer education and psychosocial support approaches both at the facility and the community level, while also encouraging creativity and innovation beyond the minimum standards.

There are 5 sections in the guidelines:

Section 1 provides an overview of the global and local picture of MTCT, efforts for elimination, and the rationale for and process of developing the KMMP guidelines.

Section 2 provides information on the essential package of services that will be provided to all women, with a special focus on HIV-positive women, by Mentor Mothers in health facilities and Community Health Workers in communities.

Section 3 provides information on the terms of service and support systems for Mentor Mothers, including guiding principles and the minimum standards for recruitment, remuneration, training, management, and other areas of support.

Section 4 outlines the Monitoring and Evaluation framework for the KMMP, designed to measure the progress and impact of KMMP activities under one united approach.

Section 5 identifies the roles of different partners in implementing the KMMP guidelines.

Section:

1 Background

1.1 Global Trends

Great strides have been made in curbing the HIV epidemic, including mother-to-child transmission of HIV (MTCT). By providing antiretroviral prophylaxis to pregnant women living with HIV, more than 350 000 new HIV infections among children have been averted. By 2010, new child infections had fallen to an estimated 390 000 [340 000–450 000], down 15% from 2001. The majority of child infections averted (86%) were in sub-Saharan Africa. Although this progress should be celebrated, much more must be done to eliminate mother-to-child transmission and achieve an HIV-free generation.

The proportion of women living with HIV has remained stable at 50% globally, although women are disproportionately affected in sub-Saharan Africa (59% of all people living with HIV). The rapid increase of coverage of HIV treatment and prevention services for pregnant women has resulted in a doubling of cumulative HIV infections averted. In higher income countries with greater access to new drugs and comprehensive care, the pediatric transmission is almost zero, which demonstrates that PMTCT interventions do work and that global gaps can be equalized with solutions that take into account specific country contexts and needs.

1.2 Kenyan Picture

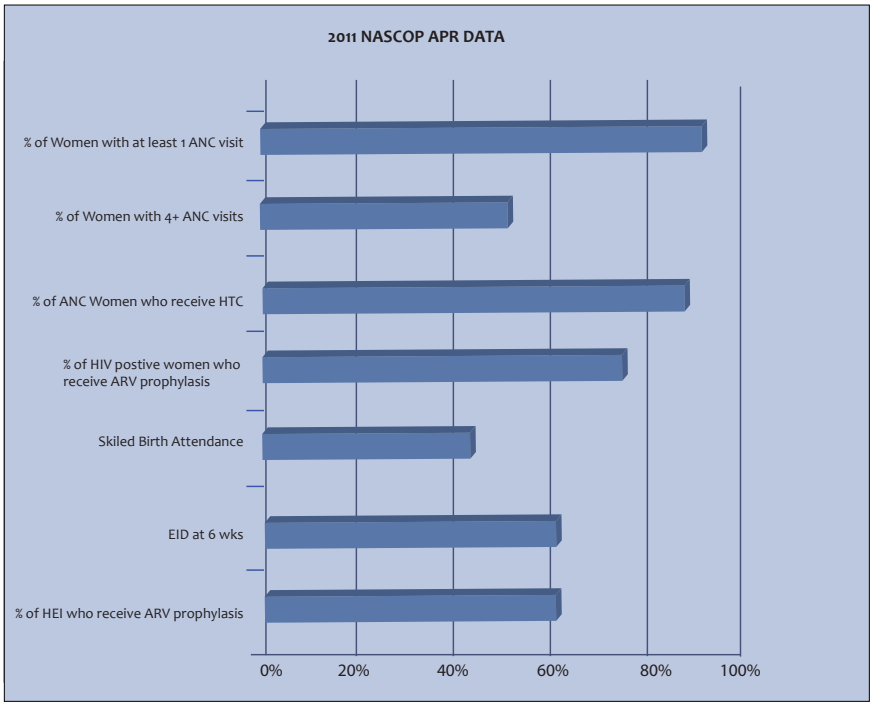
Although heterosexual intercourse accounts for more than 77% of all new infections, Kenya's epidemic disproportionately affects women. UNAIDS estimates that in 2010, 57.5% of the 1.6 million Kenyans living with HIV were women. According to the 2010 National HIV Indicators for Kenya, an estimated 87,000 HIV-positive mothers and their infants were in need of PMTCT services in 2010. Without intervention, the risk of mother-to-child transmission of HIV is 20–45% with the highest rates of transmission seen in populations with prolonged breastfeeding. However, this risk reduces to 2-5% when comprehensive interventions are provided. An estimated 32,000 child infections have been averted in Kenya since 2004, with much more work to be done.

The Government of Kenya has committed to deliver a comprehensive set of interventions to prevent mother-to-child transmission. With this commitment, Kenya has seen a scale-up of PMTCT services to 61% of health facilities, roll-out of revised PMTCT guidelines, and intergration of PMTCT services within antenatal, maternity and child welfare services. As a result, about 81 % of pregnant women are counselled and tested for HIV and 78% of the HIV-positive women receive antiretroviral (ARVs) for

prophylaxis, (NASCOP *Annual Program Review,* 2011). A large proportion of these however (33%), still receive single dose Nevirapine as opposed to recommended combination ARV regimens (Kenya *Universal Access Report*, 2010).

The latest program data indicates that the MTCT rate is declining amid many challenges. However, there are regional variations in the coverage and effectiveness of PMTCT interventions. Routine service statistics reveal a continuing drop-off from care along the cascade of ANC and PMTCT interventions *(Table 1.2.)* with approximately 44% of pregnant women benefiting from skilled birth attendance and few HIV-exposed infants benefiting from early HIV diagnosis and treatment.

Table 1.2: uptake of PMTCT services in Kenya.



1.3. The Global Plan and the Kenya eMTCT Framework

The Millennium Development Goals (MDGs), adopted in 2000, designated the empowerment of women, maternal health, child health and HIV/AIDS as four of the eight priorities for the advancement of global health and development. By 2015, goals three, four, five, and six aim to: eliminate gender disparity in education, reduce global under-five mortality rates by two-thirds, decrease the maternal mortality ratio by three-quarters and halt and begin to reverse the spread of HIV/AIDS. PMTCT has come into increasing focus as a vital step towards realizing all four goals.

With this in mind, the *Global Plan*, released in 2011 by UNAIDS, re-focuses efforts to eliminate mother-to-child transmission of HIV (eMTCT) and keep mothers with HIV alive and healthy. The plan pinpoints two goals to be reached by 2015: a 90% reduction of childhood HIV infections (translating to <5% MTCT rates), and a 50% reduction of HIV-related maternal deaths. The plan supports solutions that are adapted to national and sub-national settings, with a core set of programmatic and policy standards. In these standards, the *Global Plan* calls for the use of "*Mentor Mothers*," as defined below.

A Mentor Mother is:
A mother living with HIV who is trained and employed as part of a medical team to support, educate, and empower pregnant women and new mothers about their health and their babies' health.

Working as non-technical members of the PMTCT team from local communities, Mentor Mothers help to reduce stigma, increase community communication and mobilize demand for services. All of these are aspects of the Global Plan and address barriers to PMTCT uptake. The KMMP uses a task-shifting approach to promote the meaningful involvement of women living with HIV in their own health service delivery, thereby enabling overburdened nurses and clinical staff to focus on what they are uniquely qualified to do: deliver clinical care. As integrated members of the health care team, Mentor Mothers become leaders and role models, inspiring and educating clients to make healthy choices for themselves and their families.

The KMMP is an integral component of the National eMTCT Framework, which seeks to eliminate MTCT by 2015 and contribute to maternal health and child survival by achieving universal access to comprehensive PMTCT services. The KMMP dovetails with other national frameworks including the *Community Health Strategy* and the eMTCT Framework, including the *"Kata Shauri"* campaign. As the national behavior change communication (BCC) strategy for PMTCT, the Kata Shauri campaign raises awareness of available services through various media modalities. The work of Mentor Mothers and Community Health Workers within the KMMP therefore complements the campaign's key messages at the facility and community levels.

1.4 Overview of the KMMP

The Kenya Mentor Mother Program was developed to fill a core set of gaps in PMTCT and related Maternal, Newborn and Child Health (MNCH), and HIV/AIDS treatment, care and support.

A National Best Practice Assessment on Peer education and psychosocial activities in Kenya and evidence based best practices of peer education approaches in the region informed the development of the KMMP model.

A key guiding principle of the KMMP is that peer education and psychosocial support work together to motivate behavior change and reduce stigma. Using facility and community approaches, the KMMP seeks to address barriers to PMTCT care by integrating mothers living with HIV into the health sector to provide education and support, building on their own experience and serving as role models for positive living and healthy choices.

The KMMP trains and employs Mentor Mothers to share the most recent information and best practices of PMTCT treatment, care and support with their peers in a facility setting. Through pre-test group education sessions, one-on-one and couples counseling, support groups and defaulter tracing, Mentor Mothers provide a safe, confidential and non-judgmental space for mothers and their partners to receive information on how to live positively, protect and care for their infants and navigate the health system. Linked to Community Health Workers at the community level, the KMMP ensures a continuum of care for each client.

The meaningful involvement of people living with HIV/AIDS (MIPA) is a cornerstone of the KMMP. By integrating Mentor Mothers into PMTCT care, the program provides a space for people living with HIV (PLHIV) to contribute to eMTCT efforts and to combat stigma as well as the lack of knowledge and awareness that is prevalent in Kenyan communities. As one participant commented during the October 2011 meeting on the Global Plan for eMTCT in Johannesburg, South Africa:

> *"We as PLHIV should be recognized as equal partners in elimination efforts. There is a need to recognize the expertise of PLHIV. We are not just recipients of services but have much more to offer."*
>
> *~ Martha Tholanah ~*

The *National Guidelines* outline the minimum standards for quality in PMTCT peer education and psychosocial support service delivery and routine monitoring. Despite the presence of such activities throughout the country that are implemented by various organizations, current approaches remain fragmented in the absence of clear national standards. This document fills this gap by defining the key components of such activities at the facility and the community level, as well as the required support systems for integrating Mentor Mothers into the health system. The *National Guidelines* do not intend to remove the space for creativity and innovation in these approaches. On the contrary, the MOH hopes to inspire ongoing dialogue about quality improvements from the clearly defined starting point outlined herein.

KMMP Objectives

As part of the national PMTCT program, the KMMP and all other PMTCT components strive towards one unified goal: **elimination of MTCT and the improvement of maternal and child health**. The KMMP contributes to this over-arching national goal through three sub-objectives:

1) Quality peer support services are available for women and their infants (through the integration of Mentor Mothers in the health delivery team)

2) Mother-baby pairs seek timely MNCH services (through community-based activities by CHWs)

3) Mother-baby pairs are retained in care and adherent to available services (through facility-based activities by Mentor Mothers)

All three of these objectives are achieved through the empowerment of women as Mentor Mothers and as clients, as well as through employment, access to support networks, increased confidence and self-efficacy, improved knowledge and information and demand creation. Additionally, the reduction of stigma and discrimination paves the way for each objective to be realized. The details of these elements are further outlined in the KMMP Results Framework in Section 4.

Finally, the KMMP presents opportunities to deploy activities and approaches within the 4 prongs of PMTCT, addressing identified gaps in PMTCT uptake.

Table 1.4: The Four Prongs of PMTCT and Opportunities for Peer Education & Psychosocial Support Interventions

Prongs	Opportunities for KMMP Interventions
Prong 1: Primary prevention of HIV infection in women of reproductive age	Improve counseling and community messages on HIV awareness for HIV-negative pregnant women and their partners through partner/couple sessions and group health talks; actively promote HIV re-testing in pregnancy for all HIV-negative women.
Prong 2: Prevention of unintended pregnancies among HIV-positive women	Promotion of safe sex through the use of modern family planning (FP) practices, referrals to family planning services for eligible clients, and couples counseling, support groups and group education that address FP needs and issues to PMTCT and CCC clients.
Prong 3: Interventions to reduce transmission from HIV infected pregnant women to their children	Prong 3 is the priority focus of the KMMP. Mentor Mothers provide education and psychosocial support on PMTCT interventions, and work to reduce the underlying stigma and discrimination that make it difficult to uptake services.
Prong 4: Care and support for women, children and families infected by HIV and AIDS	Mentor Mothers provide postpartum continuing education and PSS to address the issues that arise after delivery that can threaten the health of mother and their baby, including adherence to ART, uptake of EID, enrollment in pediatric care, nutrition and immunizations. Referrals to ongoing care and community-based support services are another aspect of the program.

Section:

2 Package of KMMP Services

2.1. Introduction

"Package of Services" refers to the minimum standards for peer education and psychosocial support services provided to the client. These include facility-based services provided by Mentor Mothers and community-based activities carried out by Community Health Workers. Examples of these services include group health talks, individual and couples education and support, support groups, defaulter tracing, community mobilization and client referrals, among others. This section therefore defines the elements of these standards to be provided by all implementing facilities and partners. .

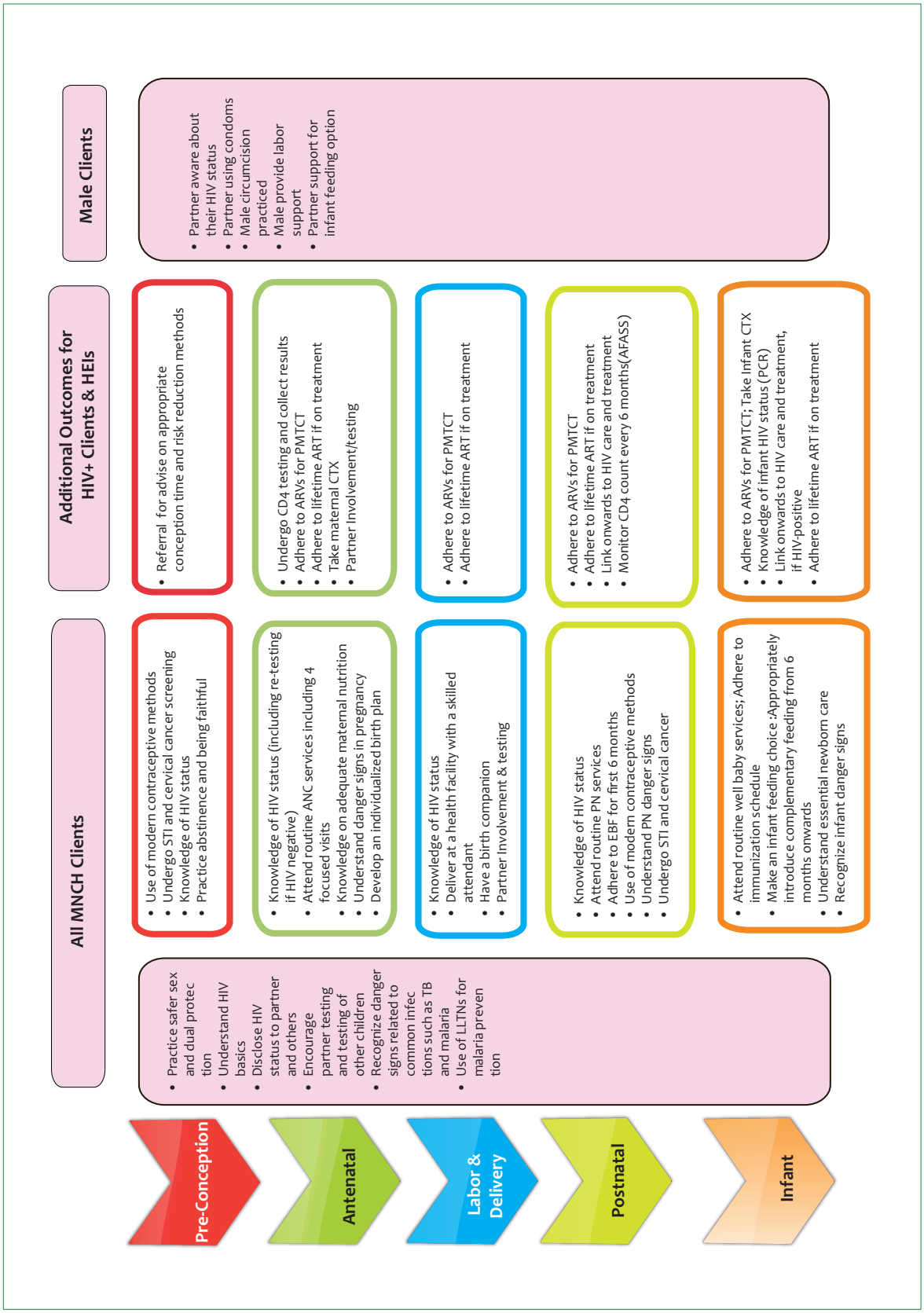
2.2. Target Population

The primary target population of the KMMP is PMTCT clients. PMTCT clients are defined as HIV-positive pregnant women and new mothers and their babies up to 18 months post-partum.

The secondary target populations of the KMMP are: HIV-positive female CCC clients, HIV-negative MNCH clients, male partners and children up to 5 years. The KMMP supports targeted activities related to all four prongs of PMTCT, including support to HIV-negative women of reproductive age to remain negative and family planning support to HIV-positive women to prevent unintended pregnancy. The KMMP also extends targeted support to all MNCH clients at both the facility and community level to promote comprehensive maternal and child health where feasible.

2.3. Desired Client Outcomes

The table *(table 2.3)* below details the expected client outcomes from KMMP services for all MNCH clients, with a priority focus on PMTCT clients.



2.4. Roles and Responsibilities:

Mentor Mothers & Community Health Workers

The KMMP package of services is delivered by two distinct yet connected roles: Mentor Mothers (MMs), who are based at the health facility, and Community Health Workers (CHWs), who are based in the community (as per the *Community Health Strategy*). MMs and CHWs collaborate with and complement each other by providing linkages between facilities and communities to support clients, increase demand for services and educate on PMTCT and related health topics in different but related venues: the health facility and the local community.

The Mentor Mother Team Leader (MMTL), who reports to the facility in-charge, supervises Mentor Mothers. Further details on the role of the Mentor Mother Team Leader are outlined in Annex B. CHWs report to Community Health Extension Workers (CHEWs) as per the *Community Health Strategy*.

Mentor Mothers *do not* provide direct medical care or treatment, nor do they replace the roles and responsibilities of clinical staff. Mentor Mothers play a task-shifting role to enhance the education and psychosocial support component of PMTCT service delivery, with a view of achieving defined client outcomes.

The model further defines the core elements in the delivery of KMMP services by the mentor and the CHW as listed below;

Table 2.4: KMMP core elements for Mentor Mothers and Community Health Workers

MENTOR MOTHERS ***(Facility)***	COMMUNITY HEALTH WORKERS ***(Community)***
Core Elements • Provide one-on-one peer education and psychosocial support to PMTCT clients and couples. • Co-facilitate support groups for PMTCT clients and couples. • Conduct defaulter tracing of priority PMTCT clients. • Facilitate group pre-test HIV education for pregnant women. In addition • Co-facilitate group health talks in facility waiting areas on key messages on PMTCT and MNCH • Refer PMTCT, MNCH and CCC clients for other services within the health facility and to community-based services. • Encourage partner involvement in MNCH services, education and psychosocial support.	Core Elements • Facilitate messaging & education related to MNCH basics • Promote early ANC attendance and skilled delivery • Conduct defaulter tracing within communities through CHEWs • Refer HIV-positive pregnant women and new mothers to facility-based clinical services and PMTCT support groups run by Mentor Mothers In addition • Lead community mobilization related to MNCH, PMTCT and male involvement to create demand for services • Facilitate community-based MNCH support groups for mothers, irrespective of HIV status • Link women to other available community-based services and activities

2.5. Standards for Mentor Mother Services

As outlined in Table 2.4 above, Mentor Mothers provide a range of services within health facilities to achieve desired client outcomes. The details and corresponding standards of these activities are detailed in the charts below.

2.5.1. General Group Health Education

Description
Mentor Mothers (with the facility nurse) facilitate general group health education talks for women and their partners accessing outpatient services at the health facility. Group health education talks are offered as part of the facility's monthly roster of health talks developed by the facility nurse.
Purpose
To raise awareness and motivate behavior change related to MNCH and PMTCT topics aligned to desired client outcomes (Table 2.3).
Place
Held at MCH waiting areas, out-patient waiting bays, and the CCC.
Frequency
Daily, depending on the volume of the facility and the need for Mentor Mother support.
Duration
General group health education talks last approximately 30 minutes.
Implementation Standards
• Planning and preparation for the talk by the Mentor Mother(s) is done with the facility nurse prior to the presentation. • Topics are selected in line with desired client outcomes of the KMMP, e.g. STI screening, family planning, safe motherhood, child health & immunization, nutrition, HIV basics, HIV care and treatment, male involvement, stigma & discrimination and others • Methodologies used to support group education include use of IEC materials, video clips and documentaries and/or role plays & skits

2.5.2. Group Pre-Test HIV Education

Description
Mentor Mothers facilitate group pre-test education sessions for all pregnant women during antenatal care prior to HIV testing, with the support of the facility nurse.
Purpose
To encourage pregnant women to undergo HIV testing, prepare women for the results of the test whether positive or negative and motivate behavior change.
Place
Held within a designated room at the MCH.

Frequency
Every day that HIV testing is offered to pregnant women at the facility.
Duration
Group pre-test HIV education sessions usually last 45 min - 1 hour.
Implementation Standards
• Mentor Mothers first observe a nurse giving a group pre-test education session for HIV before taking over the responsibility and should prepare an outline of the talk in advance • The content of the session focuses on the importance of HIV testing in pregnancy, the implications of positive and negative results, PMTCT basics, safe motherhood basics and the role of the male partner

2.5.3. One on One Education and Psychosocial Support Sessions

Description
Mentor Mothers provide one-on-one education and psychosocial support to PMTCT clients through mentorship. A minimum of one session is also provided to each HIV-negative woman during pregnancy to promote primary prevention and broader MNCH objectives.
Purpose
To provide emotional, psychosocial and educational support to clients through the provision of health education and sharing of the Mentor Mother's experience, to create awareness and facilitate the uptake of available PMTCT services, to empower women and facilitate positive living.
Place
Held in a private environment – preferably a dedicated room within the health facility that protects confidentiality.
Frequency
Daily
Duration
While the duration of a one-on-one session depends on the needs of the client; on average, new client sessions usually take 45 – 60 minutes and re-visit sessions take 20 min.
Implementation Standards
• Mentor Mothers respect and protect the confidentiality of clients at all times • Tea is provided where feasible • The content of a one-on-one session is guided by the needs of the client and the content of the KMMP curriculum, aligned to the desired KMMP client outcomes in Table 2.3 above • Mentor Mothers use one-on-one sessions as opportunities to invite clients to attend support groups and encourage clients to return with their male partners • With consent of the client, the facility nurse can be invited to support certain aspects of the education as required

2.5.4 Couples Education and Psychosocial Support Sessions

Description
Mentor Mothers provide education and psychosocial support to PMTCT clients and their partners through mentorship.
Purpose

TTo provide emotional, psychosocial and educational support to client couples through education and the sharing of the Mentor Mother's experience, to create awareness and encourage partner support for uptake of PMTCT and other services, to empower couples and facilitate positive living.
Place
Held in a private, conducive environment – preferably a dedicated room within the health facility that protects confidentiality.
Frequency
Daily and monthly for the support groups
Duration
While the needs of the clients will determine the duration of the session, on average, new client sessions should take 60 minutes and re-visit sessions 30 min.
Implementation Standards
• Mentor Mothers respect and protect the confidentiality of clients at all times • Tea is provided where feasible • The content of couple sessions is guided by the needs of the clients and the content of the KMMP curriculum, aligned to the desired KMMP client outcomes in Table 2.3 above • Mentor Mothers use couples sessions as opportunities to invite clients to attend couples support groups • With consent of the couple, the facility nurse is invited to support certain aspects of the education as required • Couples can be self-referred or by the facility • Male partners are routinely offered HIV testing

2.5.5. Support Groups (Women & Couples)

Description
Mentor Mothers co-facilitate support groups for HIV-positive pregnant women and new mothers, as well as support groups for couples, with technical guidance from the facility nurse.
Purpose
To provide emotional, psychosocial and educational support to clients through experience sharing and the provision of health education, to create awareness and facilitate the uptake of available PMTCT services, to empower women and facilitate positive living.
Place
Held within the health facility (indoors or outdoors) in an environment that ensures client confidentiality.
Frequency
Support groups for HIV-positive pregnant women and new mothers are held weekly for new clients (*newly diagnosed clients during their first 4 SG sessions*) and once a month for old clients (*clients who have previously attended at least 4 previous SG sessions*) unless determined otherwise by low client volume or clients needs. Support groups for couples are held at least once a month or more frequently as dictated by client volume.

Duration
The duration of a support group meeting is approximately 2 hours.
Implementation Standards
• A Mentor Mother facilitates support groups with a clinician (PMTCT coordinator) to handle technical issues. The Mentor Mother draws on support from the facility nurse to provide technical content beyond the Mentor Mother's capacity • Support groups are held for HIV-positive women only as well as for couples. A mixture of both approaches at each facility is encouraged to promote private time for women to discuss issues among themselves and opportunities for male involvement • Support groups mix antenatal and postnatal clients together to facilitate opportunities to learn from the experiences of others • The ideal number of participants per support group is 15 – 20, with a maximum of 25 • Support group meetings have a structured agenda that is prepared by the Mentor Mother in advance • A generic support group agenda is: opening prayer, topic & discussion, experience sharing, wrap-up and planning for next meeting • Support group topics are selected jointly by the Mentor Mother and the support group members, are relevant to the majority of the group members and are guided by the KMMP curriculum and desired client outcomes (see Table 2.3) • Where feasible, a meal is shared at support group meetings. In cases where this is not feasible, tea and a snack are shared at minimum • PMTCT clients transition to community and CCC-based support groups after 18 months post-partum.

2.6. Standards for Joint Services: Mentor Mothers & Community Health Workers

The following two service standards pertain to activities that are carried out in partnership between facility-based Mentor Mothers and community-based CHWs (governed by the *Community Health Strategy*):

- Defaulter tracing
- Referrals and linkages

2.6.1 Defaulter Tracing

Description
Mentor Mothers trace and track priority PMTCT and MNCH clients who have dropped out of care at key points along the cascade and follow-up by telephone through SMS and calls. Clients that cannot be successfully traced through the telephone are referred onwards to the CHEW for home tracing in the community by CHWs.
Purpose
To reduce the number of PMTCT and MNCH clients (mothers or mother-baby pairs) who default from care at critical time points in the PMTCT and ANC cascade. Defaulter tracing also helps to identify key factors that lead to defaulting, for the purpose of program analysis and problem solving.
Frequency

Mentor Mothers scan their client logbooks and other M&E tools on a weekly basis to identify priority clients who have defaulted from care. The implementation of defaulter tracing (sending SMS messages, making phone calls and conducting home visits) can take place on a schedule appropriate for each facility (e.g. daily in the afternoons when service volume is low or weekly on a designated day allocated for defaulter tracing).
Duration
Outlined in Table 2.6.1 below.
Implementation Standards
• The protection of client confidentiality is the key priority for Mentor Mothers, CHEWs and CHWs when conducting defaulter tracing and must be upheld at all times • Mentor Mothers/CHEWS/CHWS do not use any language through SMS or phone calls relating to knowledge of a client's HIV status (e.g. "testing", "PMTCT", etc.) • CHEWs do not indicate any client's HIV status when referring the client to a CHW for a home visit • CHWs conduct home visits with a focus on general health, encouraging the client to return to the health facility

CHWS are required to receive an onsite PMTCT orientation in-service training based on the national PMTCT community orientation package for CHWs. CHWs must also receive training on confidentiality in order to conduct home visits of PMTCT clients. In cases where CHWs are not present or not yet capacitated in these areas, refer to section 2.9 below: **KMMP in Special Circumstances.**

Table 2.5.6: Protocol for Defaulter Tracing by Mentor Mothers & CHWs

STEP 1

Mentor Mothers obtain consent for defaulter tracing:
- At first visit or as soon as possible thereafter
- Document the nature of consent obtained (1)
- The client always has the right to decline or revoke her consent for defaulter tracing

STEP 2

Mentor Mothers record client contact information, including:
- Full name, including any nicknames used at home
- Phone number and alternate phone number
- Village/residence and physical landmark
- Contact information of treatment buddy, where applicable
- Best time of day / week to visit at home

STEP 3

Mentor Mothers identify defaulted clients:
On a weekly basis using longitudinal registers, diaries or EMR, clients who have missed targeted ANC and PNC visits are identified and prioritized for follow-up using the following priority scale

	Call	Physical contact
PMTCT priority clients (2)	Immediate	Within 3 days of call
AN re-testing (3)	3rd trimester	Within 1 week of call
PN 6 week visit (4)	7 weeks PN	Within 1 week of call

STEP 4

Mentor Mothers conduct telephonic defaulter tracing:
- Confirm consent for telephone follow-up
- Send a generic SMS encouraging the client to return to their health facility using neutral messaging in that protects confidentiality (e.g. " Kindly attend your missed ANC appointment at the BORA health facility by the end of this week")
- Begin phone calls on the following day if there has been no response or if the client has not returned to the facility, with the same encouraging message
- When the phone is answered, first confirm that the client in question is the one speaking before proceeding with the conversation, encouraging the client to return to the health facility

STEP 5

Trained CHWs conduct defaulter tracing home visits: (5)
- Mentor Mothers provide the names of unresolved defaulter tracing clients to the CHEW
- The CHEW provides the CHW with a facility generated defaulter list (mixture of MNCH and other clients)
- The CHW visits the household of the defaulted MNCH client, and provides generic message encouraging client to visit the MNCH unit within 2 days using the community referral form
- Resolution of the client's status is documented and the MNCH / MM team is informed

STEP 6

Resolution of the client record:
- Mentor Mothers document each case, noting whether the client attended, was not traced, declined further support, is deceased or has relocated
- Documenting reasons whey clients have defaulted is also a best practice, enabling the team to problem solve and improve service delivery to promote retention

NOTES on Table 2.5.6

(1) ***Clients can provide different forms of consent to Mentor Mothers, which are documented through*** the following codes:

- ***T:*** *Full consent for telephonic follow-up. The phone belongs to the client and full consent is provided for both phone calls and SMS.*
- ***CO:*** *Call only. Either the phone does not belong to the client, or the client cannot read, and consent is provided for calls only (no SMS).*
- ***NT:*** *No consent is provided for any form of telephonic follow-up.*
- ***H:*** *Full consent for home follow-up. The client consents to being visited at home by a CHW and/or MM in a way that protects her confidentiality.*
- ***NH:*** *No consent is provided for any form of home follow-up.*

(2) ***PMTCT priority clients*** *are defined as HIV-positive pregnant women and post-partum mothers who are in immediate need of PMTCT interventions (e.g. CD4 / PCR results available, non-attendance for PMTCT prophylaxis / HAART, etc.)*

(3) ***AN re-testing*** *refers to all HIV-negative pregnant women who have not returned for HIV re-testing during their 3rd trimester of pregnancy*

(4) ***PN 6 week*** *visit refers to all PMTCT clients who have not returned to the health facility with their baby at 6 weeks post-partum, as a proxy for immunizations, PCR testing, infant CTX, and PN care for the mother*

(5) *Where feasible and appropriate or necessary, Mentor Mothers may also conduct home visits for defaulter tracing*

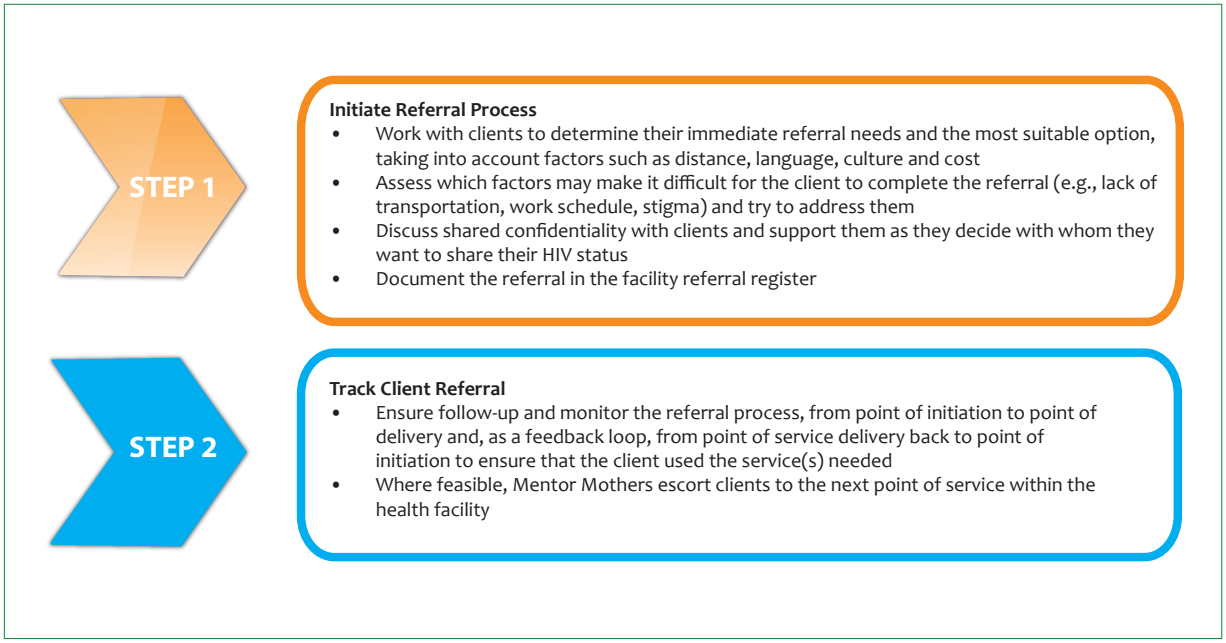
2.6.2. Referrals and Linkages

Description
Mentor Mothers and Community Health Workers refer and link PMTCT and MNCH clients to available health facility and community-based services according to client need and service availability.
Purpose
To assist clients, their caregivers and family members to obtain the highest quality of life through access to supportive services; to facilitate clients' active participation in decisions affecting their lives; to promote teamwork, partnership and continuity of care for each client.
Place
• Within the health facility (e.g. a Mentor Mother refers a post-partum client to family planning services) • Within the community (e.g. a CHW links a mother with an income-generating project) • From the facility to the community (e.g. a Mentor Mother links an HIV-positive client with a community-based support group) • From the community to the facility (e.g. a CHW refers a pregnant women to the facility for antennal services)
Frequency
Daily
Duration
N/A
Implementation Standards

Mentor Mothers, health facility staff, CHEWs and CHWs liaise with one another to access updated information on available care and support services, including other health facilities and organizations within the community. Support from implementing partners to conduct this type of mapping exercise is helpful.

For referral and linkage steps, see Table 2.6.2 below.

Table 2.6.2: Protocol for Referrals and Linkages



2.7. Standards for Community Health Worker Services

The role of the CHW is to provide broad-based support for primary health care promotion and prevention. Under the KMMP aligned with the *Community Health Strategy*, CHWs will conduct the range of MNCH and PMTCT activities within the community as outlined in Table 2.4 above.

In addition to this focus, the CHW will carry out similar activities on other focus areas as per their health promotion mandate - e.g. nutrition, hygiene, malaria, TB, etc. Where feasible, the KMMP activities in the community will use existing community groups such as women's groups to achieve its objectives, including messaging and support groups.

The standards for the community-level MNCH and PMTCT service delivery approaches are governed by the *National Community PMTCT Orientation Package* and the *Community Health Strategy*. These standards therefore are not repeated here.

2.8. Male Involvement in the KMMP

Male partner involvement in PMTCT is essential for successful mother and baby outcomes. Specifically, it is difficult for HIV-positive pregnant women and mothers to fully participate in PMTCT care when her partner does not know her or his own HIV status, is unwilling to provide financial resources for clinic visits and facility delivery or opposes exclusive feeding options due to prevalent socio-cultural beliefs.

Furthermore, men often control decisions about contraception and family planning and may disregard an HIV-positive woman's reproductive choices.

When a PMTCT client has a committed and supportive male partner, infants have a 40% greater chance of HIV-free survival, and mothers adhere better to ARV prophylaxis. Effective involvement of men in HIV care and prevention programs also has the potential of improving reproductive and family planning services, HIV prevention and treatment and gender equality initiatives, thereby reducing many of the social and health-related problems that go hand-in-hand with gender inequality.

2.8.1. Male Partner Involvement

Description
With the consent of the client, Mentor Mothers and CHWs welcome the participation of male partners in the delivery of KMMP services and activities.
Purpose
To raise awareness amongst male partners regarding PMTCT, HIV and MNCH basics and their role as partners; to promote disclosure of HIV status between sexual partners; to improve the uptake of and adherence to PMTCT and MNCH related services; to empower couples to live positively with HIV.
Place
Facility and community.
Frequency
Continuous (e.g. couples education and support services), and on designated days (e.g. couples support groups).
Duration
As per above service standards.
Implementation Standards
Facility-based sessions that include men follow the implementation standards outlined in the previous sections. Topics covered with male partners are aligned to the desired client outcomes of the KMMP (Table 2.3). In addition: • The role of the male partner in supporting his wife during the PMTCT journey (e.g. financial, emotional, logistical) • Encourage the male partner to be tested for HIV • Support couples to brainstorm / trouble-shoot challenges they might face together as they try to uptake and adhere to necessary services (e.g. exclusive infant feeding) Within the ***health facility***, other optional approaches are: a. Holding male clinics outside of the standard "8-5" clinic hours b. Encouraging men to attend the clinic through partner notification slips and partner invitation letters c. Targeting men in group health education at various service delivery points. • Within the ***community***, other optional approaches are: a. Using community events, such as football games, as a platform for PMTCT and HIV prevention awareness raising b. Gaining support from traditional leaders and village elders through community forums to change the attitude of men c. Promoting ***"Kata Shauri"*** messaging to change male behavior through communication material and methodologies.

2.9. KMMP in Special Circumstances

The Kenya Mentor Mother Program will operate smoothly within an established and functioning health system at the facility and in the community. However, it is recognized that due to weak links and gaps within the health system and in special circumstances, adopted KMMP approaches will be necessary to reach KMMP objectives and desired client outcomes. The KMMP will continuously be integrated into or strengthen existing systems where feasible to address gaps in the continuum of care.

Where there is no functioning Community Unit / CHEW / CHWs:

- The facility will designate a focal community–facility linkage person (e.g. community nurse, defaulter tracer, outreach worker, peer educator) to carry out the role of the CHW, with a focus on defaulter tracing for priority clients. Where necessary and feasible, Mentor Mothers may make home visits as part of defaulter tracing.

Where there is a Community Unit / CHEW / CHWs with limited capacity:

- As an initial step when formulating a Community Unit, facilities will provide training for CHWs on client confidentiality and on the *National Community PMTCT Orientation Package*, with support from implementing partners.

When clients are in transit or in emergency situations, including refugee camps:

- Mentor Mothers will strive to maximize their limited contact with clients in emergency situations by having at least one one-to-one session with each client as a minimum standard.
- Where Mentor Mothers are present in emergency situations, an expanded focus on MNCH issues for all clients is also appropriate.

For marginalized, nomadic or hard-to-reach populations:

- An adapted KMMP approach will be used, which will be aligned to existing health service delivery approaches. For example, Mentor Mothers can be integrated into mobile outreach clinics. Where a Mentor Mother may not be available, implementing partners in these regions will support the staff to deliver KMMP approaches at community or facility level.
- Where Mentor Mothers are present in health systems with marginalized, nomadic or hard-to-reach populations, the approaches outlined for emergency situations may also be appropriate

Section:

3 Terms of Service & Support Systems for Mentor Mothers

3.1. Introduction

Achieving the goal of eliminating new HIV infections among children and keeping their mothers alive will require stronger sustainable human resources for health at the facility and community levels. Through the KMMP, Kenya is strengthening human resources by harnessing the capacities of communities at both levels by:

1) Integrating women living with HIV into health facilities as **Mentor Mothers** – mothers living with HIV who are trained and employed as part of a medical team to support, educate and empower pregnant women and new mothers about their health and that of their baby

2) Engaging **Community Health Workers** to complement facility-based services with the provision of community-based support for MNCH more broadly.

This section also outlines the role of the **Mentor Mother Team Leader**. A group of facility-based Mentor Mothers is supervised and led by the Mentor Mother Team Leader. She herself is also a Mentor Mother and in addition to her work with clients, she supervises the group of Mentor Mothers at the health facility to ensure that this additional management responsibility does not overburden the facility-in-charge. The Mentor Mother Team Leader liaises closely with the facility in-charge to ensure the delivery of coordinated, quality services through a teamwork approach.

*A "**community health worker**" is defined as a health worker chosen by the community who performs a set of essential health services, receives standardized training outside the formal nursing or medical curricula and has a defined role within the community and the larger health system.*

Terms of Service refers to the employment approach used to engage Mentor Mothers, such as selection criteria, the recruitment process, the terms of employment and remuneration.

Support Systems refers to the approaches that can be put in place to support Mentor Mothers and promote quality service delivery, such as training, supervision and management, employee wellness and implementation of an exit strategy for Mentor Mothers.

For each of these components, this section outlines:

- **Guiding principles that inform the development and application of standards**
- **KMMP standards as the minimum benchmark for quality**
- **Additional implementation notes and best practices**

3.2 Standards for Terms of Service and Support Systems

Guiding Principles	KMMP Standards	Implementation Notes & Best Practices
3.2.1 Mentor Mother Selection Criteria		
° *Women living with HIV must be the center of the response* ° *Mothers are a community's greatest resource* ° *Peer mentorship motivates behavior change and combats stigma*	Mentor Mother • HIV-positive mother • Recent PMTCT experience (6 months - 2 years) • Minimum of Standard 8 education • Has disclosed HIV status to at least one person within her household • Lives within the local community Mentor Mother Team Leader Same as above, plus: • Minimum of Form IV education • A certificate in counseling or other related fields is an added advantage	• The HIV status of a mother's baby is not used as a selection criteria to become a Mentor Mother • The eligibility period for Mentor Mothers begins at 6 months post-partum, in support of exclusive infant feeding for HIV-exposed infants • Mentor Mothers are required to have disclosed their status to at least one person within the household and must be willing to continue disclosing their status to KMMP clients • Recruiting for Mentor Mother Team Leaders with a Form IV level of education is not always possible and where applicable a lower level applicant can be considered. Ultimately, the Team Leader must be literate, numerate and capable of leading a group of Mentor Mothers • Membership in an existing support or social group is an added advantage.
3.2.2 Mentor Mother Recruitment Process		
° *Fair and transparent recruitment processes based on merit help to promote program integrity, ensure the widest range of applicants and promote equal opportunity for all* ° *The MOH is the custodian of the KMMP and is therefore actively involved at all levels of implementation*	• An open advertisement is posted in the facility and appropriate surrounding areas, including local administration areas, for 2 weeks • Short-listing of applicants is conducted by the facility with local implementing partner (LIP) oversight • Interviews are conducted by an interview panel comprised of key facility staff and local implementing partner (LIP) staff.	• Where they already exist, Mentor Mother Team Leaders are also included in the interview panel for new Mentor Mothers • To promote a fair and transparent recruitment process, interviews for Mentor Mothers and Mentor Mother Team Leaders follow a structured guide, and the selection panel uses the competencies of the job profile to guide their selection decisions • All appointments for the Mentor Mother position are only done after participating in a structured interview

Guiding Principles	KMMP Standards	Implementation Notes & Best Practices
3.2.3 Terms of Mentor Mother Employment		
° *Mentor Mother services are aligned with facility working hours to ensure a continuous facility presence and to promote continuity of care* ° *Mentor Mothers are integrated into health facilities as members of the professional team* ° *The experience of being a "peer" related to one's PMTCT journey changes with time; the duration of this reference point is therefore limited* ° *The KMMP seeks to empower as many women as possible from local communities as Mentor Mothers*	• A Mentor Mother is contracted for 2 years, and the contract is renewable thereafter, based on performance • The number of Mentor Mothers per facility is determined largely by the facility workload and the ability of LIPS and Hospital Management Team (HMT) to support the Mentor Mothers (see Annex D) • In low volume facilities, one Mentor Mother may be recruited and clustered with the appropriate referral facility to ensure oversight and support from a Mentor Mother Team Leader • Mentor Mothers work full-time (40-hour work week, aligned with facility hours) • The terms of Mentor Mother employment are governed by Kenya labor law, including an entitlement to leave	• In certain types of facilities, it may also be appropriate for Mentor Mothers to work on weekends to provide support to maternity clients • Having a written contractual agreement in place with each Mentor Mother is a best practice • Employment of Mentor Mothers should always be linked to supporting their eventual transition out of the role (see Exit Strategy below)

Guiding Principles	KMMP Standards	Implementation Notes & Best Practices
3.2.4 Mentor Mother Remuneration		
° *The meaningful involvement of people living with HIV/AIDS (MIPA) includes fair compensation for a valuable contribution to health service delivery* ° *Program sustainability and cost-effectiveness are essential principles to promote national scale-up of the KMMP* ° *The KMMP values the empowerment of women through various means, including financial*	Mentor Mothers are remunerated as per the general category of Kenya's most recent minimum wage legislation • Annual increments are provided as per Kenya labor law • Mentor Mothers adhere to the Code of Practice at all times (see Annex D)	• Mentor Mother remuneration is differentiated from CHW compensation due to the full-time nature of the role and the increased level of complexity and responsibility • In the short to medium term, Mentor Mothers will be employed by LIPs and HMTs • In the long-term, it is proposed that the Mentor Mother role be drawn into the Kenyan Public Service Commission scheme of service for consideration into the MOH cadre
3.2.5 Mentor Mother Training		
° *Initial and ongoing training are essential to program quality* ° *PMTCT, HIV and MNCH are constantly evolving fields, and the need for continuous knowledge updates must be anticipated* ° *Mentor Mother service delivery is competency-based and includes the provision of psychosocial support for complex emotional issues* ° *The KMMP values the empowerment of women through various means, including knowledge acquisition*	• Mentor Mothers undergo a standardized pre-service training based on the MOH approved curriculum for Mentor Mothers • The duration of this training is 2 weeks for Mentor Mothers and an additional days for Mentor Mother Team Leaders • Pre-service training includes provision of a serialized certificate • Mentor Mothers receive additional modular in-service training throughout their tenure; at a minimum, this training is provided annually	• Mentor Mother pre-service training can also include shadowing / mentorship in existing KMMP model sites • Best practices related to pre-service training include facility staff involvement in training, facility induction, completion of an orientation checklist and provision of ongoing on-the-job training once deployed

Guiding Principles Practices	KMMP Standards	Implementation Notes & Best
3.2.6 Mentor Mother Supervision & Management		
° *The KMMP seeks to task shift a set of non-technical responsibilities from over-burdened clinical staff to a new cadre. The line management responsibilities related to this cadre must be also considered to avoid the added burden of supervision* ° *Performance development management is an essential ingredient to promote program quality* ° *Mentor Mothers are integrated into health facilities as valuable members of the MNCH team*	• Where more than one Mentor Mother is required at a facility, the Mentor Mothers are supervised by a Mentor Mother Team Leader • The team leader reports directly to the appropriate facility focal person • Mentor Mother Team Leaders receive routine performance appraisals from their LIP employer and the designated facility focal person • Mentor Mothers receive routine performance appraisals from their Mentor Mother Team Leader • Mentor Mothers hold weekly team meetings at the health facility with the appropriate facility staff	• Monthly meetings of Mentor Mother Team Leaders are encouraged to promote team-building and continuous quality improvement across health facilities in a geographic area • Work scheduling is as good management practice, improves clinic operations and has an impact on service uptake by ensuring access to and availability of care on demand

3.2.7 Mentor Mother Employee Wellness		
° *HIV continues to be highly stigmatized, and many Mentor Mothers have traveled their own difficult journeys as PLHIV* ° *Self-awareness and self-acceptance are essential pre-requisites for mentoring* ° *The ability to set interpersonal boundaries is essential to prevent burnout in any peer educator role* ° *A holistic, all-encompassing approach to employee wellness, including counseling supervision and employee assisted programs is required*	• Content on self-awareness and inter-personal boundaries are essential components of pre- and in-service training for Mentor Mothers • All Mentor Mothers are provided with clear job descriptions outlining the boundaries of their role (see Annex A); facility staff are also sensitized to the boundaries of the role • All Mentor Mothers continue to have access to treatment, care and support as PLHIV	• Monthly meetings for Mentor Mothers (mentioned above) can also act as a vehicle for the provision of wellness support • Where resources are available, additional wellness support is encouraged for Mentor Mothers, including counseling sessions, group or individual debriefing and skill building, and employee recognition (e.g. rewards, verbal appreciation)
3.2.8 Mentor Mother Exit Strategy		
° *The KMMP supports the empowerment of women through various means, including providing employment opportunities to as many women as possible, and supporting Mentor Mothers to grow beyond their roles* ° *The contribution of Mentor Mothers is a valuable component of health service delivery, which should be acknowledged and recognized*	• Mentor Mothers are equipped with financial and entrepreneurial skills through in-service training • Linkages to other support organizations are part of continuous support • At the end of the contract period, graduation/pass out ceremonies are held to recognize the contribution of the Mentor Mother to the program, including bestowing certificates	• Mentor Mothers can be encouraged to participate in social groups that focus on generation of financial income • Where possible, the program should provide an environment that allows for transition back into a career, education path or social transformation

Section:

4 Monitoring And Evaluation

4.1 Introduction

The KMMP monitoring and evaluation (M&E) framework aims to track the program's contribution to achieving Kenya's eMTCT goal, which is:

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

Specifically, the objectives of the KMMP M&E framework are to:

- Monitor the progress and measure the contribution of the KMMP as part of the national PMTCT program;
- Guide KMMP implementing partners on M&E processes, tools and indicators to effectively measure the contributions of their activities;
- Promote data driven decision-making and accountability, and the collection of lessons learnt for dissemination and collective analysis.

Monitoring and evaluation of the KMMP is integrated within Kenya's national eMTCT M&E framework as well as the Global Plan's M&E approach, which share a common set of priority indicators:

- Prevention of new pediatric HIV infections
- HIV-free child survival
- Maternal health and survival

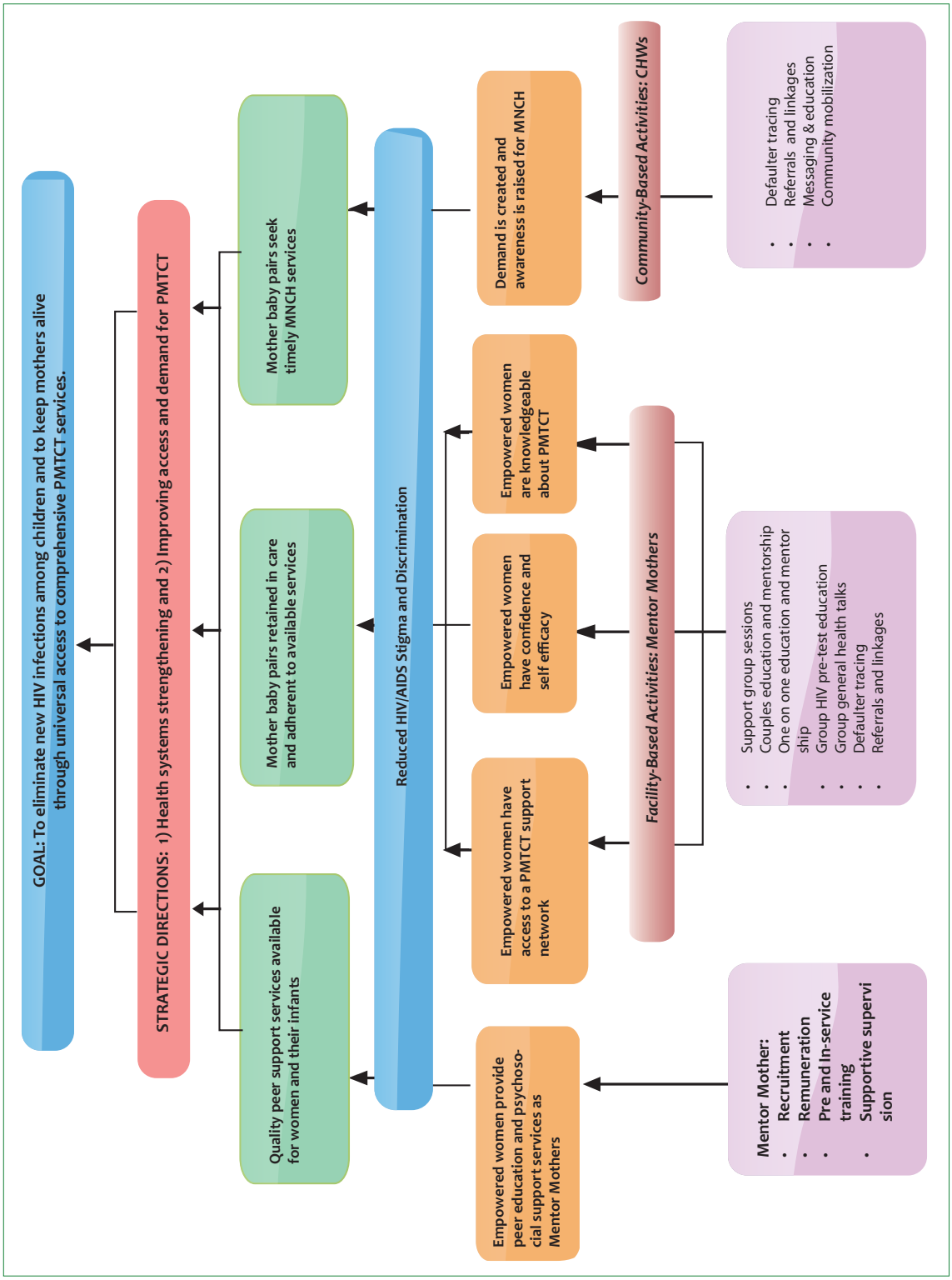
In addition to these existing outcomes of interest, the KMMP's contribution will be measured through a limited set of additional priority indicators related to the unique contribution of Mentor Mothers and Community Health Workers in areas such as disclosure and client retention, as known pathways for service uptake and adherence. Routine monitoring data, based on PMTCT output level indicators captured at the facility level, will feed into the existing national reporting system via the District Health Information System (DHIS) for country level reporting and utilization by relevant stakeholders.

4.2 KMMP Results Framework

The KMMP Results Framework maps the key activities, processes and outcomes that will be used to track the contributions of KMMP service delivery towards the overall goal of eMTCT, aligned to the strategic directions of the national eMTCT Framework.

Facility-based Mentor Mothers are empowered and positioned to provide quality peer education and psychosocial support services at health facilities, through recruitment, training, employment and supportive supervision. The services that Mentor Mothers provide empower mother-baby pairs to stay retained in care and adherent to available services through increased knowledge, confidence, self-efficacy and access to a support network. Mothers also seek timely access to MNCH services through the support of Community Health Workers. The joint contribution of these approaches reduces stigma and discrimination for clients, for health care workers, and within the community at large.

Table 4.2 KMMP Results Framework



4.3 KMMP Indicators

Successful implementation of the KMMP will require continuous short-term monitoring alongside a medium-term evaluation strategy to provide evidence for analysis and continuous program improvement. KMMP indicators are aligned with the national eMTCT Framework and Global Plan indicators where appropriate. Below is a snapshot of the priority indicators for KMMP measurement, with targets set for achievement by the year 2015. Some indicators will be tracked quarterly, while others lend themselves to annual analysis through evaluation methodology.

Table 4.3 KMMP Indicators

Area to Monitor	Performance Indicator	Definition	Baseline	2015 Targets	Reporting Frequency	Data Source
Coverage	Number of KMMP sites in the country	Number of sites implementing KMMP services according to national guidelines	-	-	Quarterly	KMMP reporting tool
	Percentage of KMMP sites in the country	**Numerator**: Number of KMMP sites **Denominator:** Number of PMTCT sites	0	50%	Annual	KMMP reporting tool
	Number of HIV-positive women enrolled in KMMP services	Number of HIV-positive women enrolled in sites implementing KMMP services according to national guidelines	-	-	Quarterly	KMMP reporting tool/ KMMP monthly summary sheet
	Percentage of HIV-positive pregnant women enrolled in KMMP services	**Numerator**: Number of HIV-positive pregnant women enrolled in KMMP services **Denominator**: Number of HIV positive pregnant women (national, county, facility)	0	50%[1]	Annual	KMMP reporting tool
	Number of HIV-negative women enrolled in KMMP services	Number of HIV-negative women enrolled in sites implementing KMMP according to national guidelines	-	-	Quarterly	KMMP reporting tool/ KMMP monthly summary sheet

1 National target
2 National Road Map to Maternal and Child Heath in Kenya , August 2010
3 KMMP clients
4 EMTCT Framework for Kenya, 2012-2015
5 KDHS 2008/09

Quality	Number of Mentor Mothers who received pre-service training	Number of Mentor Mothers who undergo pre-service training using the national KMMP curriculum	-	-	Quarterly	KMMP monthly summary sheet
	Number of KMMP support group sessions	Number of KMMP support groups sessions	-	-	Quarterly	KMMP monthly summary sheet
	Percentage of KMMP sites implementing a defaulter tracing mechanism	**Numerator:** Number of KMMP sites implementing a defaulter tracing mechanism according to national guidelines **Denominator:** Number of KMMP sites	0	80%	Quarterly	KMMP reporting tool
	Percentage of PMTCT clients who have disclosed their HIV status to their sexual partner	**Numerator:** Number of PMTCT clients who have disclosed their HIV status to their sexual partner **Denominator:** Number of PMTCT clients	-	50%	Quarterly	KMMP HIV-positive Logbook
	Percentage of HIV-positive pregnant women delivering at a health facility	**Numerator:** Number of HIV-positive pregnant women delivering in a health facility **Denominator:** Number of HIV-positive pregnant women	44%[2]	90%	Quarterly	KMMP HIV-positive Logbook
Client Outcomes[3]	Percentage of HIV-positive women who finished four antenatal visits[4]	**Numerator:** Number of HIV-positive pregnant women who finished four antenatal clinics **Denominator:** Number of HIV-positive pregnant women	47%[5]	80%	Quarterly	KMMP HIV-positive Logbook
	Percentage of HIV-exposed infants exclusively breastfed for the first 6 months	**Numerator:** Number of infants born to HIV-positive women who were exclusively breastfed for the first 6 months **Denominator:** Total HEI aged 6 months and above	32%[5]	80%	Quarterly	KMMP HIV-positive Logbook
	Percentage of HIV-exposed infants who receive a PCR test at 6 -8 weeks	**Numerator:** Number of HIV-exposed infants who receive a PCR test at 6 – 8 weeks **Denominator:** Total number of HIV-exposed infants who are > 6 weeks	-	80%	Quarterly	KMMP HIV-positive Logbook

4.4 KMMP Data Collection and Reporting

Data collection for KMMP indicators will be achieved through use of data collection tools maintained at the facility level and completed on a daily basis by Mentor Mothers. Mentor Mothers capture information on their interactions with pregnant women and new mothers (program outputs) and information on actions or services taken up by clients (program outcomes). The Mentor Mother Team Leader reports on KMMP activities on a monthly basis to the facility in-charge by using a standardized Monthly Summary Sheet. Team Leaders are also able to abstract data from facility-level tools for routine analysis, communication and continuous quality improvement.

4.5 Data Quality

The following mechanisms will help to support data quality assurance for the KMMP:

- Use of standardised data collection tools
- Implementation of standardized pre-service M&E training for all Mentor Mothers
- Provision of a standardized M&E reference guide for use at the site level by all Mentor Mothers
- Routine site supervision visits
- Periodic data quality audits using a standardized template
- Use of a standardized continuous quality improvement process - Let's SOAR ('Strengthening Outcomes by Analysing Results')

Let's SOAR is implemented on a routine basis as a KMMP standard for continuous quality improvement. The process draws on facility level data and empowers Mentor Mothers to work in partnership with health facility staff to utilize data for decision making on a routine basis.

4.6 Evaluation

Evaluation of the KMMP will measure the contribution of the KMMP to the Kenyan PMTCT program, and will explore questions that require more complex methods than routine monitoring over longer periods of time.

KMMP evaluation will serve to:

- Inform decisions on operations, policy, or strategy related to ongoing or future program interventions;
- Demonstrate accountability to decision-makers (donors and other stakeholders);
- Identify and document best practices and lessons learned.

Section:

5 Implementation of the KMMP – Roles and Responsibilities

5.1. Introduction

Implementation of the KMMP is coordinated by the Ministry of Health and will be rolled out in a phased approach by local implementing partners (LIPs). LIPs will receive targeted capacity-building support from **mother2mothers to** develop KMMP activities or improve their existing programs, aligned to the standards outlined herein. The roles and responsibilities of the various partners are defined below.

5.2 Ministry of Health (MOH)

Through the National AIDS and STI Control Program (NASCOP), the Ministry of Health (MOH) coordinates the implementation of technical HIV programs in Kenya, including the KMMP. All PMTCT activities are coordinated jointly with the Division of Reproductive Health (DRH).

At the national level, NASCOP and DRH have jointly convened a sub-committee of the PMTCT Technical Working Group (TWG) to focus on KMMP development and implementation. The KMMP sub-committee is comprised of diverse stakeholders to support the MOH in developing the KMMP guidelines and supporting continuous guideline review and revision.

Through NASCOP and the DRH, the MOH holds the over-arching responsibility for the following key areas pertaining to the KMMP at the national level:

- Development and ongoing revision of a national curriculum package for Mentor Mothers (pre-service and in-service content)
- Sensitization of implementing partners and MOH teams at the sub-national level to KMMP planning and expectations
- Routine monitoring of KMMP performance against select indicators and periodic evaluation to review program progress
- Provision of continuous supportive supervision and quality oversight

At the regional level, health management teams and the AIDS control committees will carry out various activities, including:

- Interpret and disseminate the KMMP
- Coordinate and oversee KMMP service delivery performance as an integrated program activity
- Monitor and evaluate KMMP service delivery
- Facilitate reporting from the regional level to the national level
- Coordinate KMMP activities at the community level with community health extension workers

The KMMP will be integrated as part of the agenda for regional quarterly health sector reform meetings at the county level for multi-sector stakeholders, providing a forum for discussion on emerging issues in KMMP implementation.

5.3 Local Implementing Partner (LIPs)

Local Implementing Partners (LIPs) are local non-governmental organizations (NGOs), faith-based organizations (FBOs), community-based organizations (CBOs), private sector organizations. and MOH structures that have previously implemented peer education and psychosocial support services in PMTCT or that have decided to undertake the delivery of services of this nature. With planning and the provision of capacity-building support, LIPs are expected to evolve and align their programming approaches with KMMP standards.

AT the regional level, LIPs will actively participate in MOH-led stakeholder forums pertaining to PMTCT to promote teamwork and joint planning regarding KMMP implementation.

At the health facility and community levels, LIPs will implement KMMP activities within their respective geographic areas through:

- Provision of quality KMMP services to clients within health facilities and communities, according to minimum service standards
- Employment of Mentor Mothers, according to the minimum standards for terms of service and support systems
- Support for site-level KMMP logistics and commodities
- Monitoring of KMMP service delivery and progress against indicators, in partnership with MOH counterparts
- Timely and accurate reporting at the county level
- Participation in relevant stakeholders' forums

5.4 Development Partners

National development partners are represented in the KMMP sub-committee as outlined above. They provide technical input and support aligned to their area of expertise and act as strategic partners to ensure the long-term integration, viability and sustainability of the KMMP as a nationally-owned program component.

Section:

6 Annexes

Annex A: Mentor Mother Job Profile

Reports to: Mentor Mother Team Leader

Purpose

To provide peer education and psychosocial support to pregnant women, mothers and their families; to prevent HIV transmission to babies; to promote maternal and infant health and to empower women to live positively with HIV. A Mentor Mother provides these services by drawing on her personal experience as an HIV-positive woman, her training and guidance from her supervisors and the health care team.

Requirements

- HIV-positive mother
- Recent PMTCT experience (6 months - 2 years)
- Minimum of Standard 8 education
- Has disclosed HIV status to at least one person within her household
- Lives within the local community

Key Responsibility Areas

- Conduct group health talks related to PMTCT and MNCH in facility waiting areas
- Facilitate group pre-test HIV education for pregnant women
- Provide one-on-one peer education and psychosocial support to PMTCT clients and couples
- Co-facilitate support groups for PMTCT clients and couples
- Conduct defaulter tracing of priority PMTCT clients
- Refer PMTCT, MCH and CCC clients to other services within the health facility and to community-based services
- Encourage partner involvement in MCH services, education and psychoso cial support

Key Outcomes

- Client behavior change through the provision of education, psychosocial support and positive role modeling
- Reduced loss to follow-up and improved client retention and adherence
- Peer education and psychosocial support integrated as a core component of PMTCT and MNCH service delivery
- Reduced stigma and discrimination and improved client disclosure
- Improved participation of male partners

Annex B: Mentor Mother Team Leader Job Profile

Reports to: Facility in charge/ MNCH in charge/ PMTCT coordinator (as appropriate)

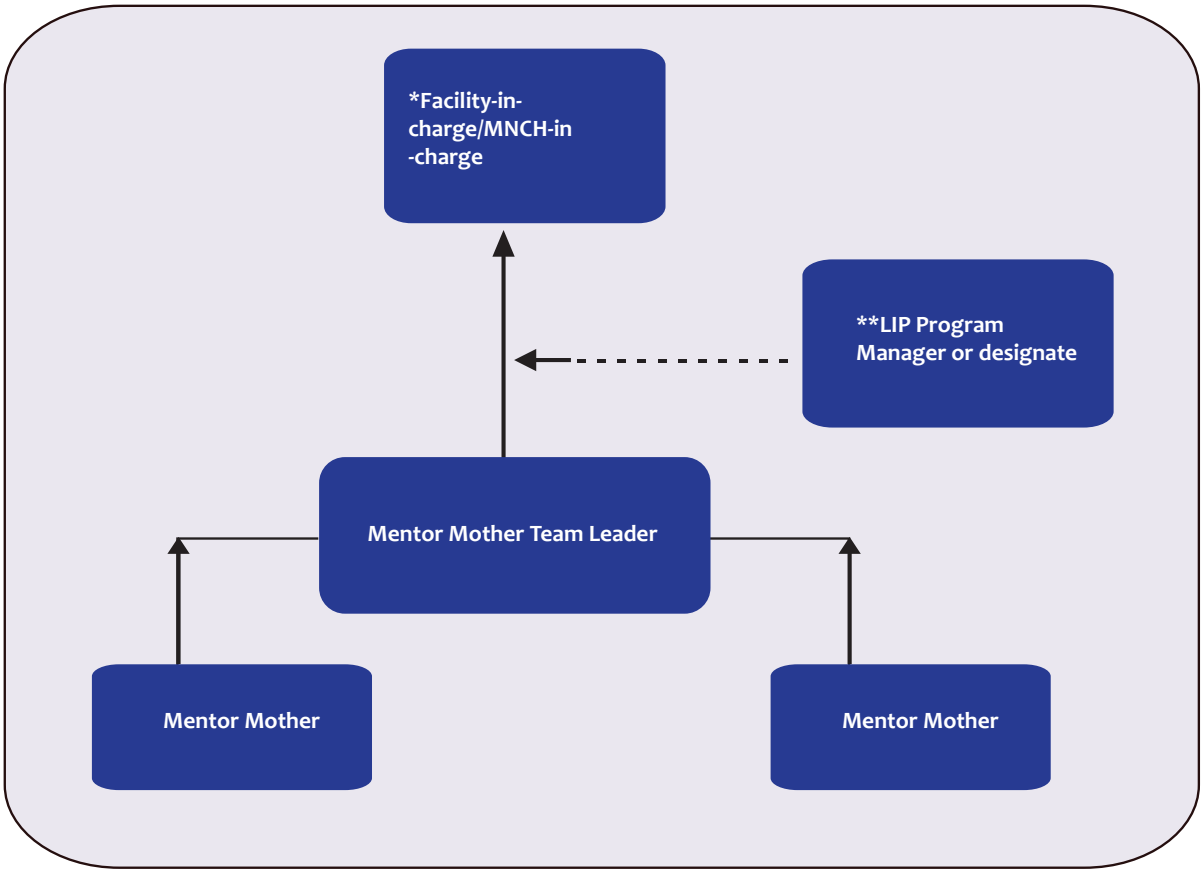
Purpose
In addition to the Mentor Mother job profile, to promote KMMP integration and quality service delivery in partnership with the facility-in charge.

Requirements
Same as a Mentor Mother, plus:
- Minimum of Form IV education
- A certificate in counseling or other related fields is an added advantage

Key Responsibility Areas
Same as Mentor Mother, plus:
- Work closely with the in-charge to integrate KMMP services at facility level into existing facility processes and services
- Coordinate Mentor Mother activities at the facility level through mapping, work scheduling and allocation to facility entry-points
- Provide supervisory support to individual Mentor Mothers, identify ongo ing learning needs and promote action planning for continuous quality improvement
- Oversee the collection of data and all administrative responsibilities (e.g. food ordering, storage of confidential client information)
- Update the facility-in -charge on a regular basis on overall KMMP service delivery

Key Outcomes
Same as a Mentor Mother, plus:
- Integrated service delivery, effective use of human resources, teamwork and communication between Mentor Mothers and with health facility staff
- Reduced gaps in client flow through analysis and MM positioning
- Improved referral processes and linkages
- Provision of quality KMMP service delivery, with oversight of service com ponents
- Facility-based Mentor Mother services linked effectively to community-based CHW services through the CHEW and other approaches
- Quality documentation of services delivered and use of data to guide decision making and continuous improvement

Annex C: KMMP Reporting Structure



*The team leader reports to the facility-in-charge or the MNCH in-charge as applicable at the specific health facility.

**The local implementing partner provides supportive supervision in the roll out and delivery of KMMP activities.

Annex D: Code Of Practice for Mentor Mothers

The Code of Practice defines the set of rules that guide how Mentor Mothers (and Mentor Mother Team Leaders) behave in the workplace. Its purpose is to regulate acceptable standards of behavior, and it includes a code of conduct, a code of ethics and a section on personal responsibility.

All new Mentor Mothers and Team Leaders are introduced to the Code of Practice by their line manager as an integral part of their induction at the health facility.

1. Code of Conduct

The conduct of Mentor Mothers is governed by the following values, to which all Mentor Mothers commit:

- **Respect:**

  Mentor Mothers demonstrate respect to clients and fellow colleagues at all times, including hospital staff, personnel, fellow Mentor Mothers and Community Health Workers.

  They respect diversity and promote the equality of all people without any discrimination, irrespective of sex, race, age, tribe, language, religion, ability, sexual orientation or other status.

  Mentor Mothers also support community values that encourage respect for others and willingness to work together to find solutions, in the spirit of compassion and mutual support.

- **Team Work:**

  Mentor Mothers recognize that while staff members hold different roles in the facility, they are all working towards the same goals of supporting pregnant women and new mothers living with HIV and will work together as a team towards this end.

- **Conflict Management:**

  Mentor Mothers address all conflicts among colleagues in a manner that is open, respectful, professional and consistent with the objectives of the KMMP.

- **Honesty:**

  Mentor Mothers practice honesty within the team and when using the facility's supplies and equipment.

- **Reliability:**

  Mentor Mothers honor working hours and are reliable and punctual in their presence at the health facility.

- **Dress code:**

  Mentor Mother dress in a smart casual manner to inspire confidence and respect cultural diversity, in compliance with the KMMP dress code as advised by the Ministry of Health.

2. Code of Ethics

The practice of Mentor Mothers is governed by the following principles, to which all Mentor Mothers commit.

2.1. General approach-

- All clients are treated in a professional manner.
- All Mentor Mothers are cognizant of their personal and professional limitations and ask for help when needed.
- All Mentor Mothers have a primary responsibility to devote their professional and personal knowledge and skills to uplift and benefit each individual, group and community.

2.2. Ethical approaches for the client

- Mentor Mothers uphold and respect each client's right to confidentiality by
  - » Never revealing a client's HIV status directly or indirectly thorough hints or insinuation to other parties including family members, even when pressured to do so.
  - » Never revealing a client's HIV status directly or indirectly through carelessness, such as during defaulter tracing over the phone or through home visits.
  - » Ensuring restricted access to client records.
- Mentor Mothers provide the highest quality of service to each client without bias or preference.

2.3. Ethical approaches for group services

- Generate and respect group ground rules.
- Encourage and foster group unity, team work and respect for diversity and differences.
- Demonstrate and encourage good listening skills and participation from members.
- Respect the right of individuals to choose not to disclose or share their personal experiences until they are ready to do so.
- Educate on and uphold a member's right to confidentiality.

3. Personal Responsibility

- While the organization will be embrace the GIPA principle and comply with the Kenyan National Code of Practice on HIV/AIDS at the Workplace each Mentor Mother ensures that she herself has access to HIV treatment, care and support.
- Each Mentor Mother is responsible for understanding the boundaries of her role and to seek guidance and assistance for areas beyond her capacity.

Annex E: KMMP Roll-Out & Staffing Guidance

The KMMP will be rolled out in a phased cascade approach based primarily on the prevalence of HIV. Ideally each LIP will saturate its respective geographic region(s) with comprehensive KMMP activities at the facility and in the community. However, in the face of constrained financial resources, LIPs are encouraged to initiate Mentor Mother support at high volume PMTCT facilities and move downwards to low volume facilities , according to budget, population in need, the presence of other partners and other factors. Guidance on staffing ratios for Community Health Workers at the community level is provided in the *Community Health Strategy*, and is therefore not repeated here. Guidance on staffing ratios for Mentor Mothers within health facilities is provided here and can be tailored by each LIP to the unique context of each location.

The table below is a summary guide to staffing levels for Mentor Mothers based on new PMTCT client enrollment. New PMTCT client enrollment is used as a proxy to estimate workload, acknowledging that Mentor Mothers also deliver services to HIV-negative mothers, CCC clients and other secondary clients.

Table E: Guide for Mentor Mother Staffing Levels

# New PMTCT Clients Enrolled per Month	Estimated # of MM Required
>40	5
30-39	4
20-29	3
10-19	2
<10	1

**Inclusive of the Mentor Mother Team Leader, at sites with more than 1 Mentor Mother*

The correct staffing level for each facility is influenced by many factors, however, and LIPs are encouraged to analyze the unique context when deciding on how many Mentor Mothers to employ. Examples of these factors include:

- Newly enrolled PMTCT clients usually require a longer interaction time with a Mentor Mother than previously enrolled (re-visit) clients
- Mentor Mothers provide services at all potential entry points for women of reproductive age and infants, including the CCC, CWC, FP and labor and delivery wards. Therefore, available services and activity levels at all services points will determine the Mentor Mother staffing pattern in a given facility.
- Mentor Mothers will have at least 1 one-on-one session with each HIV-negative ANC client as a standard of care. Therefore ANC service levels can also be used to guide staffing.
- At the start of service delivery, LIPs will face a backlog of clients in need. This will include both antenatal and post-natal PMTCT clients who require support. This backlog leads to very high client volume at the onset of service delivery, which then tapers off as services become routine. Staffing of Mentor Mothers should be based on the projected tapering off of demand, rather than on the volume of the initial backlog.

As services are cascaded out to increasingly low volume facilities (e.g. small health centers and most dispensaries), often only 1 Mentor Mother is required to cover the workload. LIPs are encouraged to consider the following when staffing at this low volume level:

- of services that can include a stronger focus on HIV-negative clients and MNCH and/or an expanded role for home visits and community activities to fully maximize the contributions of the Mentor Mother at this level.
- If possible, low volume health facilities can be clustered with corresponding referral facilities to provide a network of care and support from a nearby Mentor Mother Team Leader.

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Ministry of Health

USAID
FROM THE AMERICAN PEOPLE

mothers2mothers

unicef

National AIDS and STD Control Program (NASCOP)
Ministry of Public Health and Sanitation, Kenya
PO Box 19361-00202 Nairobi, Kenya
Tel: +254.20.272.9549 or 272.9502
Email: head@nascop.or.ke