Texas Children's Global Health Network

26TH NETWORK MEETING

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Wednesday, 5 November 2025

Session 1

Please Scan the QR code to view the online **Program Guide**.

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Fundația Baylor Marea Neagră

Energizer Time: Let’s Recharge! ⚡

Leader

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JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Workshop: Navigating Difficult Conversations and Enhancing Clinical Care Through Effective Communication Skills

Ms. Stefania Mihale,

Ms. Mihaela Bogdan,

Ms. Sewelo Sosome,

Dr. Elizabeth Rodriguez,

Dr. Khanh Linh Nguyen

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JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Navigating Difficult Conversations & Enhancing Clinical Care Through Effective Communication Skills

Ms. Stefania Mihale, Ms Mihaela Bogdan, Ms. Sewelo Sosome, Dr. Elizabeth Rodriguez, Dr. Khanh Linh Nguyen

“A golden key opens any gate even the one of heaven.”

Romanian Proverb

Objectives

- Bring into spotlight the health care communication
- Raise awareness on the impact of effective communication on clinical outcomes and patient satisfaction
- Identify good practices
- Learn about instruments that can be used to improve doctor – patient communication

Communication

- Verbal speech + non-verbal communication used in order to get a point across
    - Bidirectional
- Fundamental clinical tool

Effective Communication in Health Care Settings

The utmost importance when delivering health care:

- Influences the costs
- Is influenced by
  - Healthcare literacy
    - Health literacy
    - Numerical literacy
  - Cultural competency
  - Language barriers

Effective Communication in Health Care Settings

Research clear links the quality of communication and:

- Patient satisfaction
  - Involved, heard
- Retention in care
- Prevention of errors (incorrect dosages, delayed uptake in care)
- Facilitates better adherence
  - Increases understanding and acceptance of diagnosis/ importance and effect of treatment
- Building strong, trusting relationships with medical staff (doctors, nurses, etc)

NAVIGATING DIFFICULT CONVERSATIONS

1. Identify common types and triggers of difficult conversations in clinical settings (e.g., delivering bad news, handling patient dissatisfaction, addressing non-adherence).

2. Demonstrate effective communication techniques—such as active listening, empathy, and non-verbal cues—to build trust and rapport with patients and families.

3. Apply structured communication frameworks (e.g., SPIKES, LEAPS, CAT or motivational interviewing) to manage emotionally charged or sensitive interactions.

4. Recognize and manage personal emotions and biases that can affect communication and clinical decision-making during challenging encounters.

5. Develop patient-centered strategies to resolve conflict, improve shared decision-making, and enhance the overall quality of care and patient satisfaction.

Group Work

1. Get into groups of 10.
2. Ensure there is a good mix of different countries.
3. Ensure there is at least 1 Doctor and/or nurse per group.

Reflection

Can you remember a scenario you had to have a difficult conversation?

HIV Disclosure – Good or Bad?

GROUP DISCUSSION

Communication Assessment Tool – 10 minutes

1	2	3	4	5
poor	fair	good	very good	excellent

Please use this scale to rate the way the doctor communicated with you.
Circle your answer for each item below.

The doctor	poor				excellent
1. Greeted me in a way that made me feel comfortable	1	2	3	4	5
2. Treated me with respect	1	2	3	4	5
3. Showed interest in my ideas about my health	1	2	3	4	5

Key Errors Illustrated

1. No introductions
2. Multiple questions at once
3. No sign posting
4. **Rushed** consultation – no active listening
5. Not acknowledging the clients feelings/ emotions – lack of empathy
6. **Coercing** testing- no discussion/ explanation
7. **No follow up set**

HIV Disclosure – Good or Bad?

GROUP DISUCSSION

Communication Assessment Tool - 10 minutes

1	2	3	4	5
poor	fair	good	very good	excellent

Please use this scale to rate the way the doctor communicated with you.
Circle your answer for each item below.

5.	Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6.	Let me talk without interruptions	1	2	3	4	5
7.	Gave me as much information as I wanted	1	2	3	4	5

Key Strengths Illustrated

1. **Greetings** and **introductions**- roles clarified
2. **Background set** – recap on previous information and the purpose of the meeting
3. **Safe Space-** ensured privacy, confidentiality
4. **Assessed** information known- dialogue
5. **Supportive and encouraging -** calm, not rushed.
6. Information given in **small chunks-** checked understanding
7. **Explored feelings** of both clients – empathetic
8. **Next steps discussed-** information offered, anticipatory guidance

Cancer Diagnosis Disclosure – Good or Bad?

GROUP DISCUSSION

Communication Assessment Tool – 10 minutes

1	2	3	4	5
poor	fair	good	very good	excellent

Please use this scale to rate the way the doctor communicated with you.
Circle your answer for each item below.

8.	Talked in terms I could understand	1	2	3	4	5
9.	Checked to be sure I understood everything	1	2	3	4	5
10.	Encouraged me to ask questions	1	2	3	4	5
11.	Involved me in decisions as much as I wanted	1	2	3	4	5

Key Strengths Illustrated

1. **Safe setting** – calm, private, supportive.
2. **Checks perception** – respects caregiver's starting point.
3. **Simple, clear language** – no jargon.
4. **Empathic validation** – acknowledges guilt, witchcraft belief without judgment.
5. **Includes child** – invites them to speak, reassures with honesty.
6. **Pauses and silence** – space to absorb.
7. **Supportive closure** – information, follow-up, family inclusion.

Cancer Diagnosis Disclosure – Good or Bad?

GROUP DISCUSSION

Communication Assessment Tool – 10 Minutes

1	2	3	4	5
poor	fair	good	very good	excellent

Please use this scale to rate the way the doctor communicated with you.
Circle your answer for each item below.

12.	Discussed next steps, including any follow-up plans	1	2	3	4	5
13.	Showed care and concern	1	2	3	4	5
14.	Spent the right amount of time with me	1	2	3	4	5

Key Errors Illustrated

1. No preparation or supportive environment.
2. **Overuse of medical jargon; lack of lay explanations.**
3. Dismissal of **cultural beliefs** and emotions.
4. No **validation** of caregiver's grief, fear, or guilt.
5. Lack of **empathy** from social worker.
6. **Excluding** the child, failing to address their emotions.
7. **Rushed disclosure** with no space to digest news.

Communication Assessment Tool (CAT)

Key points:

- Developed by Dr. Gregory Makoul
- Reliable
- Valid
- Evidence-based instrument
  - Developed through vigorous psychometric testing
  - The results are no affected by physician specialty/ patient gender, race, level o education, self-reported medical status, any previous encounter with the physician
- Benchmark rating does not exist
- Designed to gauge patient perceptions of communication with health professionals
- An instrument to assist in
  - Measuring
  - Improving communication

Communication Assessment Tool (CAT)

Key points:

- Well received by clinicians
  - Provides tangible, actionable results
  - Serves as a diagnostic to prioritize areas for improvement
  - Highlights essential communication tasks
- Can be used for: doctors, nurses, other health care team members or as an self-evaluation tool
- Written at a 4th grade reading level
- Usage
  - The patient has to respond based on a single, recent physician encounter

Communication Assessment Tool (CAT)

Description

- Focuses on the achievement of communication tasks rather on prescribing ways to accomplishing them
- Simple and straightforward tool with items accessible to patients across literacy levels
- Based on the research the recommendation is collecting 20-30 forms per physician
- Snapshot of patient perceptions
- Opportunity for reflection for the physicians on their interpersonal and communication skills: reinforcing strengths and identifying areas for improvement

Communication Assessment Tool (CAT)

Key points:

- 15 items: 14 for evaluating the communication skills of the doctor + 1 for the doctor's staff
- 5 point scale:
  - 1= poor
  - 2= fair
  - 3= good
  - 4= very good
  - 5= excellent
- Results
  - overall scores – average of the first 14 items and offers a general sense of how patients view the physician's communication skills
  - individualized feedback based on item scores

1	2	3	4	5
poor	fair	good	very good	excellent

Please use this scale to rate the way the doctor communicated with you.
Circle your answer for each item below.

The doctor	poor				excellent
1. Greeted me in a way that made me feel comfortable	1	2	3	4	5
2. Treated me with respect	1	2	3	4	5
3. Showed interest in my ideas about my health	1	2	3	4	5
4. Understood my main health concerns	1	2	3	4	5
5. Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6. Let me talk without interruptions	1	2	3	4	5
7. Gave me as much information as I wanted	1	2	3	4	5
8. Talked in terms I could understand	1	2	3	4	5
9. Checked to be sure I understood everything	1	2	3	4	5
10. Encouraged me to ask questions	1	2	3	4	5
11. Involved me in decisions as much as I wanted	1	2	3	4	5
12. Discussed next steps, including any follow-up plans	1	2	3	4	5
13. Showed care and concern	1	2	3	4	5
14. Spent the right amount of time with me	1	2	3	4	5

The doctor's staff	poor				excellent
15. Treated me with respect	1	2	3	4	5

CONCLUSION

1. Communication is central to quality care
2. Difficult conversations are part of clinical practice
3. **Key skills re-inforced**
    a) Active listening and empathy
    b) Clear, honest and respectful dialogue
    c) Managing emotions- both yours and the patients
    d) Applying structured communication frameworks
4. Effective communication builds **connection and healing**
5. **Take homes**
    a) Pause and listen first
    b) Acknowledge emotions
    c) Be clear and compassionate

QUESTIONS?

Workshop: Navigating Difficult Conversations and Enhancing Clinical Care Through Effective Communication Skills

Session Evaluation

A quick, 1-minute “check in” to listen to your views. Your voice matters!

Please Scan the QR code to participate in the Session Evaluation.

https://www.surveymonkey.com/r/NWM2025SessionEval

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Oral Abstracts & Discussion: Maternal, Neonatal, and Reproductive Health: Advancing HIV Care and Prevention

Moderators: Dr. Chikondi Chiweza, Dr. Eunice Ketangenyi

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Improving Neonatal Outcomes Through Kangaroo Mother Care:

Implementation Experience from Area 25 Community Hospital, Malawi.

Tiwonge Msonda, Tariro Chimhanda, Melvin Kunsembe, Mwayi Kazembe, Benard Natoto, Chikondi Chiweza, Nomsa Kafumba, Jeffrey Wilkinson, Maya Brasher, Monika Patil

Presented by: Dr. Mwayi Peter Kazembe

Outline

- Background
- Program descriptions
- Implementation setup
- Outcomes
- Results
- Lessons and future directions
- Conclusion
- Acknowledgements
- References

Background

- Prematurity = leading cause of neonatal mortality in Malawi (19%)
- 13% of deliveries at Area 25 are preterm
- Hypothermia-related neonatal deaths are preventable and prompted intervention
- Ministry of Health is scaling up Kangaroo Mother Care (KMC)

Program description

<u>Objectives</u>: to provide warmth, nutrition, monitoring for low birth weight (LBW) infants

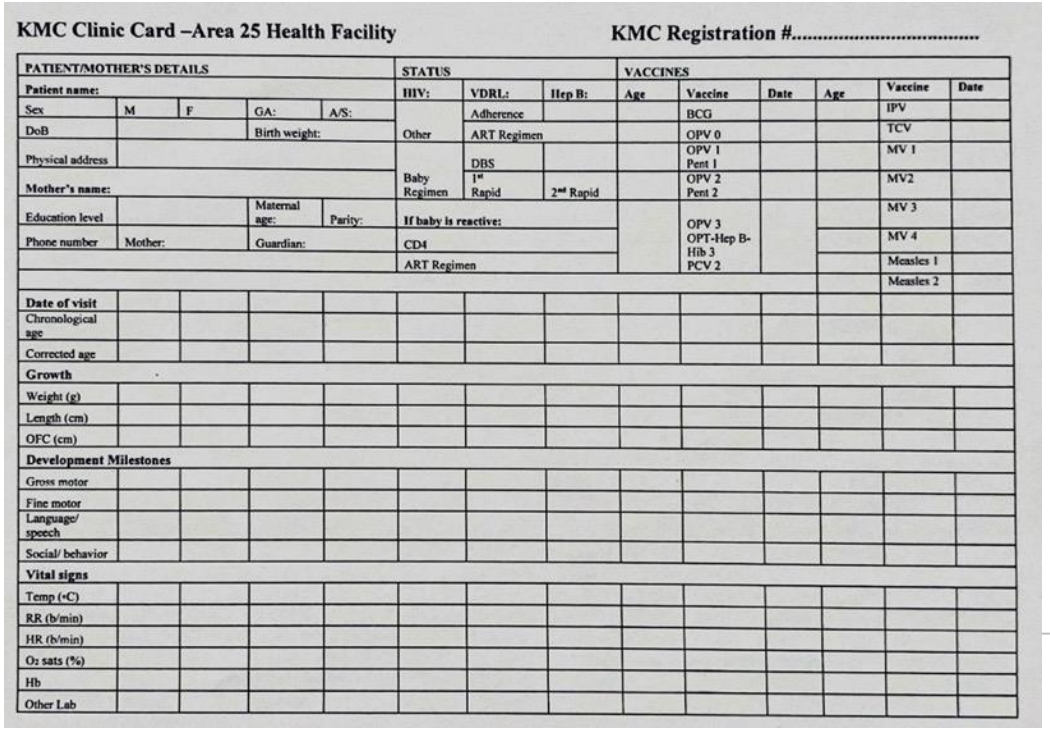
- KMC ward launched June 2024
- Staffed by clinicians, nurses, attendants
- Standardized protocols, dedicated ward space, training & follow-up system

Implementation set-up

- Staff training: initially for 50 nurses and 14 clinicians, plus on-the-job training for new staff
- Equipment: 6 beds, blankets, heaters, room thermometer
- Data collection tools: registers, feeding charts, clinic cards

Outcomes (Indicators)

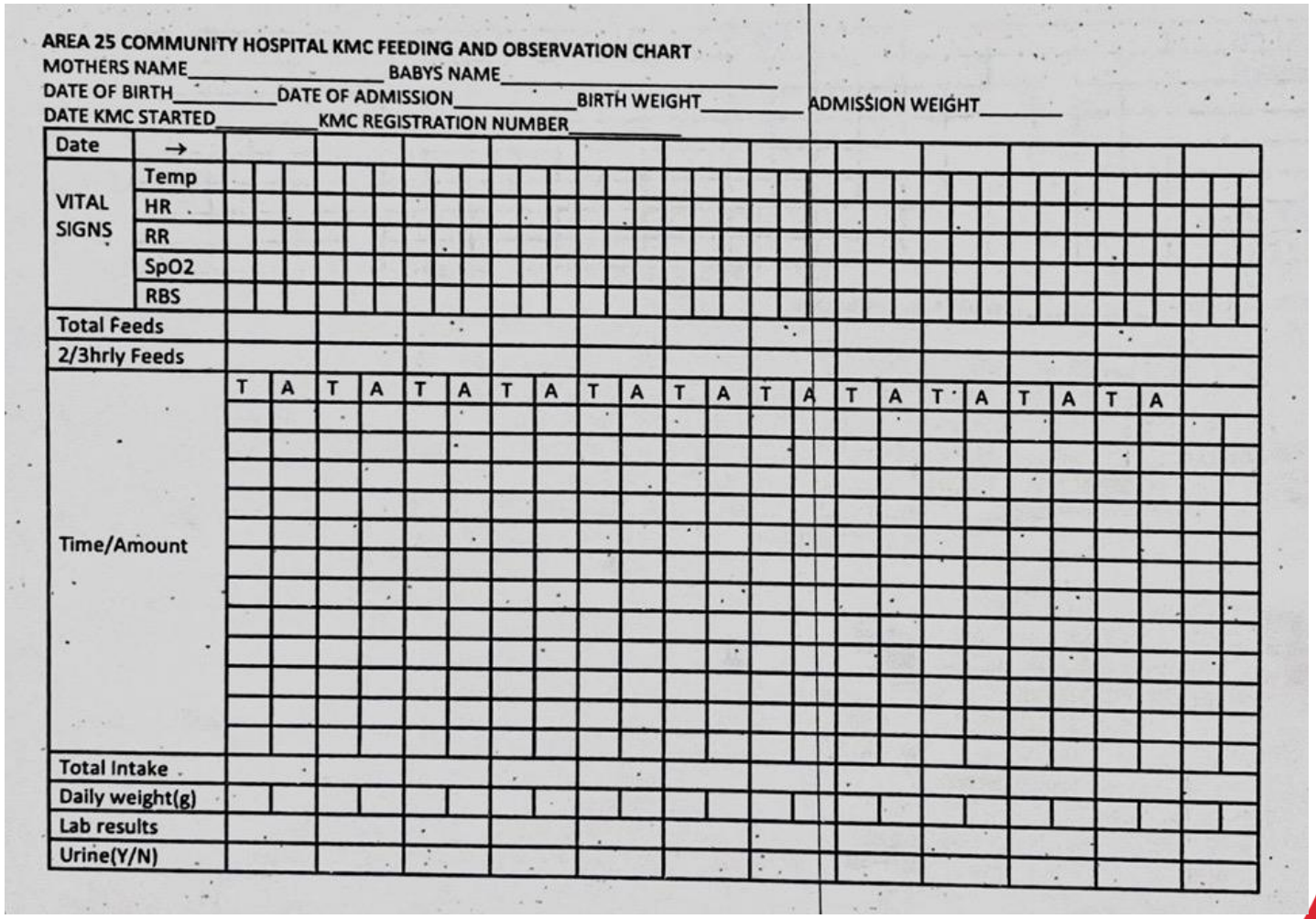
- Admissions
- Hypothermia rate
- In-hospital mortality
- Post-discharge clinic attendance
- # of healthcare workers trained



KMC Clinic Card –Area 25 Health Facility

KMC Registration #.....

PATIENT/MOTHER'S DETAILS					STATUS			VACCINES					
Patient name:					HIV:	VDRL:	Hep B:	Age	Vaccine	Date	Age	Vaccine	Date
Sex	M	F	GA:	A/S:		Adherence			BCG			IPV	
DoB			Birth weight:		Other	ART Regimen			OPV 0			TCV	
Physical address						DBS			OPV 1 Pent 1			MV 1	
Mother's name:					Baby Regimen	1st Rapid	2nd Rapid		OPV 2 Pent 2			MV2	
Education level			Maternal age:	Parity:	If baby is reactive:				OPV 3 OPT-Hep B-Hib 3 PCV 2			MV 3	
Phone number	Mother:		Guardian:		CD4							MV 4	
					ART Regimen							Measles 1	
												Measles 2	
Date of visit													
Chronological age													
Corrected age													
Growth													
Weight (g)													
Length (cm)													
OFC (cm)													
Development Milestones													
Gross motor													
Fine motor													
Language/ speech													
Social/ behavior													
Vital signs													
Temp (•C)													
RR (b/min)													
HR (b/min)													
O2 sats (%)													
Hb													
Other Lab													



AREA 25 COMMUNITY HOSPITAL KMC FEEDING AND OBSERVATION CHART

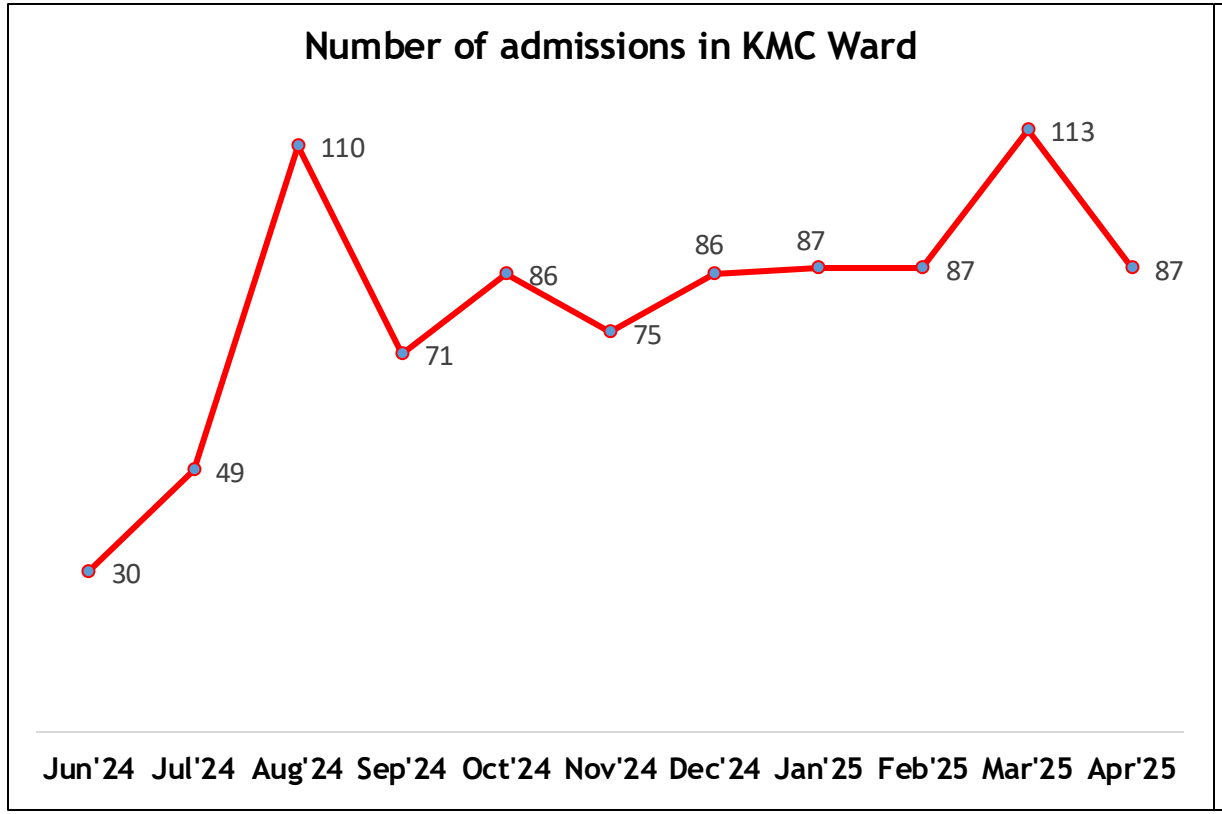
MOTHERS NAME_____ BABYS NAME_____

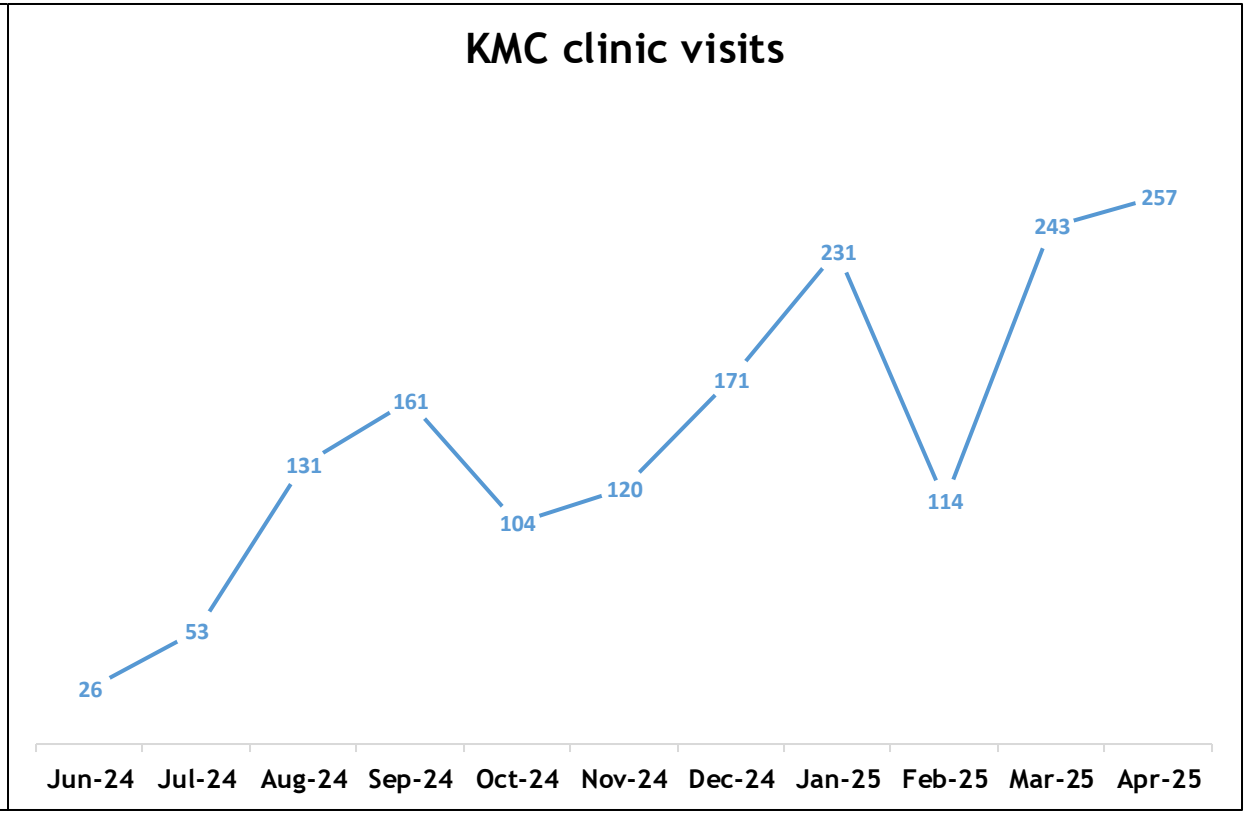
DATE OF BIRTH_____DATE OF ADMISSION_____BIRTH WEIGHT_____ ADMISSION WEIGHT_____

DATE KMC STARTED_____KMC REGISTRATION NUMBER_____

Date	→																								
VITAL SIGNS	Temp																								
	HR																								
	RR																								
	SpO2																								
	RBS																								
Total Feeds																									
2/3hrly Feeds																									
Time/Amount		T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A
Total Intake																									
Daily weight(g)																									
Lab results																									
Urine(Y/N)																									

Results: Admissions

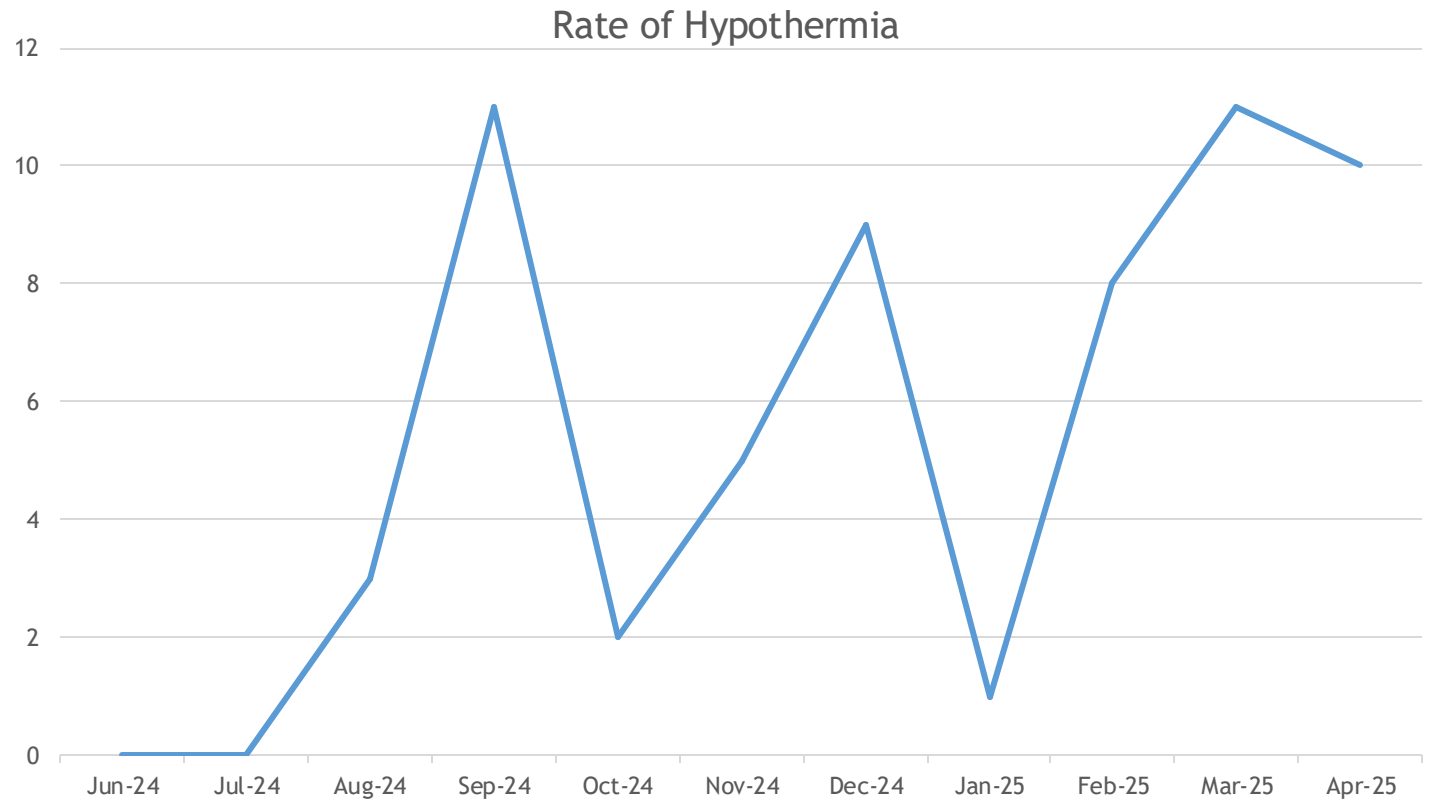




This graph shows a continued increase in the number of neonates admitted in the unit over time.

This graph shows a continued increase in the rates of infants presenting to follow-up clinic.

Results: Hypothermia



The number of babies experiencing hypothermic episodes while admitted in the ward fluctuates over time. Overall, the rates are slowly increasing.

Results: Mortality & Training

- 0 in-hospital neonatal deaths since KMC started
- High post-discharge follow-up attendance
- 64 healthcare workers trained in initial training

Lessons learned:

- KMC is effective in reducing neonatal deaths in low-resource settings
- Success due to community engagement & staff commitment
- **Challenges:**
  - Persistent hypothermia due to systemic and environmental factors
  - Space limitations
  - Power outages

Future Directions:

- Expand ward space
- Introduce respiratory support for infants <1500g
- Ensure nutritional supplementation
- Offer skill-building activities for mothers
- **Immediate Kangaroo Mother Care (iKMC)**

Conclusion

- KMC = feasible, life-saving, community-accepted intervention
- Area 25’s experience demonstrates the impact on neonatal outcomes

Acknowledgements

Ministry of Health, Malawi

Baylor College of Medicine Children's Foundation Malawi

Area 25 Community Hospital staff & families

Texas Neonatal Baylor Team

In partnership with

References

UNICEF. UN IGME Child mortality report 2020 [Internet]. 2020. 52 p. Available from: https://www.unicef.org/media/60561/file/UN-IGME-child-mortality-report-2019.pdf

26TH NETWORK MEETING

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Texas Children's Global Health Network

Optimizing PrEP Uptake Among Pregnant and Breastfeeding Women: Lessons from the Tingathe Program in Malawi (2022-2025)

Joseph Magaleta, Chrissy Kayuni, Fraser Tembo, Tapiwa A. Tembo, Elizabeth Wetzel, Katherine R Simon, Carrie Cox.

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Baylor College of Medicine Children's Foundation Malawi

Background

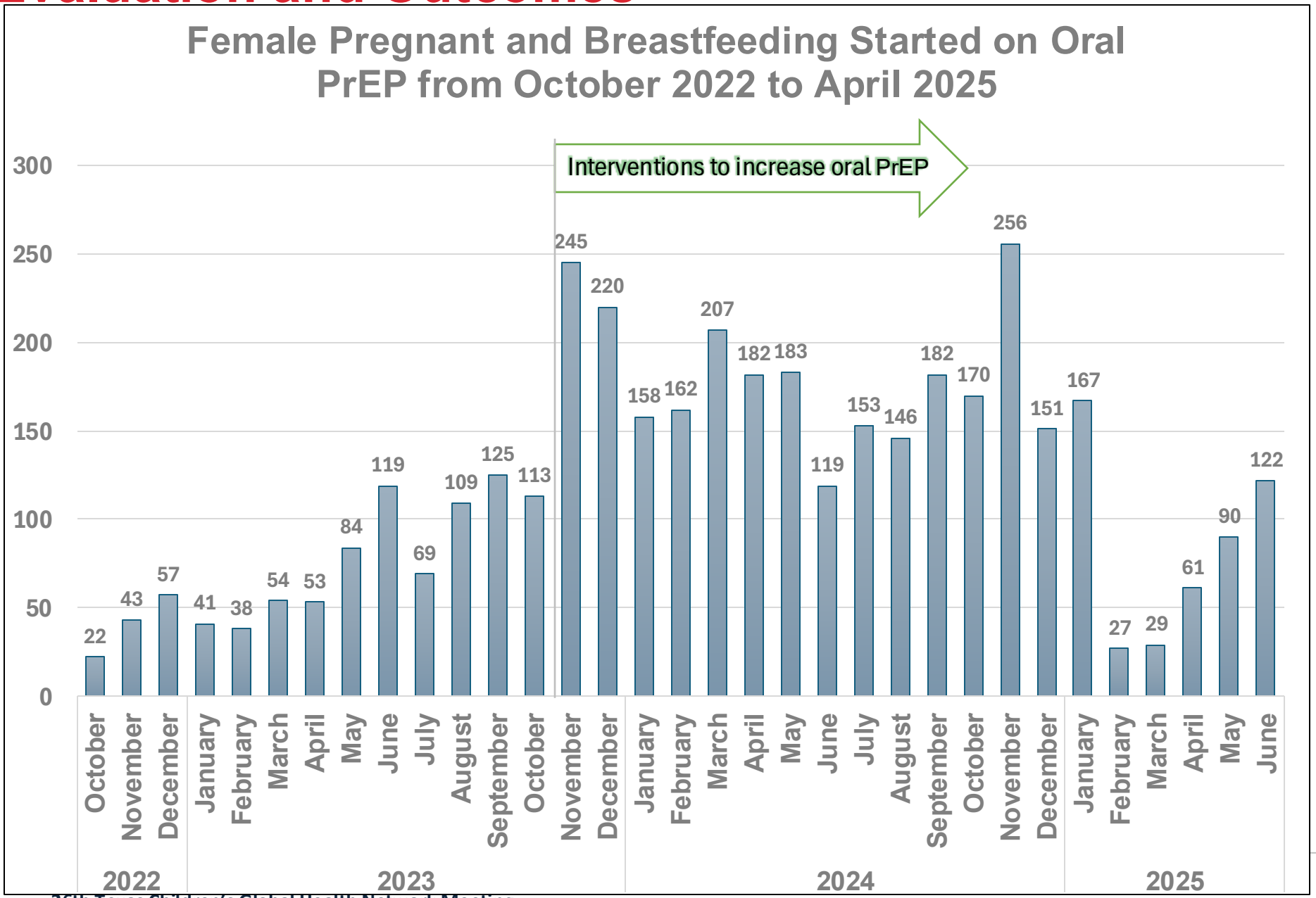
- 2020 Malawi guidelines recommend pre-exposure prophylaxis (PrEP) for people at high risk of HIV.
- Since its introduction, pre-exposure prophylaxis (PrEP) has provided a proven and effective HIV prevention method among pregnant & breastfeeding women (PBFW)
- We describe lessons learned following implementation of optimized interventions to increase access to PrEP services for pregnant & breastfeeding women at rural health facilities supported by Baylor Foundation-Malawi (BFM) Tingathe program in Malawi

Description

Baylor Foundation-Malawi (BFM) supported PrEP at 51 health facilities (HF) starting in 2022 and expanded to 74 health facilities by September 2024 across 5 districts

Year	HF(n)	Interventions
2022	51	• Training of PrEP providers • Activation of facilities • Provision of PreP Services
2023	52	• Training of one additional facility with ongoing support to existing sites as above & Additional interventions as below towards the end of 2023
2024	74	• Facility staff orientation • Health talks delivered at entry points • Extending service delivery beyond ART clinics to Antenatal clinic (ANC), outpatient Department and Under Five Clinics. • On-the-job mentorship was provided to lay cadres and clinical staff • Supportive, non-judgmental care and escorting clients for seamless access. • Staff conducted daily checks of referral documentation, scheduled PrEP providers, and identified designated service rooms. • Monthly data reviews helped identify and address gaps. Facility staff conducted awareness, screening, referral, and initiation efforts.

Evaluation and Outcomes



Trends

- ✓ Slow increase from Oct 2022 – Sep 2023.
- ✓ Uptake rose from Nov 2023 – Jan 2025.
- ✓ Decline Feb–Mar 2025, which coincided with the disruption in the delivery of HIV prevention and care services due to a Stop Work Order issued by the US government.
- ✓ The Uptake rose again from April 2025 – June 2025

Lessons Learned

Increasing the number of facilities alone is not sufficient to enhance access to PrEP services

More efforts are needed to optimize uptake.

Uptake improved when facilities consistently provided:

- Ongoing mentoring & orienting new staff,
- Conducting health talks,
- Performing referral checks,
- Scheduling providers,
- Ensuring dedicated service rooms and conducting regular data reviews.

Integrating PrEP within routine service delivery lines such as Antenatal Clinic (ANC), Outpatient Department(OPD), and Under-5:

- Continuity of access even with limited staff,
- Shared responsibility across different service points,
- Greater resilience during disruptions.

Next Steps

- Support the Ministry of Health(MOH) to institutionalize PrEP integration within routine facility services to sustain delivery during future disruptions.

- Strengthen the Ministry of Health (MOH) coordination in pre-exposure prophylaxis (PrEP) service delivery

- Adopting adaptive service delivery models and contingency plans are essential to mitigate the risk of service disruptions and maintain continuity of services

Acknowledgments

- Malawi Ministry of Health
- Baylor College of Medicine Children's Foundation Malawi
- Tingathe Program Team
- US Government
- Texas Children's Hospital Global Health Network

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Texas Children's Global Health Network

SCALE-UP OF HUMAN PAPILLOMA VIRUS (HPV) TRIAGE FOR CERVICAL CANCER SCREENING FOR WOMEN LIVING WITH HIV IN MANGOCHI DISTRICT, MALAWI

Chisomo Imfaitenga, Florence Msosa, Fraser Tembo, Golden Kang'oma, Carrie M Cox (Baylor College of Medicine Children's Foundation Malawi & Baylor College of Medicine, Texas, USA)

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Background

- Cervical cancer is the most common cancer in Malawian women of reproductive age.
- Cervical Visual Inspection with Acetic acid (VIA) is the main screening method in Malawi
- Malawi's CECAP adopted HPV triage for women aged 25–49 per WHO 2021 guidelines with ongoing scaleup

Implementation Description

- HPV triage was launched in June 2024 across 5 facilities with VIA-trained staff.

- Key components:
  - **Clinical & lab training** on HPV collection, testing, and interpretation.
  - **Supply of commodities** including HPV kits and documentation tools
  - Staff **sensitization and mentorship**
  - **Integration with ART clinics** through self-collection of HPV samples by eligible women.
  - Utilization of **community health workers for follow-up** and tracing.

Evaluation and Outcomes

	VIA ONLY June 2023- May 2024			VIA and HPV TRIAGE June 2024 - May 2025					
Facility	VIA only	HPV tests	Completed CECAP screening	VIA only	HPV tests	HPV negative	HPV POS VIA done	Completed CECAP screening	% completed CECAP screening
Facility 1	1010	0	1010	354	542	343	97	794	89%
Facility 2	225	0	225	28	255	181	19	228	81%
Facility 3	74	0	74	48	123	79	12	139	81%
Facility 4	405	0	405	229	92	64	5	298	93%
Facility 5	95	0	95	40	202	146	3	189	78%
Total	**1809**	**0**	**1809**	**699**	**1214**	**813**	**136**	**1648**	**86%**

- Similar numbers of women were identified and screened
  - **1809** v **1913**
- Screening completion was **100%** with VIA only v **86%** with HPV triage
  - Overall HPV positivity was 33%
- Follow-up ongoing for **265 (17%)** women with **HPV+ results** who need **VIA**

Lessons Learned

- Roll out of HPV triage is feasible with available staff and materials.
- Competing priorities in the lab make same day results difficult and strengthening systems of follow up and capture of women who need VIA after HPV+ results at next ART visits are critical to complete CECAP screening
- HPV+ triage decreases number of women who need VIA performed by CECAP trained providers
- Sustainability depends on continued financial support for expensive commodity that is not locally available as well as lab and clinical human resource for testing.

Next Steps

- **Continued engagement to build and support strong collaboration and coordination with lab services to reduce HPV result turnaround time and improve same-day VIA completion are ongoing**

- Explore expansion of HPV triage to more sites, pending available resources

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Texas Children's Global Health Network

Exploring HIV Knowledge Among Youth in the Sauti ya Vijana Program

Presenter: Dr. Lilian B. Komba (MD, MMED)

Authors: Sekela Mwasumbi, Lilian Komba, Elizabeth Senkoro, Lumumba Mwita, John Galis, Dorothy Dow

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Agenda

- Background
- Methods
- HIV Knowledge - UNFPA, HIV-KQ-18 used in SYV
- Results
- Conclusion

Background

- Young people (10-24 years of age) make up >60% of the Tanzanian population and are vulnerable to sexually transmitted infections including HIV and unintended pregnancies.
- Levels of comprehensive HIV knowledge range from 25-46% in sub-Saharan Africa1,2
- Strengthening HIV knowledge in this age group is essential for improving prevention and treatment, reducing stigma, and empowering young people to make informed health decisions
- We report on Sauti ya Vijana (The Voice of Youth, in English) a mental health and life skills intervention that aims to address these needs for AYA-HIV in Tanzania.

1. Chan, et al, JIAS 2018, PMID: 30063290
2. Bago M, et al. Frontiers of Public Health, PMID 40994744

Research questions

- What is the level of HIV knowledge among AYA-HIV enrolled in SYV compared to national statistics?

- Does participation in Sauti ya Vijana improve HIV knowledge among AYA-HIV compared with the enhanced standard of care group at 6-months?

Methods

- The **HIV-Knowledge Questionnaire (HIV-KQ-18)** evaluated HIV knowledge across three domains: transmission myths, prevention strategies, and treatment-related information with responses “true”, “false” or “I don’t know”.
- Responses were categorized as correct if the correct answer was chosen; incorrect, included wrong answers and ”I don’t know."
- **Overall knowledge scores** were determined by the **percentage of correct responses** (0-100%).
- **A subset of questions** were mapped to UNFPA knowledge questions to compare SYV respondants’ knowledge to a national sample based on **ALL four questions answered correctly.**
- Descriptive statistics were used to evaluate participant knowledge at baseline and 6 months using Stata/SE 18.0 and R 4.4.1.

Carey, M.P., Schroder, K.E.E. (2002). Development and Psychometric Evaluation of the Brief HIV Knowledge Questionnaire. AIDS Education and Prevention, 14(2), 172-182.

HIV Knowledge: UNFPA

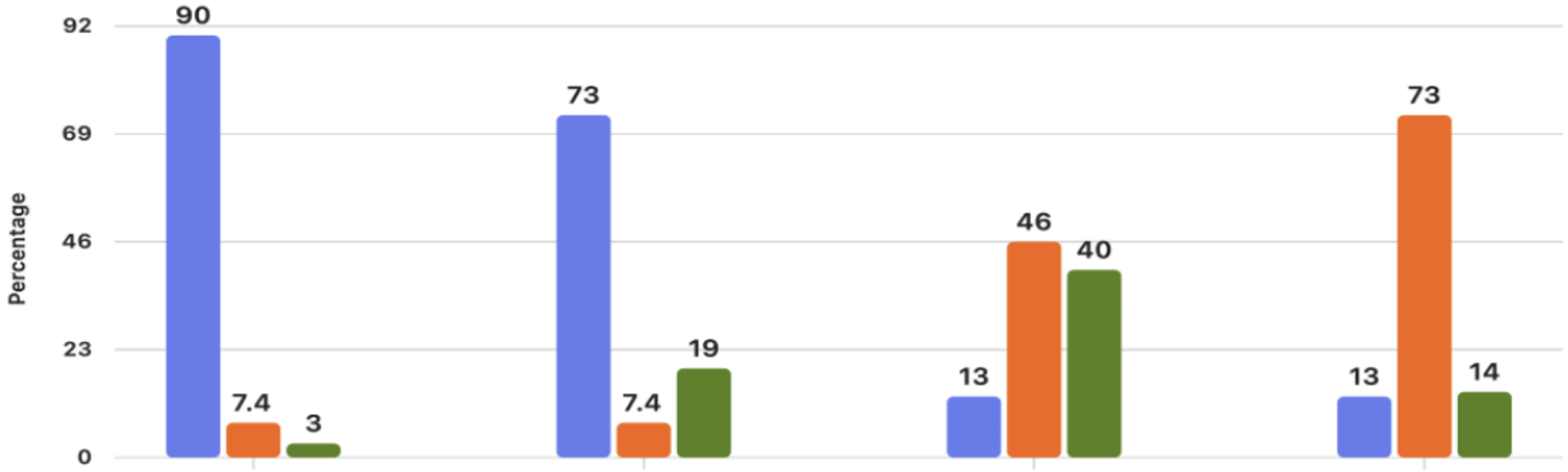
UNFPA Questionnaire	
1. Can HIV risk be reduced by having sex with only one faithful, uninfected partner? YES	37% answered ALL correctly
2. Can the risk of HIV be reduced by using condoms? YES	
3. Can a healthy-looking person have HIV? YES	
4. Can someone get HIV by sharing a meal (food) with an infected person? NO	
5. Can a person get HIV from mosquito bites? NO	

https://tanzania.unfpa.org/sites/default/files/pub-pdf/Factsheet_hivaids_23nov.pdf

HIV Knowledge: HIV-KQ-18 used in SYV

HIV-KQ-18	
(Q2) A person can get HIV by sharing a glass of water with someone who has HIV. Correct answer: FALSE	**27% answered ALL correctly**
(Q7) People who have been infected with HIV quickly show serious signs of being infected. Correct answer: FALSE	
(Q11) There is a female condom that can help decrease a woman's chance of getting HIV. Correct answer: TRUE	
(Q14) Having sex with more than one partner can increase a person's chance of being infected with HIV. Correct answer: TRUE	

HIV-KQ-18: Four Questions that map to UNFPA and responses at baseline



A person can get HIV by sharing a glass of water with someone who has HIV.
Correct answer: FALSE

People who have been infected with HIV quickly show serious signs of being infected.
Correct answer: FALSE

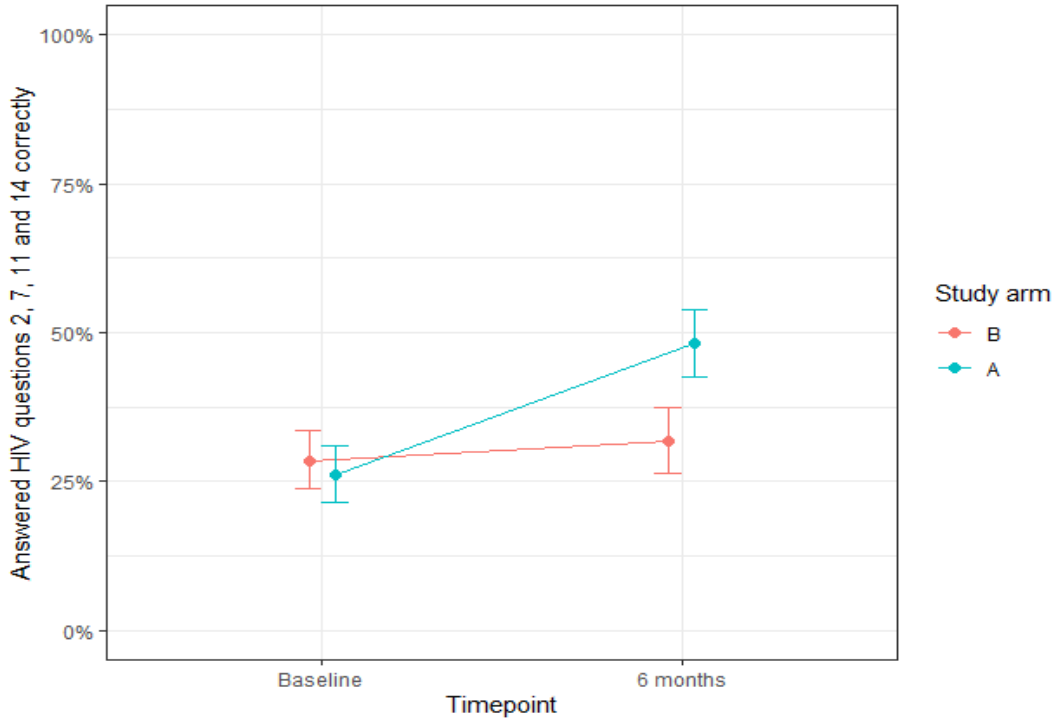
There is a female condom that can help decrease a woman's chance of getting HIV.
Correct answer: TRUE

Having sex with more than one partner can increase a person's chance of being infected with HIV.
Correct answer: TRUE

Results: Across Arms

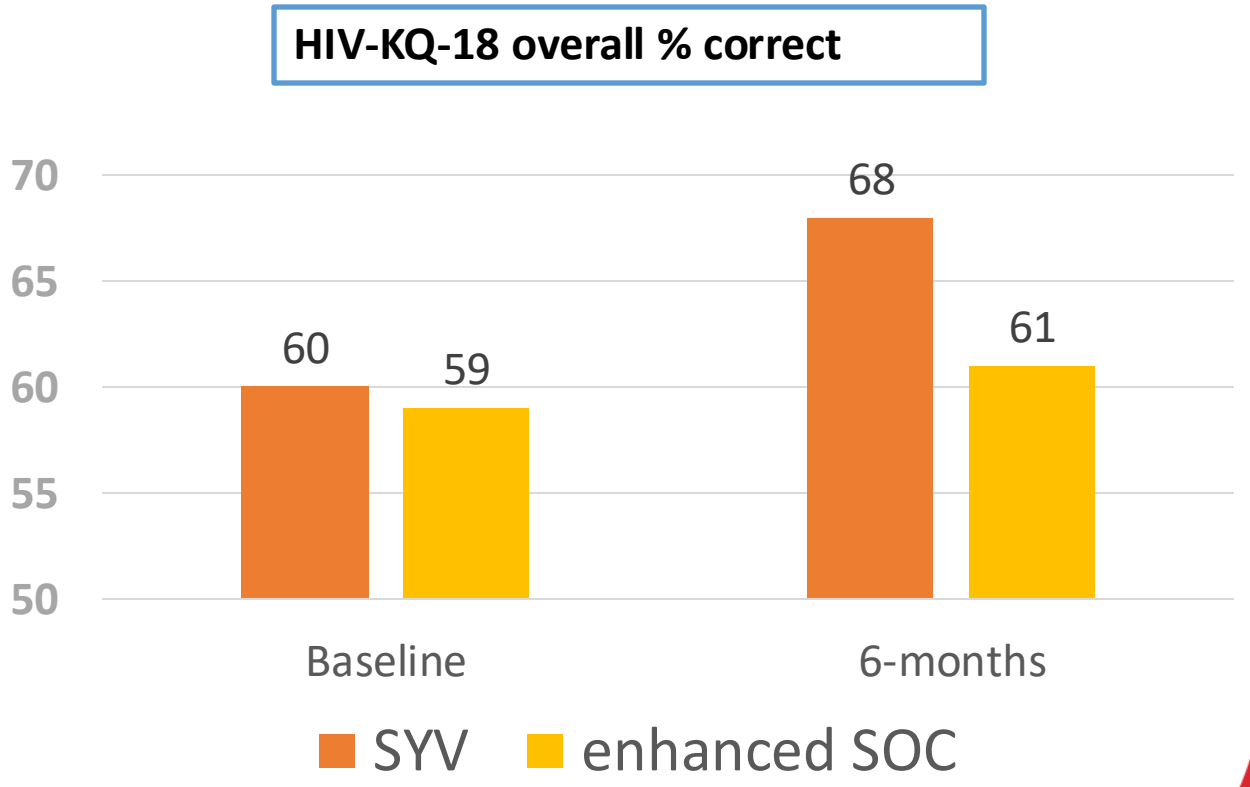
Characteristic	SYV		Enhanced SOC		Arms combined	
	Baseline N = 349[1]	6 months N = 309[1]	Baseline N = 341[1]	6 months N = 300[1]	Baseline N = 690[1]	6 months N = 609
Answered all 4 questions (2, 7, 11 and 14) correctly	91 (26%)	149 (48%)	97 (28%)	95 (32%)	188 (27%)	244 (40%)

- HIV knowledge on the four UNFPA equivalent questions improved more in SYV compared to the enhanced SOC.



Results: Change in % correct of all HIV KQ 18 Knowledge Questions

- There was a **statistically significant** improvement in HIV knowledge in the SYV arm compared to eSOC
  - Estimated mean difference (95% CI) **5.66 (2.44, 8.88)**



Conclusion

- **HIV knowledge significantly improved** in the SYV arm compared to enhanced standard of care at 6-months.

- Despite this gain, **knowledge gaps persists** and interventions need to continually address HIV knowledge to improve HIV prevention and reduce HIV-related stigma.

- The gains seen in the SYV intervention arm support **the importance of scaling up SYV** towards providing comprehensive, gender-sensitive, and contextually adapted HIV education in Tanzania.

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Sauti ya Vijana Refresher Training January 15 - 18, 2024
Dar es Salaam, Tanzania

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

Evaluation of Hepatitis B Testing Coverage and Yield Among Pregnant Women Accessing Antenatal Care Services in Five Districts in Malawi

Teferi Beyene[1,2], Elijah Kavuta[1], **Victor Guzani**[1], Gomezga Chitsulo[1], Gift Kaunda[1], Stephen Chu[1,2], Carrie Cox[1,2], Katherine R Simon[1,2], Tapiwa Tembo[1]

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Background

- Hepatitis B virus (HBV) remains a significant global health concern, with an estimated 296 million individuals living with chronic infection globally.
- Prevalence among pregnant women in Africa is estimated at 5.9%, transmission rates can be as high as 90% among women with high HEP B viral load but early treatment and timely infant immunization can prevent transmission by up to 95%.
- In November 2022, Malawi introduced opt-out HBV testing during antenatal clinic (ANC) as part of its strategy to prevent mother-to child-transmission of HBV.
- We describe HBV testing coverage and yield among pregnant women tested in five districts across central and southern Malawi.

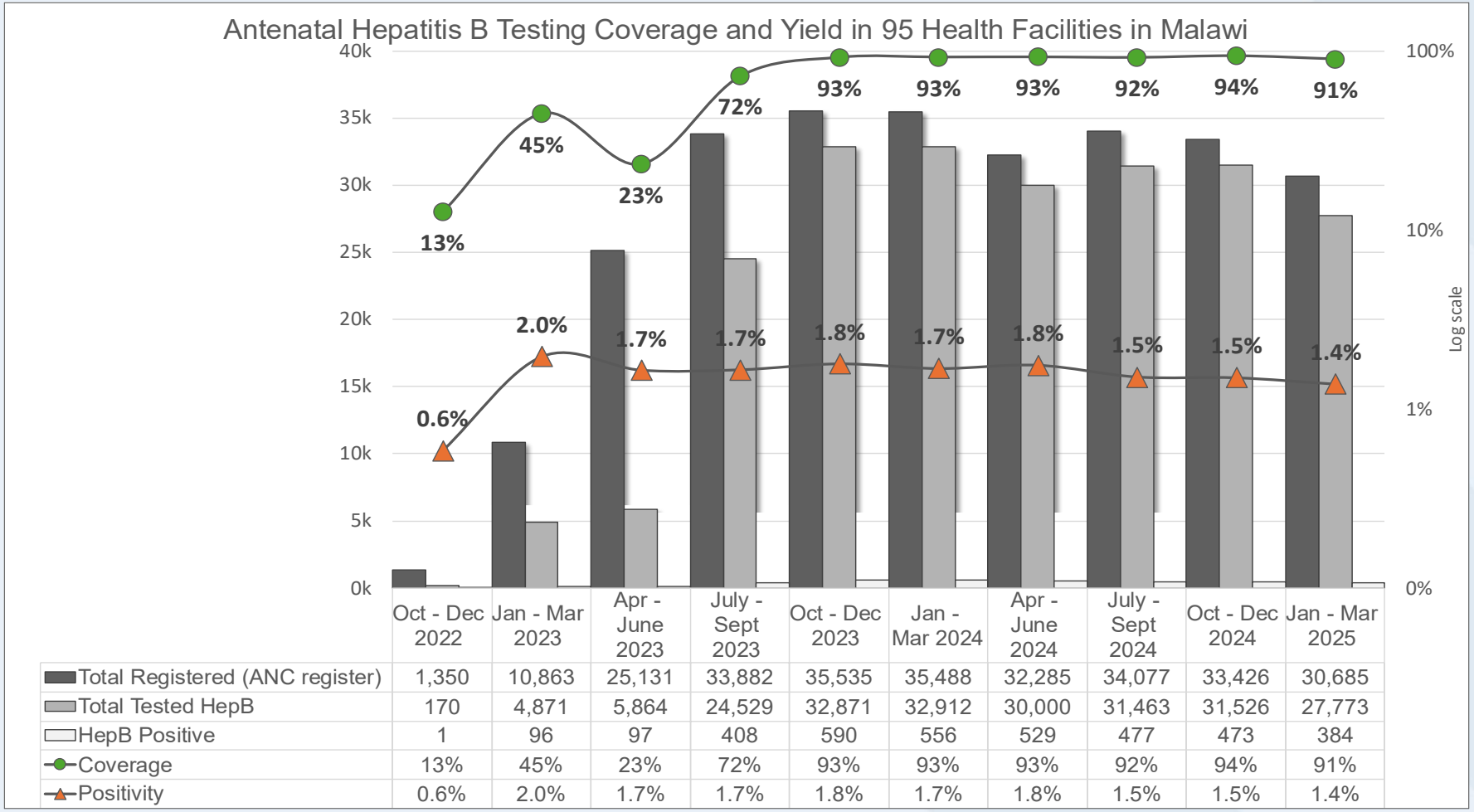
Methods

- De-identified programmatic data was used for analysis
- We describe Hepatitis B virus yield among pregnant women tested at ANC at 95 health facilities between October 2022 and March 2025.
- Descriptive statistics were used to summarize
  - testing coverage over time
  - overall yield
  - positivity rates by age group
- Associations between HBV positivity and maternal age were assessed using Chi-square tests with a 95% confidence interval.

Results

- From October 2022 to March 2025:
  - 272,722 pregnant women attended their first antenatal care visit
  - 221,979 (81%) were tested for HBV
  - 3,611 (1.6%) tested Hep B positive.

Hepatitis B Virus screening coverage increased from 13% in 2022 to >90% by Oct-Dec 2023 and persisted >90%



	Oct - Dec 2022	Jan - Mar 2023	Apr - June 2023	July - Sept 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - June 2024	July - Sept 2024	Oct - Dec 2024	Jan - Mar 2025
Total Registered (ANC register)	1,350	10,863	25,131	33,882	35,535	35,488	32,285	34,077	33,426	30,685
Total Tested HepB	170	4,871	5,864	24,529	32,871	32,912	30,000	31,463	31,526	27,773
HepB Positive	1	96	97	408	590	556	529	477	473	384
Coverage	13%	45%	23%	72%	93%	93%	93%	92%	94%	91%
Positivity	0.6%	2.0%	1.7%	1.7%	1.8%	1.7%	1.8%	1.5%	1.5%	1.4%

- Testing volumes **increased** overtime
- HBV yield remained stable
- Absolute number of women diagnosed with HBV increased ~4-5 fold

➢ HBV positivity rates were highest among women 25-49 years and older

Age Group	Total Tested (N)	Negative	Positive	HBV Positivity Yield (%)	95% Confidence Interval (CI)
10-14	620	619	1	0.3%	0% – 0.9%
15-19	61,815	61,594	221	0.4%	0.3% – 0.4%
20-24	73,894	73,060	924	1.3%	1.2% – 1.3%
25-29	39,954	39,018	936	2.3%	2.2% – 2.5%
30-34	25,891	25,105	786	3%	2.8% – 3.3%
35-39	14,814	14,263	551	3.7%	3.4% – 4%
40-44	4,136	3,976	160	3.9%	3.3% – 4.5%
45-49	690	660	30	4.4%	2.8% – 5.9%
50+	75	73	2	2.7%	0.7% – 9.2%

Table 1: Age-Stratified Hepatitis B Testing and Yield Among Pregnant Women in Malawi

Conclusion

- Antenatal HBV testing coverage increased markedly over time.
- Age-related differences in HBV testing yield were seen and likely reflect the lasting impact of Malawi's infant hepatitis B vaccination program.
- On-going efforts are underway to
  - Evaluate linkage-to-treatment rates
  - Ensure timely infant prophylaxis to sustain progress towards eliminating mother-to-child transmission of HBV.
  - Develop systems and tools to enhance tracking and documentation of women previously diagnosed with HBV

Texas Children's Global Health Network

26TH NETWORK MEETING

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Mother to Child Transmission of HIV: A Descriptive Study of HIV Positive Infants Diagnosed in Public Health Facilities in Mid-Eastern Uganda Between January 2022 and December 2024.

Presenter: Charles Amaku

Co-authors: R. Nakayima[1], D. Twisa[1], F.M. Mugenyi[1], E.A Bonet[1], A. Onyege[1], P. Serunjogi[1], K. Katulege[1], W. Akobye[1], A. Mugume[1], J. Nakawesi[2], D. Kiragga[2]

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Baylor College of Medicine Children's Foundation Uganda

Agenda

- Background
- Methods
- Results
- Conclusion
- Recommendations
- Study Limitations

Background

>95% Children < 5 years living with HIV acquired HIV through Mother to Child Transmission

Mid western Uganda among the top 5 regions with HIV positive infants (0-2 years)

257 HIV Positive infants were reported between Jan 2022 and Dec 2024

Urgent need to identify Risk Factors for the MTCT of HIV among the HEIs

BFU supported a Clinical Chart Review for Mother-Infant pairs using the Ministry of Health Positive Infant audit Form.

Methodology

Study Design

Descriptive study employing retrospective clinical chart review of MIPs

Study Setting

Study area-Mid-Eastern Uganda, HIV Prevalence rate of 4.2%, has 465 facilities (1RRH, 7 GH, 20 HC IVs, 200 HCIIIs and 137 HCIIs. 70% are under BFU support.

Inclusion Criteria

All HIV positive infants and their mothers diagnosed at BFU-supported public health facilities between January 2022 and December 2024.

Data Collection, Analysis

- Used MoH HIV positive infant audit form to collect data from Mother Infant Pair (MIP) clinical charts.
- Variables included early infant diagnostic tests; infant and maternal characteristics.

- Data processed in Microsoft Excel Windows 11 and analyzed using SPSS version 20.
- Data was summarized into frequencies and percentages.

Results

Infant Characteristics

Variable	Result
infant median age at HIV positive diagnosis	6.0 months.
Birth from Home	44.87%
EID test at 2 months or earlier	20.9%
Received ARV prophylaxis at birth	17.52%
Exclusive Breast Feeding	72.22%

Maternal Characteristics

Variable	Result
Maternal median age	28.0 years
Maternal ART Duration	5.0 months.
HIV diagnosis during Breast Feeding	53.07%
ART initiated during breastfeeding	61.40%
had sexual partners with unknown HIV status	56.20%
On ART for 3 months or less	43.70%
Viral load test results: non-suppressed viral load results (>200c/ml)	63%

Conclusion, Recommendation & Limitations

Conclusion:	The study revealed suboptimal access to PMTCT services to this cohort of patients, leading to MTCT of HIV.
Recommendations:	Pre-conception HIV testing and counseling for women of childbearing age and their sexual partners.
	Enhance community HIV screening through empowering village health teams (VHTs), community health extension workers (CHEWs) and other community actors.
	Further research using other rigorous research methods to provide in-depth understanding and determine causality of MTCT of HIV in the region.
Study Limitations	The retrospective nature of the study design and chart review meant limited depth of data collected and research questions.
	The observational nature of the study means the results are not repeatable and the findings are limited to this sample.
	No cause and effect established. The study only attempted to answer the “what?” without the “why?”. It only described the situation.

NWM2025

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Texas Children's Global Health Network

Determinants of Detectable Viral Load Among Pregnant and Breastfeeding Women in Routine HIV Care and Prevention at Baylor Mwanza CoE

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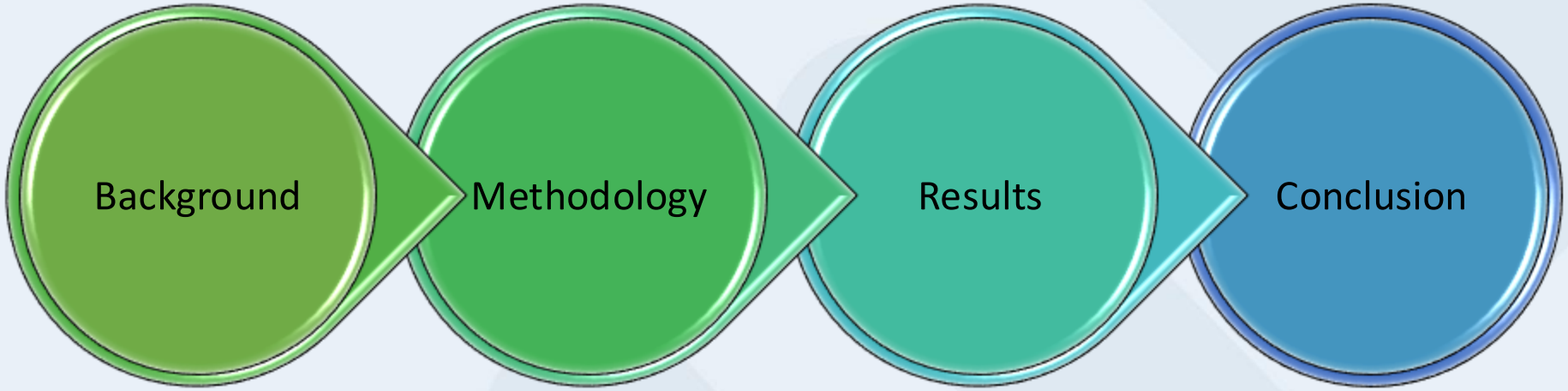
[1]Baylor Children's Foundation-Tanzania, Mwanza CoE

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Agenda



Background

- Maternal viral load suppression is essential for preventing mother-to-child transmission (PMTCT) and ensuring optimal maternal health.
- WHO recommends maintaining viral loads below 50 copies/mL throughout pregnancy and breastfeeding to prevent vertical HIV transmission.
- Despite ART scale-up in sub-Saharan Africa, many women remain unsuppressed during pregnancy and lactation, threatening PMTCT progress.
- In Tanzania, although Option B+ has expanded PMTCT coverage, disparities and client-level challenges persist, especially in routine care settings.
- Most existing studies focus on controlled or tertiary hospital environments, leaving a gap in understanding real-world service delivery contexts.
- This study therefore assessed factors linked to detectable viral load among PBW at Baylor–Mwanza to inform targeted PMTCT program improvements.

Methodology

A retrospective/Quantitative cross-sectional study using routine clinical data from **March 2022 to March 2024**.

Included **227 HIV-positive PBW** enrolled at Baylor COE, Mwanza.

Data covered demographic, clinical, and treatment-related variables.

Descriptive statistics, Bivariate Analysis (χ^2) and **Multivariate Analysis (Binary logistic regression)** were used to identify associated factors at **$p < 0.05$**

Results 1/3 : Descriptives

Of the 227 women analyzed, **82.4% were breastfeeding,** dominantly **above 24 years (183; 80.6%),** with a **median age of 33 years**.

Most clients were **unstable (212; 93.4%) with** nearly half being in **WHO Stage I (98; 43.2%)**

Almost all clients were on **first-line ART (216; 95.2%)** and **in care for over one year (226; 99.6%)**

Scheduled visits dominated (182; 80.2%), yet a noticeable **transfer-out rate (27; 11.9%)**

Despite good monitoring with **acceptable HVL intervals (183; 80.6%)**, about **one-quarter (63; 27.8%)** still had **detectable viral loads**

Results 2/3 : Bivariate Analysis

Variable	Category	n	n %	Adjusted Residual		Pearson χ^2	df	p-value
				Undetectable VL	Detectable VL			
Age Group	Below 18	12	5.3%	1.5	–1.5	7.4	2	0.025
	18–24	32	14.1%	2.1	–2.1	7.4	2	0.025
	Above 24	183	80.6%	–2.7	2.7	7.4	2	0.025
PBW Status	Breastfeeding Mother	187	82.4%	4.2	–4.2	18	1	<0.001
	Pregnant Woman	40	17.6%	–4.2	4.2	18	1	<0.001
Differentiated Service Delivery Model (DSDM)	Early Presenter	9	4.0%	–3.4	3.4	20.2	3	<0.001
	Late Presenter	3	1.3%	–2.8	2.8	20.2	3	<0.001
	Stable	3	1.3%	–0.2	0.2	20.2	3	<0.001
	Unstable	212	93.4%	4.1	–4.1	20.2	3	<0.001
Turnaround Time (TAT)	Acceptable TAT (≤ 30 days)	168	74.0%	10.7	–10.7	114.2	1	<0.001
	Not Acceptable TAT (≥ 30 days)	59	26.0%	–10.7	10.7	114.2	1	<0.001
HVL Taking Interval	Acceptable Interval (≤ 90 days)	183	80.6%	11.9	–11.9	142.1	1	<0.001
	Not Acceptable Interval (≥ 90 days)	44	19.4%	–11.9	11.9	142.1	1	<0.001

Results 3/3 : Multivariate Analysis

Dependent Variables	B	S.E.	df	OR	95% C.I/OR		p-value
					Lower	Upper	
PBW Status [Breastfeeding Mother]	-0.23	0.82	1	0.796	0.16	3.93	0.780
Age_Group	-	-	2	-	-	-	0.379
Below 18	-0.44	1.10	1	0.643	0.08	5.50	0.687
18–24	-1.48	1.09	1	0.227	0.03	1.92	0.174
DSDM	-	-	3	-	-	-	0.917
Early Presenter	0.96	1.34	1	2.598	0.19	35.76	0.475
Late Presenter	-12.49	2,4347.61	1	0.000	0.00	wide CI	1.000
Stable	-16.57	5,199.39	1	0.000	0.00	wide CI	0.997
Turnaround Time [Acceptable TAT (≤ 30 days)]	-1.44	0.68	1	0.237	0.06	0.90	0.034
HVL Taking Interval [Acceptable Interval (≤ 90 days)]	-34.45	7,369.84	1	0.000	0.00	wide CI	0.996
Omnibus $\chi^2 = 153.86$, $p < 0.001$ (model is significant, Nagelkerke $R^2 = 0.710$ (strong explanatory power), Hosmer–Lemeshow $p = 0.923$ (good fit), Classification accuracy = 92.1%							

Conclusion

Strengthen	Younger clients (<24 years) achieved higher viral suppression (p=0.025); strengthen adherence support for older adults.
Breastfeeding	Breastfeeding mothers suppressed better than pregnant women (p<0.001); enhance adherence and follow-up during pregnancy.
Maintain	Unstable clients had superior suppression (p<0.001); maintain close monitoring and improve early ART engagement.
Improve	Acceptable TAT (≤30 days) predicted suppression (p=0.034); improve laboratory efficiency, strengthen sample transportation.
Ensure	Acceptable HVL taking interval (≤90 days) predicted suppression (p=0.034); ensure regular and timely VL testing.

26TH NETWORK MEETING | NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

ENGAGING PEERS AND DISTRICT-LED MENTORSHIPS TO ACCELERATE HIV, SYPHILIS, AND HEPATITIS-B TESTING.

Presenter: Mary Mugabekazi

Co-authors: Micheal Juma, Edgar Sserunkuma, Annet Zalwango, Richard Jjuuko Kyakuwa, Denise Birungi, Phoebe Monalisa Namukanja, Linda Kisakye, Dithan Kiragga

Baylor College of Medicine | BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Baylor College of Medicine Children's Foundation Uganda

Background:

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Aims to **eliminate mother-to-child transmission (eMTCT) of HIV**, syphilis, and hepatitis B (HBV) during pregnancy, intrapartum, and postpartum

Sept 2024

9 Districts + 1 City Achieved

- 99% HIV Testing
- 97% Syphilis Testing
- **34% Hepatitis B- Testing**

Root Causes

Using a Fishbone, secondary drivers were:

- Stockouts of HBV Kits
- Non-targeted health education
- Knowledge gaps among midwives

Aim

To describe the role of peers and district-led mentorships in accelerating HIV, syphilis, and HBV testing among pregnant women attending ANC1

BAYLOR COLLEGE OF MEDICINE Children's Foundation UGANDA

Methodology

Data Analysis for 156 BFU Facilities

For HIV, Syphilis, and Hepatitis B testing

Supported Root Cause Analysis

Engaged Work Improvement Teams to analyse reasons for suboptimal HBV testing

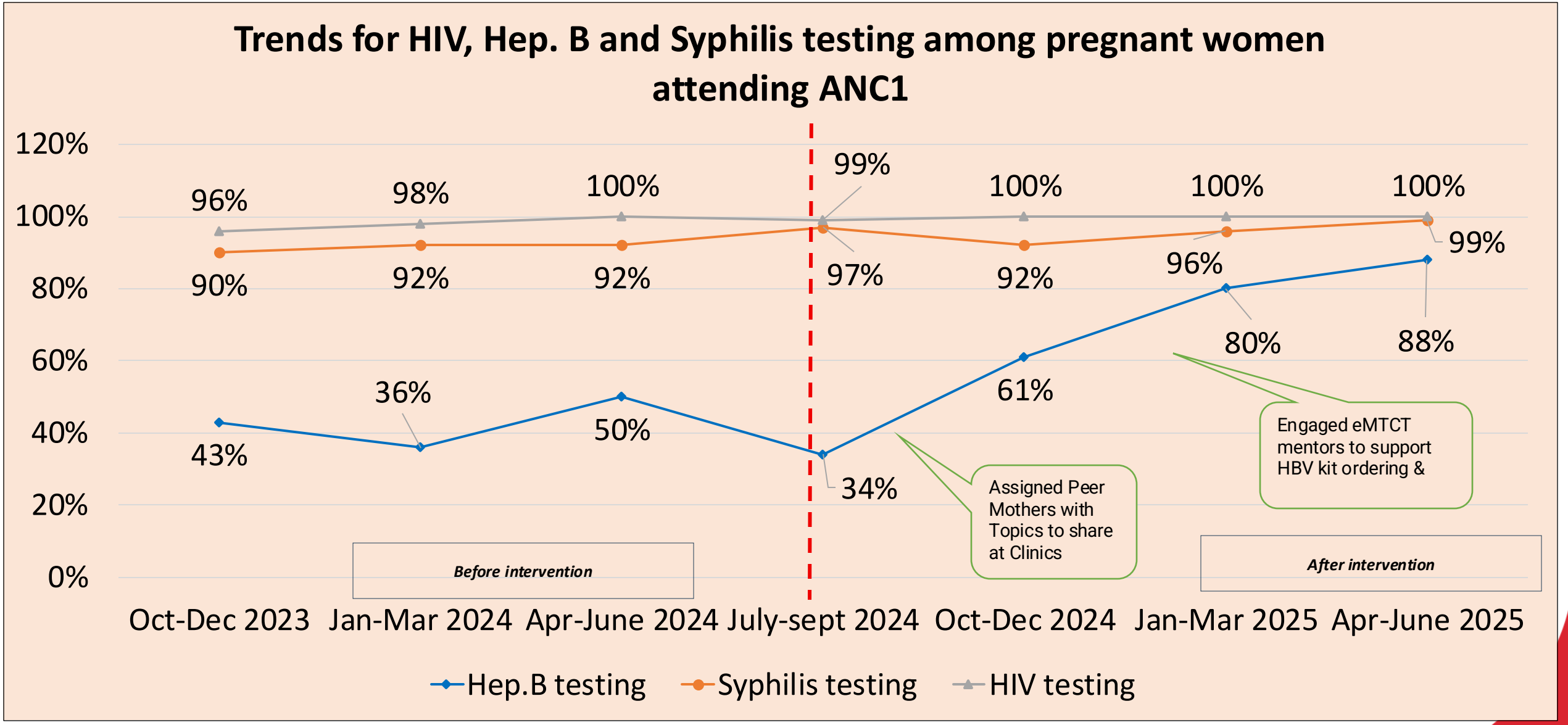
Targeted Health Education at MCH clinics

Assigned Peer Mothers with Topics to share at Clinics

Capacity Building

Engaged eMTCT mentors from high-performing facilities- supported HBV kit ordering, and redistribution during the mentorships

Results


Trends for HIV, Hep. B and Syphilis testing among pregnant women attending ANC1
120%
100%
80%
60%
40%
20%
0%
96%
98%
100%
99%
100%
100%
100%
90%
92%
92%
97%
92%
96%
99%
43%
36%
50%
34%
61%
80%
88%
Assigned Peer Mothers with Topics to share at Clinics
Engaged eMTCT mentors to support HBV kit ordering &
Before intervention
After intervention
Oct-Dec 2023
Jan-Mar 2024
Apr-June 2024
July-sept 2024
Oct-Dec 2024
Jan-Mar 2025
Apr-June 2025
Hep.B testing
Syphilis testing
HIV testing

Lessons Learned, Conclusion, and Next Steps

Lessons Learned:

- Peer-to-peer mentorship model enables knowledge transfer and sharing of best practices
- Peer mothers are resources for routine client education
- Routine stock monitoring and commodity redistribution are crucial

Conclusion:

The project demonstrates the effectiveness of peer mentorship and district-led support in improving HIV, syphilis, and HBV testing rates among pregnant women.

Next Steps:

1. **Focus on managing Hepatitis B positive cases**
2. **Improve HBV testing volumes to match HIV and syphilis testing rates**
3. **Use data to inform decisions on triple elimination performance**

Questions & Answers ❓

Tea Break ☕

15-minutes