

Evaluation of the Partnership For HIV-Free Survival Four-Country Overview: Kenya, Lesotho, Tanzania, and Uganda

Findings

This brief presents findings from the evaluation of activities related to the Partnership for HIV-Free Survival (PHFS). It focuses on eight components that contributed to the partnership's success in Kenya, Lesotho, Tanzania, and Uganda:

- Mother-baby pairs
- Mother-baby clinics
- Integration of services
- Community engagement
- Partnership
- Quality improvement
- Coaching
- Knowledge exchange

The findings are drawn largely from rapid, qualitative assessments conducted in these countries between June and December 2017 by MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

Findings from assessments in individual PHFS countries are available on MEASURE Evaluation's website, here: <https://www.measureevaluation.org/our-work/hiv-aids/evaluations-of-the-who-pepfar-partnership-for-hiv-free-survival-1>.

Core Components of PHFS

Mother-Baby Pairs

The value of linking HIV-positive mothers and their HIV-exposed infants as pairs was an early and important lesson from PHFS. Seeing the mother and child together, at a single clinical visit, and tracking their patient records jointly are two key components of this approach. These components are essential to reaching the global 90-90-90 goals of the Joint United Nations Programme on HIV/AIDS, which state that by 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of those diagnosed with HIV will receive sustained antiretroviral therapy (ART); and 90 percent of those in treatment will have viral suppression. In addition, combined record keeping made it easier for clinic staff to understand and track the health of both mother and baby. The process of combining patient records was generally

straightforward; in most cases, facilities either stapled the mother and baby patient cards together or they made notes about the baby's health on the mother's card. Although combined records did improve patient care and tracking, the overall burden of data collection remained high in most facilities, owing to the multiple registers used to record data for mothers and babies.

The concept of mother-baby pairs is not new to PHFS. It was part of the existing prevention of mother-to-child transmission (PMTCT) of HIV policy in Lesotho at the outset of PHFS. However, in PHFS countries, mother-baby pairing became a more consistent and widespread practice. Facilities demonstrated greater commitment, and governments and implementing partners in participating sites developed and carried out structured approaches to pairing.

Mother-Baby Clinics

Recognizing the value of seeing mother-baby pairs in a single visit prompted many countries to designate clinic days for HIV-positive mothers and their HIV-exposed infants. These clinic days have proven to be a highly effective way to provide care to mothers and babies participating in PMTCT programs. In Uganda, facilities established "mother-baby care points" to serve these patients; in Kenya, they designated specific "HEI Days" (HIV-Exposed Infant Days) to see mother-baby pairs. Across the four countries, special clinics and days have helped create a strong partnership between healthcare workers, outreach/community teams, and PMTCT mothers that improves health outcomes for the mother-baby pairs.

Patients experience some of the following benefits: spending less time traveling to and waiting at the clinic (i.e., one visit for the pair as opposed to separate visits for the mother and the baby); developing formal and informal support groups; developing relationships with peers during the regular visits, which helps reinforce critical behaviors such as ART retention, breastfeeding, and nutrition; and creating opportunities for partner involvement in care, including disclosure of HIV status and partner testing. Clinics see some of the following benefits: providing integrated and differentiated care, improving the quality of care and support, managing fewer appointments, and tracking patients more efficiently.

Integration of Services

A logical extension of the implementation of mother-baby clinics under PHFS was the provision of integrated services for patients seen at these clinics. Integrated services include HIV testing; antenatal care; postnatal care; ART services; MCH (maternal and child health) services; and NACS (nutrition assessment, counseling, and support). The objective is to ensure that the full range of services for HIV-positive pregnant women, HIV-positive mothers, and HIV-exposed infants are available on the designated clinic days.

Integration of services eased time pressures on service providers and improved the quality of care and support they can deliver, which, in turn, contributed to better patient experiences, better retention rates of mother-baby pairs in care, and better patient outcomes (e.g., very few HIV-positive infants). A downside of integration of services was the lack of a corresponding integration of patient record keeping. In many facilities, delivering integrated services required providers to enter patient data in many different forms and registers.

Community Engagement

Community engagement was integral to the success of PHFS. Although countries had slightly different approaches to community engagement, they all used cadres of community workers to maintain connections with participating mothers. These community workers—whether they worked in the field or in facilities—played a vital role in linking mothers with services, and their follow-up activities were a key factor in retaining mothers in care.

One critical difference in approaches among countries was whether the community workers were paid or volunteered. In Lesotho, a large cadre were employed and paid by Lesotho Network of AIDS Services Organizations (LENASO); conversely, most of the community workers supporting PHFS activities in Tanzania were volunteers, who frequently struggled to afford the transportation and air-time costs associated with their work.

Partnership

A dynamic partnership among the stakeholders involved in PMTCT had a strong positive effect on the implementation of PHFS activities in a country. In Tanzania, the national PHFS steering committee—which was led by government and included civil society and implementing partners as members—laid the groundwork for coordination and shared responsibility among stakeholders at the national, regional,

district, and community levels. In Kenya, where PHFS was primarily implemented at the country level, a less-structured but equally effective partnership among county health administrators, local health facilities, and implementing partners helped create a strong sense of purpose within individual facilities and across participating facilities at the county level.

Quality Improvement

Quality improvement (QI) activities were central and essential to the success of the PHFS approach to improving the performance of PMTCT programs. At the facility level, the basic approach to identify, implement, track, and sustain improvements in service delivery and data collection relied on QI teams, QI journals, and “change ideas.” (A change idea in the PHFS QI model is a proposed action that when implemented, is anticipated to improve an indicator and a corresponding health or service delivery outcome over a defined period.) In the PHFS approach to quality improvement, QI teams would meet once a month to assess their facility’s performance on a core set of indicators, plot the performance on run charts in their journals, and develop and implement the change ideas they wanted to address and the challenges they identified.

One of the main challenges with QI is sustaining the commitment and the activities to ensure its success. Staff must be empowered and encouraged to identify opportunities for improvement and implement solutions over the long term. There is a parallel challenge to ensure that quality improvements are sustained (i.e., quality assurance). Experience with PHFS has shown that a wavering commitment to quality improvement and quality assurance activities over time does lead to a decline in performance.

Coaching

Facility-level activities were supported by regional-, district-, or county-level coaches, who made regular visits to the hospitals and clinics participating in PHFS. Coaches were trained professionals, who were affiliated with a PHFS implementing partner, government ministry, and/or department of health. The coaches worked closely with the members of each facility’s QI team to reinforce the knowledge and skills required to identify areas for improvement, and to develop and implement solutions. Launching the QI activities at the core of PHFS would not have been possible without the participation of the coaches. Their knowledge and skills were instrumental in raising awareness of the potential of QI to improve performance and in developing the necessary systems and processes for QI at PHFS facilities. As the capacity of QI teams grew and matured, the ability of the coaches to serve as mentors and external monitors remained important.

Knowledge Exchange

Within the partnership, there were multiple platforms for knowledge exchange, and all of them made significant contributions to the effectiveness of PHFS activities. Fundamentally, the exchange of knowledge and ideas at the facility level, including input by the QI coach, was essential to improving performance. Countries also had district, county, regional, and/or national learning sessions, where QI team members from different facilities could share ideas and practical experience. In addition to using these sessions to learn from one another, staff from facilities also used them as motivation to develop and implement new approaches that would enable them to outperform their peers at other facilities.

Exchange visits, country-to-country technical assistance, and quarterly webinars contributed to the exchange of knowledge. In each country, stakeholders at multiple levels (e.g., facility, district health offices, and national ministries) recognized the value of the different ways that knowledge was shared and the importance of knowledge exchange in motivating staff and improving performance.

Conclusion

PHFS activities made significant contributions to critical patient outcomes in participating facilities. The most important contribution was a drop in the number of HIV-infected infants and children. PHFS activities helped facilities in Kenya, Lesotho, Tanzania, and Uganda implement the Option B+ approach to PMTCT (lifelong ART) more effectively and, consequently, with better results. The focus in PHFS on providing services to retain mother-baby pairs in care was a critical factor in ensuring the success of Option B+. In addition, the retention activities contributed to higher rates of viral suppression among HIV-positive mothers and better overall health of their babies.

As a result of PHFS, mothers were better informed about breastfeeding; nutrition assessments of mothers and babies were done more consistently; severe and moderate acute malnutrition (SAM/MAM) in mother-baby pairs was more systematically diagnosed and treated; and nutrition counseling improved mothers' understanding of, and ability to identify and prepare, more nutritious foods for their families.

PHFS activities also had positive effects on the implementation and tracking of PMTCT activities at the facility level, including improvements in clinic operations, patient flow, patient

experience, record keeping, data quality, and data use.

Collectively, the lessons of PHFS are a compelling example of an integrated approach to service delivery, patient outcomes, and QI that works. In participating PHFS facilities, HIV-free survival among infants and children was not only a goal, it was a reality.

Background

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Methods

For the country visits, MEASURE Evaluation developed an interview guide with topics ranging from partnership structure, activity design, and perceptions of QI, to implementation, tracking specific outcomes in identified program improvement areas, successes, and challenges. The evaluation teams gathered qualitative data on PHFS design, implementation, and scale-up/spread through interviews and discussions with key stakeholders and partners and site visits to a selection of PHFS demonstration and scale-up health facilities.

Key stakeholders and partners in Lesotho, Kenya, Tanzania, and Uganda included Ministry of Health representatives, subnational-level health representatives, the local United States Agency for International Development (USAID) mission, PEPFAR implementing partners, and on-site health facility staff. When possible, the team photographed QI journals that facility teams maintained to track PMTCT indicators and outcomes. After a country visit, the evaluation team synthesized results in the following common thematic areas across interviews: community engagement (community/patient links), efficiency, existing health system/HIV structure within which PHFS was functioning, innovation, integration of services, knowledge exchange, nutrition, partnership, quality improvement activities, reach, role of USAID, and site selection.