Evaluation of the Partnership for HIV-Free Survival Country Assessment: Mozambique

The Partnership for HIV-Free Survival (PHFS) was a six-country initiative implemented between 2012–2016. It was designed to reduce mother-to-child transmission of HIV and increase child survival. This document focuses on seven components of PHFS in Mozambique highlighted by a legacy evaluation of partnership activities. The findings are based largely on a rapid assessment conducted by MEASURE Evaluation in Mozambique in January 2018. The core components follow:

- Harmonized quality improvement
- Patient records
- Mother-baby pairs
- Breastfeeding practices
- Integration of services
- Community-patient links
- Coaching

The assessment was conducted 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 of PHFS in other participating 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 in Mozambique

Harmonized Quality Improvement

PHFS activities in Mozambique began while the Ministry of Health (MISAU) was in the process of finalizing its quality improvement (QI) strategy. The timing provided an opportunity for stakeholders to harmonize indicators through a technical working group led by the HIV QI unit. As a result, the implementation of the HIV QI strategy absorbed what would have been the scale-up phase of PHFS. The current HIV QI strategy functions in a cycle that asks facilities to track national key indicators along with a series of indicators that the facility chooses, as it works to improve the site-level baseline during the cycle. The ongoing PHFS-related QI activities were integrated in the HIV QI strategy and are not referred to as a separate element. The QI strategy is implemented in all HIV facilities in the public sector and is based on a standard of care.

When the HIV QI strategy was being rolled out, HEALTHQUAL (a PEPFAR-funded project housed at the University of California at San Francisco that was part of the PHFS) provided essential QI training to MISAU staff at the central level on QI methods: data collection, interpretation of results and reporting, production of initial work plans, upgrading of indicators, and revision of action plans if activities were unsuccessful. Additionally, HEALTHQUAL trained facility personnel in the eight PHFS demonstration sites, in some cases in collaboration with the Clinical HIV/AIDS Services Strengthening Project Sofala, Manica and Tete Provinces (CHASS/SMT). Multiple supervisory and coaching visits followed the training, which focused on tracking 11 prevention of mother-to-child transmission (PMTCT) and nutrition indicators under PHFS and was critical in building and maintaining key partnerships with facilities.

Patient Records

Facilities are supposed to collect a baseline data sample and comparative results six months later and report these data up to the district, provincial, and central levels. In the Dondo Health Center, in Sofala Province (a facility with more than 5,000 HIV patients), finding patient files to record electronically and establish a baseline proved difficult. Organizing the patient files in anticipation of the next data extraction is a key activity that facilities undertake as part of the HIV QI strategy cycle. One of their QI indicators reports the number of charts found to be complete. MISAU, which tracks cyclical progress using a sample of patient records, has identified as a challenge locating enough complete patient files to fulfill its relatively low facility-based quota.

Although demonstration site staff received training on QI methods similar to that in other PHFS countries, the MISAU hasn't maintained the explicit cycle: identifying indicator results requiring improvement, planning for change, and evaluating the success of "change ideas." Even so, in some facilities PHFS activities clearly led to greater awareness of the importance of medical record keeping, improved accuracy and completeness of patient registers, and better care for patients. This awareness has led health workers and administrators to reflect on what actions or techniques can improve the quality of service delivery. This document discusses the most significant of these innovations.

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 elements of this practice. The concept of maintaining mother-baby pairs was already integrated in Mozambique's PMTCT practices. PHFS and the HIV QI strategy broadened the practice of combined appointments for the mother-baby pairs and clearly demonstrated that it is a more efficient and effective way to see these patients.

The facilities' ability to track the pairs is a challenge in Mozambique. Mother and baby medical record cards are not kept together at the antenatal care site, but, within the clinic complex, they are kept together in the *Consulta da Criança em Risco* (CCR, Clinic for Children at Risk), where mothers and exposed infants are referred for care when the baby is one month old. The mother-baby pairs are seen at the CCR until the baby is 18 months old. If the baby is HIV-positive, she or he will also begin treatment at the CCR.

Given that mother-baby cards are not filed together in most facilities, patient tracking can be complicated. Human resource constraints add to the burden of record keeping and compromise data quality. Although integration of services and implementation of the mother-baby pair model may streamline some aspects of care, maternal and child health (MCH) nurses are still overwhelmed. However, seeing mothers and babies as pairs makes follow-up easier and helps retain women in treatment.

Breastfeeding Practices

The national goal for exclusive breastfeeding (EBF) according to the MISAU's Nutrition Department is that 50 percent of new mothers practice EBF of the infant to six months of age. The goal of 50 percent is low, in light of data showing the rate was 41 percent in 2013. The MISAU has been promoting EBF for all mothers and is seeing some improvement, especially after a mass-media campaign and involvement by the country's first lady. However, at the clinic level, shifting guidelines create confusion, and there is a need for further training of MCH nurses so that they feel confident counseling mothers. The PHFS process proposed breastfeeding indicators, but the harmonization process with the HIV QI strategy eliminated most of them from the final set. Facilities are still expected to track the percentage of babies fed breastmilk exclusively at six months.

Integration of Services

Integration of services for HIV-positive mothers and HIV-exposed infants is a fundamental component of PMTCT programs in health facilities. Integrated services include antenatal care; postnatal care; Option B+; and nutrition assessment, counseling, and support (NACS). Some clinics that were formerly PHFS demonstration facilities have assigned a staff person to direct mother-baby pairs to the different sites within the facility to receive the menu of services, which has resulted in improved patient uptake and retention.

Although NACS as a "program" was not a strong feature of PHFS in Mozambique, there is a commitment to NACS activities as a positive influence on patient outcomes. In addition, nutrition is an important part of the integrated services. There was a clear commitment to capturing growth-monitoring data and using these data as part of counseling with mothers. Some sources credited PHFS with an uptick in nutrition-related record keeping and improved ability to track patient status. Through the MISAU HIV QI strategy, which indicated that clinics should choose indicators to work on cyclically, almost half of the clinics included in the first wave chose nutritional assessment, because that was perceived to be low-hanging fruit. A sample of patient files showed increases of 30–45 percent in the number of patients receiving nutritional assessments and the number of patients receiving treatment. In Sofala Province, *Programa de Cuidados Communitários* (PCC)—under PHFS—led cooking demonstrations of enriched porridges and education sessions on topics such as infant feeding and dietary diversity. These were well received by mothers, who wanted to use locally available foods rather than buy commercial products.

A high percentage of mother-baby pairs is retained in care, and cases of HIV-positive infants have decreased to 7 percent from an estimated 25 percent. Documentation, unlike services, is not integrated, and these data are duplicated across multiple registers, if they appear at all.

Community-Patient Links

Community partners play a major role in PMTCT work, and this is most evident in Sofala Province through the PCC project and in Gaza Province through University Research Co., LLC's Applying Science to Strengthen and Improve Systems. Ongoing improvements in tracking, adherence, and retention are essential for reaching 90-90-90[1] goals and rely on the work of these community-based actors.

[1] By 2020, 90 percent of people with HIV will have been diagnosed, 90 percent of those diagnosed will be in antiretroviral treatment, and 90 percent of those in treatment will be virally suppressed (Joint United Nations Programme on HIV/AIDS, 2014: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf).

On the community side, a major initiative strengthened community structures that could be used to identify pregnant women and motivate them to initiate antenatal care earlier. Previously, the identification of women who were pregnant presented a major barrier to efforts to improve PMTCT outcomes. This initiative mobilized community leaders and local organizations and worked with them to encourage women to go to a health facility as soon as they thought they were pregnant. This approach contributed to a substantial increase in women presenting during pregnancy; they were tested for HIV and, if necessary, they were started on antiretroviral therapy (ART). Another focus of the community approach under PHFS was to refer children with low birth weight or other health problems to facilities for care and HIV testing.

Complementing this initiative, methods to track patients and document referrals and counter-referrals were developed under PHFS. At the facility, an MCH nurse would schedule follow-up visits and give an appointment card to the women, liaising with community leaders to ensure that the women came back for subsequent visits. In their respective PHFS demonstration sites, PCC and University Research Co. assigned someone to accompany the patient to the health facility to ensure they were seen and that appropriate tests were completed. The MISAU eventually adopted a referral form developed by PCC under PHFS, which the community used to refer patients to the health facility. Community-based organizations planning to use the referral forms register with the local health center to let them know to expect patients. Both community-based organizations and health centers tracked the referrals, which were designed to be used in either direction.

Peer support has also been an important aspect of community-patient links. For example, a strong cadre of women living with HIV in Beira provide counseling to pregnant women on ART adherence. Mothers 2 Mothers groups held meetings at health facilities, which allowed them to take attendance and track the women not attending. Mothers 2 Mothers groups also formed ART adherence support groups called *Grupos de Apoio a Adesão Comunitária*, also known as GAACs.

Coaching

During the life of the project in Mozambique, a senior person from HEALTHQUAL acted as a QI coach and mentor to facility staff working in the eight PHFS demonstration sites. The coaching was highly valued by the participating staff members, and it is credited with helping them understand and implement the QI principles that underlie the national HIV QI strategy. The coaching continued to be valuable even as the QI knowledge and skills at the facility level grew and matured.

In addition to the coaching at the facility level, HEALTHQUAL also maintained a coaching role with the QI team at the MISAU as its strategy was rolled out. This interaction served as a useful bridge between the realities of implementing the strategy in facilities and the challenges of managing it in the health ministry.

Conclusion

In Mozambique, support for the harmonization of a QI process and its indicators is key to the success of QI in PMTCT program implementation in facilities and other HIV services. PHFS was launched at an opportune moment and contributed to the integration of nutrition and PMTCT indicators in the national HIV QI strategy. In facilities where staff appreciate the necessity and utility of QI approaches—including developing action plans to address improvement needs—members of the QI team can track programmatic implementation changes and whether they achieve the intended improved results on a given indicator. Seeing these improvements recorded on paper increases staff buy-in and ownership of QI as an integral aspect of job duties.

Improved results are evident in regions that have supported community-based approaches to PMTCT, by motivating women to seek antenatal care earlier and supporting their adherence to treatment, along with complementary approaches, such as savings clubs or community gardening. Not all of these efforts have been sustainable following the expiration of PHFS funds, and community-based efforts have in some cases been complicated by PEPFAR's shifting targets and geographic interventions.

Ongoing support to strengthen facility-level staff ownership of QI data, development of action plans, and outcomes, along with community and facility bidirectional linkages to care and psychosocial support services, would substantially contribute to continuation of the trend to reduce mother-to-child transmission of HIV and to increase retention in ART and viral load suppression, while maximizing the survival of exposed infants.

Background

The Partnership for HIV-Free Survival was implemented in six countries in eastern and sub-Saharan Africa between 2012–2016. It was a collaboration among PEPFAR, UNICEF, and the World Health Organization (WHO) to accelerate the uptake of the WHO 2010 guidelines on HIV and infant feeding in participating countries. Although specific aims differed slightly by country, the initiative was designed to reduce mother-to-child transmission and increase child survival, through improvements in breastfeeding practices, ART uptake and coverage among HIV-positive pregnant women and mothers, and overall mother-baby care.

Rapid assessments conducted in the participating PHFS countries used a qualitative lens to examine the key activities and accomplishments. The primary purposes of these assessments were (1) to review the outcomes and potentially the impact of PHFS on PMTCT programs and related maternal, newborn, and child health activities and (2) to capture good practices from PHFS implementation that can be scaled up across the region, particularly practices pertaining to the QI approach and its contributions to epidemic control. The fundamental approaches PHFS used for QI were facility-level or department-level assessments, training, on-site technical assistance, data collection, information sharing, and follow-up support. In addition, individual countries were tasked with creating a practical and locally relevant set of metrics to track changes implemented to improve program performance.

In Mozambique, the government manages health facilities, which are considered part of the national system. The PHFS steering committee chose eight demonstration sites across three districts—Gaza, Sofala, and Zambezia Districts—supported by HEALTHQUAL. The rollout of PHFS QI efforts in these three districts roughly coincided with the MISAU's piloting of its HIV QI strategy in 56 sites.

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 were health ministry representatives, subnational-level health representatives, the local 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 into the following common thematic areas across interviews: community engagement (community-patient links), efficiency, existing health system and 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.

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