**A Practical Way to Prevent**

**Mother-to-Child**

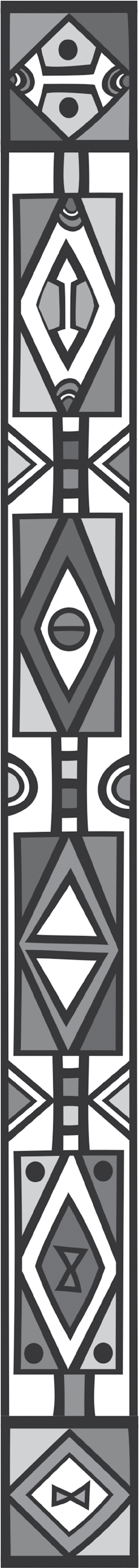
**Transmission of HIV:** Learning from the Partnership

for HIV-Free Survival

**Checklists**





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**Mother-to-Child**

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for HIV-Free Survival

**Checklists**



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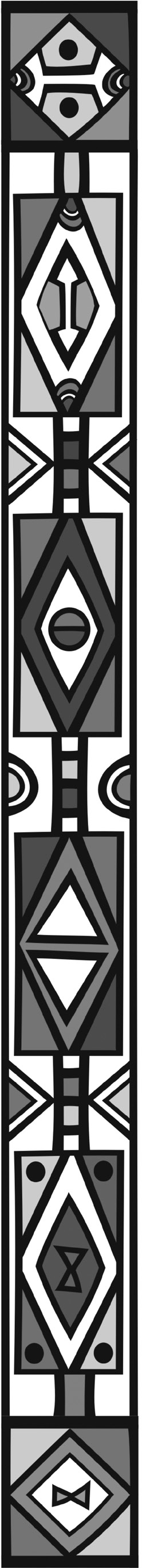
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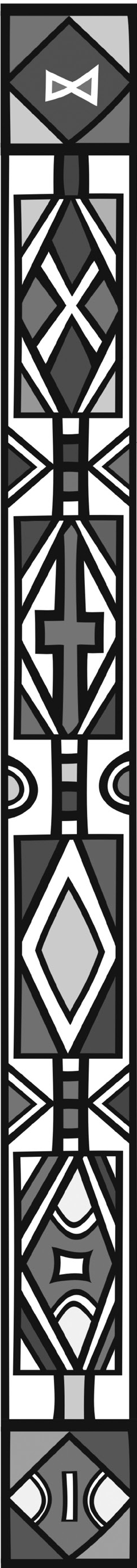
# ACKNOWLEDGMENTS

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# CONTENTS

[Acknowledgments 5](#_Toc32571140)

[Contents 6](#_Toc32571141)

[Abbreviations 7](#_Toc32571142)

[Background of these checklists 8](#_Toc32571143)

[Who should use these checklists? 9](#_Toc32571144)

[How to use the checklists 10](#_Toc32571145)

[Check out the checklists 12](#_Toc32571146)

[CHECKLIST #1: PREPARING TO LAUNCH THE PHFS APPROACH 13](#_Toc32571147)

[1. Planning and approval 13](#_Toc32571148)

[2. Site selection 14](#_Toc32571149)

[3. Community partners 14](#_Toc32571151)

[4. Technical assistance 15](#_Toc32571152)

[If technical assistance is required: 15](#_Toc32571153)

[5. Services 16](#_Toc32571154)

[6. Quality improvement practices 16](#_Toc32571155)

[7. Performance metrics and data sets 18](#_Toc32571156)

[8. Coaches and mentors 18](#_Toc32571158)

[9. Knowledge exchange 19](#_Toc32571159)

[10. Tools and training 19](#_Toc32571160)

[CHECKLIST #2: Launching the PHFS Approach 20](#_Toc32571161)

[11. Human resources 20](#_Toc32571162)

[12. Clinic logistics 20](#_Toc32571163)

[13. Operations 21](#_Toc32571164)

[14. Outreach education 21](#_Toc32571168)

[15. Messaging 22](#_Toc32571169)

[16. QI tools and techniques 22](#_Toc32571171)

[CHECKLIST #3: Sustaining the PHFS Approach 25](#_Toc32571172)

[17. Human resources 25](#_Toc32571173)

[18. QI Tools and techniques 26](#QItoolsandtechniques)

[19. Coaching and mentoring 26](#_Toc32571174)

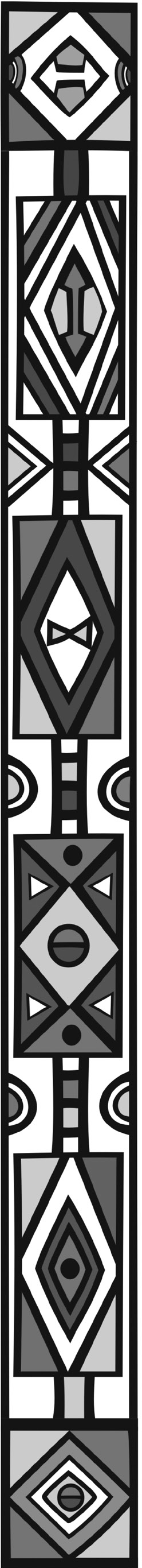
[20. Knowledge exchange 27](#_Toc32571175)

[21. Client input 28](#_Toc32571176)

[CHECKLIST #4: Extending the PHFS Approach 29](#_Toc32571177)

[22. Identifying and exploring new opportunities 29](#_Toc32571178)

# ABBREVIATIONS



ANC antenatal care

ART antiretroviral therapy

ARV antiretroviral

IYCF infant and young child feeding

MCH maternal and child health

PCR polymerase chain reaction

PDSA Plan-Do-Study-Act

PEPFAR United States President’s Emergency Plan for AIDS Relief

PHFS Partnership for HIV-Free Survival

PLHIV people living with HIV

PMTCT prevention of mother-to-child transmission

QI quality improvement

USAID United States Agency for International Development

WHO World Health Organization



# Background of these checklists

The Partnership for HIV-Free Survival (PHFS) was an innovative project designed to prevent mother-to-child transmission of HIV. PHFS brought together proven practices from prevention of mother-to-child transmission (PMTCT), quality improvement (QI), nutrition, and community outreach initiatives to improve the health outcomes for mothers living with HIV and their HIV-exposed infants. Supported by the United States Agency for International Development (USAID) and the United States President’s Emergency Plan for AIDS Relief (PEPFAR), PHFS was active from 2012 to 2016 in six sub-Saharan African countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda.

A team from the USAID- and PEPFAR-funded MEASURE Evaluation project conducted a legacy evaluation of the PHFS in 2018. We identified several compelling lessons for successful PMTCT programs from the ways the project was implemented in the participating countries. These lessons are broadly applicable to countries and facilities that are working to reduce mother-to-child transmission of HIV, increase retention in antiretroviral therapy (ART), support better nutrition practices, and improve clients’ health-seeking behaviors.

We used what we learned from the legacy evaluation to develop a manual offering guidance for identifying and implementing appropriate activities in the local context. A Practical Way to Prevent Mother-to-Child Transmission of HIV: Learning from the Partnership for HIV-Free Survival (available here: [https://www.measureevaluation.  
org/resources/publications/ms-19-182/](https://www.measureevaluation.org/resources/publications/ms-19-182/)) includes descriptions of the key lessons, tips, and an extensive checklist to help decision makers and implementers understand how and why to launch, implement, and sustain the critical activities in the PHFS approach.

We offer this separate Microsoft Word version of the checklists to make it easy for users to adapt them to their context and needs.

# Who should use these checklists?

The checklists, like the guide, were designed for use by a wide range of people and organizations involved in the HIV response, including partners in government and civil society. They were designed primarily for people who are keenly interested in improving the performance of PMTCT programs, and related activities (e.g., retention in antiretroviral therapy [ART] and nutrition assessment, counseling, and support [NACS]). Users may include health ministry directors or department heads; implementing partner technical leads; regional and district health officers; program planners in community-based organizations; and frontline health workers, to name a few. Because the checklists reflect both strategic and implementation perspectives, they can be used by people with expertise in advocacy, policy, planning, oversight, and implementation.



# How to use the checklists

The guidance manual offers an overview of the key lessons learned from the implementation of the PHFS approach to PMTCT. The checklists guide users through the approach’s implementation steps. Used together, the two components help users think through the issues and how the PHFS approach’s activities can be implemented and/or adapted for use in different contexts.

It is the responsibility of users to consider the local context when reviewing the lessons and the checklists and to consider the lessons in the local context, using this Microsoft Word version to adapt the checklists appropriately.

# Check out the checklists

The following four interrelated checklists describe the activities that should be addressed as part of the PHFS process. The checklists suggest ways to move forward with the activities, based on experience with PHFS implementation in different countries and contexts.

There is no single, right way to implement the PHFS approach. That said, most of the key activities are applicable in most settings. Some may have already been addressed in a given context, leading to focusing on other more pertinent priorities. Addressing even a few of the activities in these checklists can lead to measurable program performance improvement.

The checklists contain extensive information and directions drawn from lessons learned in the field; however, they do not necessarily address every issue or contingency relevant to a setting or situation. It is therefore important to review the issues and activities with full awareness of the local context and local dynamics. But do not be too quick to minimize or disregard any key activities in the checklists. Activities range from national planning to health facility implementation level. Each section should be reviewed to determine what is most applicable in your context.

**Checklist #1**: Preparing to launch the PHFS approach

Preparation is essential for a smooth and efficient launch of the PHFS approach in a new setting. Paying proper attention to the issues and activities in this checklist helps lay the groundwork for the implementation of the PHFS approach at national, district, and facility levels.

**Checklist #2:** Launching the PHFS approach

The success of the PHFS approach depends on the readiness and engagement of key people at district and facility levels. These people play a critical role in ensuring that the facility and its staff can support the implementation of the PHFS approach.

**Checklist #3:** Sustaining the PHFS approach

Improving the health outcomes of HIV-positive mothers and their HIV-exposed babies depend on sustaining the core components of the PHFS approach. There are specific issues that should be factored into planning and into building staff and coaching capacity to sustain the implementation of the approach.

**Checklist #4:** Extending the PHFS approach

The knowledge and skills at the core of the PHFS approach can be used to improve facility performance and client outcomes in other departments, centers, and/or programs at health centers.

## CHECKLIST #1: PREPARING TO LAUNCH THE PHFS APPROACH

Several issues should be addressed before the PHFS approach is implemented at health facilities. In most cases, these issues require that specific activities are completed and related decisions are made by relevant officials and/or managers. However, there is not a rigid sequence for addressing the different issues during this preparation phase. Work on many of the issues/activities can proceed at the same time. It is important to secure the necessary approvals for the basic proposal (sections 1.1 and 1.2) before investing substantial time in the other preparatory steps.

It is likewise important to take a common-sense approach to the preparatory work. Be sensible and resourceful. For example, identify champions and allies who can help with the activities and the approvals. Move forward with the activities that can be done more quickly and easily to build momentum for the work. Be open and available to educate stakeholders about the PHFS approach and its benefits for clients and providers. Be patient but also be persistent.

Keep in mind: The success of the PHFS approach is grounded in the provision of integrated services to mother-baby pairs at dedicated mother-baby clinics that are supported by consistent community outreach activities. Ensuring that these critical elements are in place, and having them supported by a robust QI process that is committed to the integrity of the specific activities and to the overall approach, should be the priority.

### Planning and approval

* **1.1.** Identify the key stakeholders who need to be involved in planning and approving the launch and implementation of the PHFS approach, including the designated lead stakeholder who will take responsibility for the PHFS activities.
  + In addition to overall responsibility for management and implementation of the PHFS approach at participating facilities, the lead stakeholder may also have contractual responsibilities (e.g., contracts with technical assistance providers [page 15] or the agreements with coaches and mentors [page 18]).
* **1.2.** Work with key stakeholders to develop a basic proposal that addresses how the PHFS approach’s key activities will be implemented at national and subnational levels. (Note: Key stakeholders can include HIV and PMTCT programs in national ministries or subnational departments of health, funding partners, and implementing partners.)
  + Service delivery
    - Mother-baby pairs (page 12 of the manual)
* Mother-baby clinics (page 14 of the manual)
* Integrated services (page 16 of the manual)
  + QI practices
* Facility-level use of QI tools and techniques (page 22 of the manual)
* Coaching and mentoring (page 26 of the manual)
* Knowledge exchange (page 28 of the manual)
  + Stakeholder engagement: Oversight
* Collaborative leadership
* Supervision and support systems
* Implementation plan/protocol
* Performance indicators (Appendix B of the manual)
  + Stakeholder engagement: Implementation

 Outreach activities (page 22)

* **1.3.** Secure the necessary approvals at national and/or subnational levels to allow health facilities to implement the core PHFS approach, including key activities in service delivery, QI practices, and stakeholder engagement.

### Site selection

* **2.1.** Develop a core set of selection criteria to determine where to implement the PHFS approach.  
   Key selection criteria will vary by country. Examples of relevant criteria are:
  + High rates of mother-to-child transmission
  + Low rates of participation in ANC and postnatal care
  + Low rates of retention on ART and in PMTCT care
  + Low rates of viral suppression
  + Capacity/performance of the health system
  + Capacity/readiness of a facility and its staff
* **2.2.** Use the criteria to identify facilities where the PHFS approach could and should be implemented.
* **2.3.** Conduct a rapid consultative assessment of the identified facilities to determine their capacity and readiness/willingness to implement the approach.

Note: The assessment can be conducted by a technical assistance provider.

* **2.4.** Use the results of the facility assessments, and other relevant, context-specific inputs, to select facilities at which to implement the PHFS activities.
  + Consider the proximity of sites to each other when making the selection. Clusters of sites in a given catchment area can be an efficient and effective way to provide technical support and to build capacity.
* **2.5.** Work with managers and staff at the selected facilities to plan the launch of the PHFS approach.

Issues to address are:

* + An initial facility plan to identify where and when the mother-baby clinic could operate.
  + A preliminary staffing plan that matches qualified and available staff with the different PHFS activities.
  + A basic assessment of areas where technical assistance may be required to effectively launch PHFS activities (e.g., service delivery, QI, counseling, community outreach, nutrition, data collection/quality/use).
  + A basic budget to implement the PHFS approach, including any up-front costs (e.g., facility refurbishment) and specific recurring costs that are not covered by the facilities’ operating budgets (e.g., funding for outreach workers).

### Community partners

* **3.1.** Identify and reach agreement with one or more organizations or programs in the local community (i.e., the catchment area for the participating health facility) and with the people who are willing and able to do the outreach work to support the PHFS activities.
  + Depending on the community, the organizations/programs could include a formal cadre of community health workers associated with the facility, an informal group of peer mothers, or a local organization of PLHIV.
  + The two most important factors for any partner selected are its credibility in the community and its ability to connect with clients who are (or should be) seeking services at the mother-baby clinic.
  + The key activities of the community partner are counseling/support and client tracing. Counseling/support covers several issues, including early and regular ANC for pregnant women; retention in care for mother-baby pairs; retention on ART for HIV-positive mothers; and proper nutrition for mothers, babies, and other family members. Client tracing is designed to find mothers and/or babies who have been lost to follow-up and to get them back into care and treatment.
* **3.2.** Define and establish the relationship between the health facility and the community organization(s).
  + Identify the person or persons at the facility and the community organization(s) that will be responsible for coordinating the community activities and ensuring their quality.
  + Develop a basic scope of work for the organization and its community workers, including activities, responsibilities, oversight, and accountability.
  + Develop a basic agreement between the facility and the community organization(s) covering their respective responsibilities.
  + Depending on the context, participating community organizations can be funded to provide outreach support. If funding is available, the agreement should describe the specifics of the arrangement, including any direct compensation for the community workers (e.g., stipends, travel allowances).
* **3.3.** Develop a simple training curriculum for the outreach workers to give them the knowledge and skills to provide community and household-level support to mothers.

### Technical assistance

* **4.1.** Determine whether technical assistance in any area is needed and/or available to implement the PHFS approach. Technical assistance is not a required component of the approach. Questions to consider are:
  + Are sufficient skills in place at participating facilities to implement the approach without technical assistance?
  + Can coaches and mentors provide any required technical assistance, limiting the need for specialized providers?
  + Are other technical assistance options available (e.g., online resources) that could limit the need for specialized providers?
  + Is cost-effective technical assistance available in the country and/or sufficiently near the implementing facilities to be useful?

### If technical assistance is required:

* **4.2.** Draft concise terms of reference for technical assistance providers with the capacity to provide necessary support to the facilities.
  + The terms of reference should include support for the launch of PHFS activities and their ongoing implementation.
  + Note: If coaches and mentors are going to provide technical assistance (section 4.1), the terms of reference can be used to describe the additional responsibilities.
* **4.3.** Identify and select one or more technical assistance providers with the capacity to adequately cover the different areas of expertise and the participating facilities.
  + Technical assistance providers can come from government, civil society, or the private sector. Their role is to provide as-needed support for the different aspects of the PHFS approach, including PMTCT services, QI, nutrition, and community outreach.
* **4.4.** Collaborate with the selected technical assistance provider(s) to develop an implementation plan and timeline that outline their initial and ongoing responsibilities.

### Services

* **5.1.** Create a schedule of services for clients that need to be available at the mother-baby clinic.
  + The goal should be to ensure that all relevant services are available during each visit to provide good quality of care and to make efficient use of both the clients’ and providers’ time.
  + The schedule should be aligned with national guidelines or standard operating procedures for the provision of PMTCT services to mothers and babies
* **5.2.** The services that should be on the schedule are:
  + General health and well-being (mother and child)
  + ART counseling and other services to support adherence and retention (mother)
  + ARV dispensary (mother)
  + HIV testing (early infant diagnosis, polymerase chain reaction [PCR], rapid test) (child)
  + Viral load testing (mother)
  + Breastfeeding practices (mother)
  + Growth monitoring (child)
  + Nutrition services (mother and child)
  + Family planning (mother)
  + Immunizations (child)
  + HIV testing for partners

Note: Consider whether there are other relevant services.

### Quality improvement practices

* **6.1.** Identify and agree on a simple set of QI practices that can be easily implemented at the mother-baby clinic.
  + The PHFS approach was built around the Plan-Do-Study-Act (PDSA) cycle, which is a well-known and widely used QI tool (page 22 of the manual).
  + PHFS facilities typically integrate three basic practices in a straightforward and effective approach:
* QI teams: The teams are those “who” are responsible for the QI work (page 23 of the manual).
* Change ideas: The change ideas identify “what” gets done, “when” it gets done, and “where” it gets done (page 25 of the manual).
* QI journals: The journals are a way to track the implementation and performance of the change ideas once they are implemented, including “how” and “why” they worked or did not work (page 25 of the manual).
* Note: Identifying, understanding, and tracking the “who, what, when, where, why, and how” are an essential part of every QI initiative.
* **6.2.** Identify and agree on the goals of the QI efforts. It can be useful for the objectives to be specific and ambitious. For example:
  + 95% of HIV-positive mothers retained on ART
  + 95% of mother-baby pairs retained in care
  + Basic nutrition assessments and counseling for all mothers and infants provided during every visit
  + Growth monitoring of all HIV-exposed infants performed during every visit
  + Improved completeness and accuracy of client and facility data
* **6.3.** Identify and agree on measures and data sets that will be used to track the performance of the mother-baby clinic.

### Performance metrics and data sets

* **7.1.** Identify and document a primary set of metrics and data sets that will be used to track facility performance and client outcomes.
  + Review existing metrics and data sets used at the facility level to determine what information is available and useful for tracking performance and outcomes at the mother- baby clinic. It is important to understand why the metrics and the data are useful, and how they will be used to track and improve performance and outcomes at the facility.
  + It is also important to consider how the data will be aggregated across facilities to look at broader patterns and trends in facility performance and outcomes. Drawing lessons from aggregated data may require additional qualitative data collection and analysis to understand the different contexts.
  + Determine whether current measures and/or data sets are adequate.
  + The measures should be highly practical, focusing on data that can be used to track and improve performance and outcomes.
* **7.2.** Identify and document additional measures that can be added to the primary set as facilities implement their QI activities and see performance improvements (page 34 of the manual).

### Coaches and mentors

* **8.1.** Develop a core set of qualifications for coaches and mentors who will provide support services to the facilities.
  + Key qualifications are:
* Topical knowledge and skills (e.g., PMTCT services, client counseling, QI, record keeping, and data collection/quality/use). Note: Not all coaches and mentors need to have knowledge and skills in all topical areas; however, collectively, it is important that available coaching and mentoring cover all key topical areas.
* Strong interpersonal skills (e.g., listening, verbal and written communication, collaboration/team building, problem solving, and enthusiasm/motivation).
* **8.2.** Develop the basic terms of reference or scope of work for the coaches and mentors, including an expected level of effort that considers the number of facilities supported.
  + Initially, facility and community staff are more likely to need a coach (i.e., an instructor/ teacher) to ensure that they understand the different practices, and are implementing them in an efficient and effective way.
  + Over time, staff will benefit more from having a mentor (i.e., an advisor) who collaborates with them to solve problems and improve performance.
* **8.3.**  Identify and select a roster of coaches and mentors using the core set of qualifications listed above.
* **8.4.** Agree with the selected coaches and mentors on their tasks, their level of effort, and the institutional and management support they will receive.
  + Depending on the context, the agreement may be either formal or informal. For example, a formal agreement could be a fixed contract to provide specific services. An informal agreement could be a shift in current job responsibilities enabling a coach or mentor to spend time supporting the PHFS sites.
  + Determine how the activities of the coaches and mentors will be managed, including scheduling, oversight, and accountability.
  + Determine how the coaches and mentors will be compensated for their work; (e.g., specific compensation for coaching/mentoring tasks; covered under their compensation arrangements; compensatory time).

### Knowledge exchange

* **9.1.** Identify formal and informal opportunities for frontline staff at facilities implementing the PHFS approach to share experiences and insights with colleagues in their own facility and at other facilities. Examples of knowledge exchange are:
  + Frequent (e.g., monthly) exchange of data among participating facilities seeking to improve performance in similar areas (i.e., change ideas and the corresponding run charts to track performance when the idea is implemented).
  + Regular meetings (e.g., quarterly) among QI team members at participating facilities in a specific and manageable geographic area (e.g., district; subdistrict).
  + Exchange visits between facilities.
  + Annual conference to share knowledge and experiences.

### Tools and training

* **10.1.** Use a facility assessment tool to evaluate the capacity and readiness of health facilities to implement the PHFS approach, including service delivery and QI practices. (See section 2, Site Selection, above.)
* **10.2.** Use the outline of the orientation/training program provided in Appendix A to develop

a streamlined approach to prepare facility and community staff to implement the PHFS approach. This activity can be done by a selected technical assistance provider.

* + Key topics:
* Service delivery (page 16 of the manual)
* QI practices (page 22 of the manual)
* Stakeholder engagement (page 13 of the manual)
* **10.3.** Modify/expand the above-mentioned training program to prepare the QI coaches/mentors to provide support services to facilities. This activity can be done by a selected technical assistance provider.

## CHECKLIST #2: Launching the PHFS Approach

These activities should be led by one or more people who are willing to actively promote and push for the implementation of the PHFS approach. Ideally, a group of champions would include people who work at the national, subnational, and facility levels as a way of demonstrating the breadth and depth of the commitment to the approach.

### Human resources

* **11.1.** Finalize the staffing plan for the operation of the mother-baby clinic. The staffing plan should identify who will be involved, what will they be doing, and when they will be doing it.
  + Staff assigned to the mother-baby clinic are likely to have other responsibilities in the broader facility (e.g., general MCH services) and in the staffing plan. Therefore, the operating days and times for the mother-baby clinic need to balance any competing demands on their time.
* **11.2.** Finalize the staffing plan for the outreach work, including the role of community organizations. Identify who will be involved, what they will be doing, where they will be working, and when they will be working.
  + Work closely with the community organization(s) that will provide outreach services to develop this plan.
  + Consider how facility-based and community-based outreach workers will coordinate and collaborate to provide services and retain clients in care.
* **11.3.** Identify and select staff, including facility-based and community-based workers, who will be implementing and/or overseeing the PHFS approach.
* **11.4.** Conduct an orientation and training program for the selected staff in the key activities relevant to their work. Appendix A provides an outline of an orientation/training program.

### Clinic logistics

* **12.1.** Select where the mother-baby clinic will be held at the health facility.
  + If possible, set aside a separate room (or rooms) for the clinic.
  + Consider where clients will wait for their appointments.
* **12.2.** Identify and put in place the equipment and supplies needed to provide integrated services for mother-baby pairs at the clinic.
  + Accurate weighing and measuring equipment are essential for growth monitoring and nutritional assessments.
  + Be sure to set aside secure storage for ARVs, given the high value that mothers place on picking up their drugs at the mother-baby clinic.
  + If possible, client records for the mother-baby pairs should be stored in the clinic to ensure easy access.

### Operations

* **13.1.** Designate specific days and/or times for the PHFS clinic serving pregnant women and mother-baby pairs.
  + Several factors determine when the clinic can be open, including the preferences of clients, the availability of staff, and the availability of space.
* **13.2.** Agree on what services will be available for mothers and babies at the clinic (page 16 of the manual).
* **13.3.** Set up an appointment system that can schedule and track joint visits for mother-baby pairs.
  + This system is likely to be an informal modification or workaround to the facility’s appointment system.
* **13.4.** Set up a simple record keeping system that can keep track of the mother-baby pairs, including the critical information both for mothers and babies (e.g., height/length and weight, growth monitoring, ART regimen, infant HIV test, and mother’s viral load testing).
  + This system is likely to be an informal modification or workaround to a record keeping system (e.g., client cards and registers).
  + Ensure that staff have ready access to client information both for mothers and babies at every appointment.
* **13.5.** Set up a coordination system to ensure that clinic staff and outreach workers are providing clients with consistent and complementary information, guidance, and support.
  + When clinic staff and outreach workers have a constructive and collaborative relationship, clients receive more integrated services and more effective support that extends from the clinic to their communities and homes.
* **13.6.** Set up a system for clinic staff and outreach workers to trace the mother-baby pairs who are lost to follow-up.
  + Reducing loss to follow-up is a critical component of PMTCT programs. Its success depends on close coordination and collaboration between clinic staff and outreach workers who can follow up in the community.
* **13.7.** Establish a positive, client-centered atmosphere in the clinic that makes mothers and babies feel welcome and supported.
  + The atmosphere in the clinic plays an important role in retention in care. A positive, client-centered atmosphere, combined with the delivery of good-quality services,

are an effective way of keeping mothers and babies retained in care. A welcoming atmosphere facilitates better communication between mothers and staff. It reduces stress and anxiety among the mothers and babies, encourages mothers to return for their next appointment, and encourages mothers to be more engaged in their care.

### Outreach education

* **14.1.** Develop and launch a simple, ongoing outreach education program to ensure that community members, including current and prospective clients, their partners, family members, and community influencers are aware of the benefits of the PHFS approach.
  + Topics and benefits to discuss in the outreach program are streamlined service delivery (i.e., mother-baby pairs, mother-baby clinics, and integrated services); improved health outcomes (i.e., HIV-free survival for babies and viral suppression for mothers); reduced stigma and discrimination at the mother-baby clinics; and the availability of rapid HIV tests for partners.

### Messaging

* **15.1.** Encourage mothers to continue with the mother-baby pair appointments (i.e., both mothers and babies come to all appointments) through the time of their babies’ PMTCT “graduation,” which is typically at 24 months (WHO, n.d.).
  + Ensure that mothers know the importance of the regular visits to the mother-baby clinic for services, including growth monitoring, immunizations, and HIV testing for the babies, and for general checkups for both mothers and babies to ensure their health and well- being.
  + Acknowledge the fact that some mothers will not maintain the mother-baby pair visits through to graduation, but encourage them to identify a consistent caregiver who will take responsibility for bringing the baby to his/her appointments. Even if the mother cannot continue with the mother-baby pair appointments, it is vital that the baby come to all scheduled appointments through to “graduation.”
* **15.2.** Educate mothers on the benefits to themselves and to their babies of staying enrolled and active in the PHFS program (e.g., HIV-free survival).
* **15.3.** Promote and support exclusive breastfeeding for the baby’s first six months and extended breastfeeding through 24 months.
* **15.4.** Educate mothers on the benefits of lifelong ART for themselves, including the ability of ART to reduce the transmission of HIV (e.g., the U=U or Undetectable = Untransmittable campaign).
* **15.5.** Encourage and support mothers to share and learn from each other during their time at the clinic about the health and well-being of themselves and their babies (i.e., informal support groups).
* **15.6.** Identify opportunities to bring mothers and babies together on clinic days/times to share relevant information and/or lessons (e.g., breastfeeding practices, infant/child development activities, nutritious meal planning and preparation, and the importance of HIV testing for partners).

### QI tools and techniques

The rollout of QI tools and techniques may benefit from the support of a technical assistance partner who has knowledge and experience using these tools and techniques, especially at healthcare facilities. It is important to remember that the PHFS approach was built around the PDSA cycle, which is a well-known and widely used QI tool (page 22 of the manual). In the PHFS approach, this cycle is supported by the use of QI teams, change ideas, and QI journals.

* **16.1.** QI teams: Who will participate? (page 23 of the manual)
  + Educate frontline staff, including facility personnel and affiliated community-based workers, on the reasons to implement QI practices at the clinic, including the benefits to them and to their clients (e.g., better quality services, better client outcomes, and reduced stigma and discrimination).
  + Encourage/invite a limited number of people to serve on a core QI team. The number will vary based on the size of the facility and its operations.

o Team members should have the knowledge, skills, and experience to deliver PMTCT and/or MCH services to mothers and children.

* + Encourage/invite other staff members to participate on the QI team if they have an identified need or interest.

o It is important to remember that QI is an inclusive activity, not an exclusive one.

* + Identify one or two team members to lead/coordinate the activities of the group.
  + Agree on the basic operations/activities of the QI team.
  + Schedule and hold regular meetings (e.g., once a week or once every two weeks).

o The meetings should be efficient, engaging, and interactive. They should not be hierarchical or restrictive.

* + Collect and review relevant indicator data to monitor performance on a weekly, monthly, quarterly, and annual basis.
  + Plot indicator data on run charts to better visualize performance trends.
  + Assess performance against the relevant indicators and objectives.
  + Discuss the challenges and/or barriers to improving performance.
  + Identify promising change ideas and how to implement them.
  + Track and assess the effectiveness of the change ideas to determine their effects.
  + Discuss how to sustain the relevance of the QI practices over time, including
  + identifying new issues to address as performance against existing metrics and objectives stabilizes at a high level.
  + Develop and implement a simple hands-on, learn-by-doing training program to launch the QI practices in the facility (page 22 of the manual).
* **16.2.** Change ideas: What will be done? Who will do it? When will it be done? And where will it be done? (page 24 of the manual)
  + Identify areas in which the facility is underperforming against a key metric(s). For example, only 50 percent of HIV-exposed mother-baby pairs (0–24) are in active care (e.g., they have not missed any scheduled appointments).
* Consult with the members of the QI team and other facility and community staff with knowledge and experience of both the challenge (e.g., missed appointments) and possible solutions.
* Take advantage of coaching, mentoring, and knowledge exchange to diagnose and address the issues.
* Identify, outline, and agree on change ideas that will be implemented to improve performance on the problematic metric(s), including timeframes and locations where the actions will be taken.
  + Change ideas should describe specific action(s) in sufficient detail to ensure that they are clearly understood and implemented as envisioned, including who is doing what.
  + The timeframe is applicable in multiple ways, ranging from when the change idea will be implemented (e.g., for the next three months) to when the change idea is implemented in an intervention (e.g., earlier outreach by community health workers may encourage more women to keep their scheduled mother-baby appointments).
  + Location is where the change idea will be implemented, with as much specificity as possible (e.g., in the waiting area, in the exam room, or at the mother’s home).
* **16.3.** QI journals: How and why did the change ideas work or not work? (page 25 of the manual)
  + Agree on a practical, uncomplicated form to track the change ideas implemented by the QI team.
  + Each change idea should be tracked in a separate journal.
  + Ensure that journal entries are made regularly and consistently so that the tracking information is valid and useful.
  + During meetings of the QI team, review the journals to assess the implementation and effectiveness of the change idea. Use the journals as part of the decision-making process about whether a change idea should be adopted, adapted, or abandoned.
  + Keep copies of the journals as references for future change ideas.

## CHECKLIST #3: Sustaining the PHFS Approach

The core of the PHFS approach has two interlinked sets of activities, as outlined above: (1) The ongoing delivery of integrated services to HIV-positive mothers and their HIV-exposed babies in a mother-baby clinic, including the provision of ANC for the HIV-positive pregnant woman; and (2) the use of outreach workers to provide community-based support to mothers and babies to remain in care and assist with client tracing to reduce the number of lost-to-follow-up cases.

Although these two sets of activities are essential, sustaining them depends on having a robust and rigorous QI approach that values the perspectives and input of clients, providers, and community members. The QI approach should include the consistent application of QI tools and techniques, coaching and mentoring, knowledge exchange, and community engagement.

### Human resources

* **17.1.** At least two times per year, assess the integrated staffing plan for frontline workers, including facility-based and community-based staff (that is, a plan that considers all positions together that are involved in contributing to improved client outcomes).
  + Talk directly with frontline workers about the strengths and weaknesses of the staffing plan (e.g., roles and responsibilities, number of positions, caseload/workload, quality of service delivery, client outcomes, and client satisfaction) and possible ways to improve the plan.
  + Consult with coaches and mentors about the strengths and weaknesses of the staffing plan and possible ways to improve it.
  + Use the basic QI tools and techniques to identify ways to improve the staffing plan and related issues.
  + Implement identified improvements.
* **17.2.** At least two times per year, assess the knowledge and skills of frontline staff and their managers.
  + Consult with frontline staff (i.e., facility- and community-based workers), their managers, and the coaches/mentors to determine whether the knowledge and skills of staff and managers need to be addressed/strengthened so that they are better equipped to implement the PHFS approach.
  + Use the basic QI tools and techniques to identify ways to strengthen the knowledge and skills of frontline and management staff.
  + Implement improvement activities.
* **17.3.** At least once per year, consult with frontline staff about their job satisfaction, including workload, client interactions, knowledge and skills, coaching and mentoring, QI practices, management, and compensation.
  + Consultations with frontline staff can include one-on-one interviews, group discussions, and questionnaires. It is important to confirm with staff members how they feel most comfortable sharing their views about their job satisfaction.
  + Findings from these consultations should be discussed by management at the facility level and above (e.g., district, provincial, and national levels) to determine how best to address issues that limit job satisfaction and job performance.

1. **QI tools and techniques**

* **18.1.** Hold regular QI team meetings to review performance data and identify opportunities for improvement.
  + Regular meetings may be weekly or every other week, depending on the situation. If the gap between meetings is too long, it will be difficult to track and adjust activities.
* **18.2.** Maintain updated run charts for each performance indicator.
* **18.3.** Identify and agree on change ideas that can be implemented to improve performance in specific areas.
  + For example, to reduce loss to follow-up, peer mothers should increase their contact in the community with clients who do not come to every scheduled appointment to better understand—and to help address—the reasons why they missed appointments.
* **18.4.** Implement agreed-on change ideas according to a clearly defined plan that outlines the essential “who, what, when, and where” (e.g., who will do the implementation, what will they do, when will they do it, and where will they do it?).
* **18.5.** Use a QI journal to capture information and observations about the effectiveness of the change ideas and their contributions to addressing the root problem and improving performance against the key indicator(s).
  + Adjust/refine the change idea if the results are not satisfactory.
  + Continue tracking performance to determine whether the change idea will work.
  + If a change idea is not working after it has been given a fair opportunity to succeed, including making adjustments/refinements to it, decide whether it should be dropped in favor of a new change idea.
* **18.6.** When the performance of an indicator stabilizes at a high level for an extended period (e.g., 12 months), the QI team should continue routine monitoring of that indicator to ensure that performance does not decline, but it should identify and invest more of its time and energy in improving the performance of other indicators.

### Coaching and mentoring

* **19.1.** Implement a practical plan to provide ongoing coaching and mentoring at the facility level for the QI practices.
  + Coaches and mentors should make regular visits to the facility to provide support, monitor implementation, and track results.

o The cycle of visits can and should be adjusted according to need (e.g., more frequent visits when the need is high, including when a facility is starting to implement the approach). However, it is important to keep in mind that needs are likely to change. Several issues, including staff turnover, budget allocations, clinic set-up, and client demand can affect performance.

* + Coaches and mentors should also be available by phone, e-mail, and/or text to answer questions or to share expertise.
* **19.2.** Coaches and mentors should keep frontline managers (e.g., facility and district level)   
   informed about their work. This will help ensure that the managers understand the value of   
   these activities and support their implementation over the long term.
* **19.3.** Coaches and mentors should identify straightforward and cost-effective ways to share their knowledge and experiences with each other regularly. This type of sharing can have a positive effect on the quality and utility of coaching and mentoring. It is also a useful mechanism for professional support and education.
  + Opportunities for sharing include conference calls, e-mail newsletters, blogs, basic case studies, multi district meetings, and national meetings.
  + Coaches and mentors can and should have a role in knowledge exchange initiatives implemented at the facility level (see section 20).
* **19.4.** The strengths and weaknesses of coaching and mentoring, including how they are implemented, should be regularly assessed to ensure that they continue to meet the needs of the frontline staff they are intended to support. These assessments (both formal and informal) should use the QI approach to identify issues and ways to address them.
  + When it is done well, coaching and mentoring are valuable regardless of how long a facility has been implementing the PHFS approach.

### Knowledge exchange

* **20.1.** Develop a practical and cost-effective plan for sustained knowledge exchange focused on facility-level experiences.
  + The plan should include identifying an institutional “home” and a “coordinator” with primary responsibility for implementing the plan.
  + Coaches and mentors can play a role in the knowledge exchange. However, the coaches and mentors should not guide this exchange. They can facilitate the exchange, but it is should be driven by inputs and discussion among frontline staff working day-to-day at the facilities or in affiliated outreach programs.
  + District managers can also play a role in the knowledge exchange. However, it is important that their involvement does not limit the scope of the exchange in any way. Effective knowledge exchange is an open and free-flowing exercise in which a wide range of ideas and approaches are presented and discussed.
* **20.2.** Ensure that the necessary resources, including staff time and funding for activities, are allocated to support knowledge exchange.
  + Securing sustained funding for knowledge exchange is likely to require a strong advocacy campaign that clearly demonstrates its value, including examples and testimonials from frontline staff, coaches, mentors, and managers.
  + Despite widespread recognition that knowledge exchange was an important part of the success of the PHFS, the resources allocated for it were frequently cut or eliminated over time. Consequently, it is vital to continue to demonstrate its value with testimonies and success stories from the field.

### Client input

* **21.1.** At least once per year, collect input (e.g., through interviews or questionnaires) from clients about their experiences at the mother-baby clinic.
  + Correlate client input with findings from other exercises, including human resource assessments (sections 17.1, 17.2, 17.3) and observations from frontline staff, management, coaches, and mentors.
  + Identify possible changes to activities and approaches based on client input and, where warranted, field test the changes to see whether they yield the intended results. If the results are positive, test and implement the changes widely.

## CHECKLIST #4: Extending the PHFS Approach

“Extending the PHFS approach” specifically refers to using the underlying knowledge and skills in other departments, centers, and/or programs in health facilities that are implementing the PHFS approach in their PMTCT program. Potential opportunities to extend the PHFS approach are the operation of ART centers, with a particular focus on retention in treatment and care; noncommunicable disease programs (e.g., high blood pressure; diabetes), again with a focus on retention in treatment and care; and MCH programs, with a focus on retention in care.

The capabilities of frontline staff who are implementing the PHFS approach can and should be leveraged to improve performance and outcomes in other areas of facility operations. In addition, the basic approach (i.e., providing integrated services to clients with similar circumstances and using simple QI practices to continually improve the provision of those services) can be useful in different types of facilities, ranging from rural health centers to urban hospitals. The key is capable frontline staff who have the resources and support to implement the approach.

Note: Technically, the PHFS approach can also be extended by implementing it in an increasing number of sites in a given area, either national or subnational. The larger the number of participating facilities, the greater the impact on HIV-free survival among HIV-exposed infants. The overall knowledge and skill bases will also be strengthened if more facilities and health workers are implementing the different aspects of the approach.

### Identifying and exploring new opportunities

* **22.1.** Identify departments, centers, and/or programs in health facilities implementing the PHFS approach where the approach could be adapted to improve performance and outcomes.
  + Consult with frontline staff who are using the PHFS approach about departments, centers, and/or programs that could implement an adapted version of the approach.
  + An initial assessment of these opportunities should be done at the facility level, where frontline staff have the best perspective on where and how to adapt the PHFS approach in their facility.
  + Current management structures are likely to require facilities to get agreement/sign-off from a higher level (e.g., district or above).
* **22.2.** Discuss the opportunity to adapt the PHFS approach with managers and staff of possible departments, centers, and/or programs.
* **22.3.** If an agreement is reached to extend the PHFS approach to another department, center, and/or program, develop an implementation plan for who will be involved and how, including staff and managers experienced with the approach, their counterparts in the new department/center/program, and coaches/mentors.
  + Although coaches and mentors will play an important role in adapting the approach, the role of experienced frontline staff is essential. Their ability to relate to their counterparts will be critical in the adaption and implementation process.
  + The implementation plan should outline how experienced PHFS staff will allocate their time during this process and how they will be compensated for their role.
  + The plan should also outline a basic timetable for the process of sharing the requisite knowledge and skills and supporting capacity building in the new setting.
* **22.4.** Organize a series of meetings between PHFS staff and their counterparts to discuss how the PHFS approach will be adapted.
  + It is likely that the initial adaptations will require some trial and error to determine the most effective way forward. However, it is vital to stay true to the intent and spirit of the PHFS approach.
* **22.5.** Ensure that the entire adaptation process is seen as a collaborative exercise that respects the knowledge and experience of all participants.
* **22.6.** Once the adaptation process is under way, it is important to stay true to the steps and activities of the core PHFS approach as much as possible, including steps in this checklist under Preparing to Launch the PHFS Approach (page 13), Launching the PHFS Approach (page 20), and Sustaining the PHFS Approach (page 25).

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