Evaluation of the Partnership For HIV-Free Survival
Country Assessment: Lesotho

Findings

This brief on findings from the evaluation of activities related to the Partnership for HIV-Free Survival (PHFS) in Lesotho focuses on seven components:

- Mother-baby pairs
- Breastfeeding practices
- Integration of services
- Community-client links
- Quality improvement
- Coaching
- Quality improvement versus quality assurance

Findings are drawn largely from a rapid assessment conducted in Lesotho in September 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 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 Lesotho

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 client records jointly are two key elements of this practice. The concept of maintaining mother-baby pairs was already codified in Lesotho's national prevention of mother-to-child transmission of HIV (PMTCT) guidelines. PHFS accelerated 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 clients. Many—but not all—facilities in Lesotho see mother-baby pairs on special days or at special times. The facilities' ability to track the pairs and the approach they use are challenges in Lesotho. For example, most facilities do not have separate client cards for babies. (A notable exception is in Thaba Tseka District, where Baylor University introduced cards for HIV-exposed infants.) Consequently, mother-baby cards are not filed together in most settings, which complicates client tracking.

Breastfeeding Practices

Staff in health facilities express high levels of confidence that women exclusively breastfeed for six months, based on a longstanding "culture of breastfeeding" in Lesotho. However, this level of confidence is at odds with parallel reports about mothers leaving babies with grandmothers or aunts to work in other locations. In addition, there was limited interest in tracking breastfeeding through 24 months. Health center staff observed that HIV-positive mothers typically stopped breastfeeding at 18 months.

Integration of Services

Integration of services for HIV-positive mothers and HIV-exposed infants is a fundamental component of PHFS/PMTCT programs in health facilities. Integrated services included antenatal care; postnatal care; Option B+ (lifelong antiretroviral therapy [ART]); and nutrition assessment, counseling, and support (NACS). Integrated services are often delivered on special days for mother-baby pairs, which mothers reportedly prefer, because it reduces the number of visits to the health facility, saving time, effort, and money. Offering integrated services on designated days also leads to the formation of formal and informal support groups among HIV-positive mothers.

Although NACS as a "program" was not a strong feature of PHFS in Lesotho, there is a commitment to NACS activities as a positive influence on client 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. "Nutrition corners" exist in many facilities, where all mothers can get information on topics such as dietary diversity, food preparation, and making better use of local/readily available foods.

A high percentage of mother-baby pairs are retained in care, and cases of HIV-positive infants are rare. Documentation, unlike services, is not integrated, and these data are duplicated across multiple registers.

Community-Client Links

Community partners play a major role in PMTCT work in Lesotho. Ongoing improvements in tracking, adherence, and retention rely on the work of these community-based actors and are essential for reaching the global 90-90-90 goals: 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 ART; and 90 percent of those in treatment will have viral suppression. Village health workers are key to implementation, particularly tracking and retention. Even though they are volunteers, they have broad health responsibilities in their villages; HIV/PMTCT make up only part of their responsibilities. The Lesotho Network of AIDS Services Organizations (LENASO), which is the main organization supporting people living with HIV in the country, has a large cadre of paid staff nationwide to provide different types of support, including tracking, adherence, and retention. A small cadre of paid staff work on behalf of the organization mothers2mothers in facilities and communities. These staff are not as widely placed or utilized as village health workers or LENASO staff.

Quality Improvement

Quality improvement (QI) was the focus of PHFS in Lesotho. The delayed rollout of PHFS limited the traction of the PHFS name; the ongoing work, including QI activities, is now generically referred to as PMTCT and, most important, it appears to be the standard of care.

The role of QI coaches—engaged by University Research Company, LLC (URC) under USAID's Applying Science to Strengthen and Improve Systems (ASSIST) project—was critical in building and maintaining key partnerships with facilities and district health management teams. The leadership and management of ASSIST were equally responsible for maintaining the partnership with the government.

ASSIST established QI teams at each facility, with support from a designated QI coordinator on the district health management teams (DHMTs), and through ASSIST district and national coordinators. Facilities maintain QI journals, which identify areas for improvement; "change ideas" (actions to achieve the intended results); and start/end dates for implementation of each change idea, with monthly progress tracked on a line graph. The focus is on the three core PHFS indicators: retention of mother-baby pairs in care, standard package of services, and data quality.

When ASSIST opened its office in Lesotho, the project encouraged facilities to have bimonthly QI meetings to strengthen their QI efforts. Now, facilities and DHMTs tend to have QI meetings once a month. Reports from ASSIST indicate that increasing the frequency of supervision and coaching visits to districts by the national ASSIST staff during the months leading up to project closeout substantially improved facility performance on their chosen indicators.

Coaching

Coaches from ASSIST played a vital role in establishing QI teams and activities at the facility and district levels, creating a de facto network of implementers supported by the ASSIST coaches. In many cases, the "coaching" went far beyond technical assistance, with ASSIST coaches helping to carry out QI tasks in facilities. These coaches often functioned as consultants who helped facility staff address problems. The important role of these coaches in sustaining facility- and district-level activities, as well as their parallel role as the backbone of the de facto network, raises concerns about their loss in the ASSIST closeout and questions about whether another partner will support this activity. Facility staff coaches are also part of the approach in Lesotho, but they are far less visible or active, given the role that ASSIST has played.

Quality Improvement versus Quality Assurance

The Ministry of Health had an office dedicated to quality assurance before the launch of PHFS, which focused on issues of data quality. The establishment of PHFS was an opportunity for the ministry to add a QI role, and it has used the success of PHFS to make the case for QI more broadly in the health sector. Facility staff who were able to see positive results from QI activities were more invested in the work, but most had not reached a level of achievement in the selected indicators to transition to primarily being able to monitor consistent high-level performance rather than requiring continued attention to improvement. There does not appear to be much facility-led innovation in Lesotho. However, the health ministry's ethos of quality could be considered an important innovation that influences multiple activities at the facility level. For example, one district (Thaba Tseka) used the QI journal method to improve the consistency of commodities management—in particular, timely submission of orders for antiretroviral drugs—and the recorded improvements indicate that the district will be positioned to transition to maintenance-level monitoring over time.

The evaluation team observed that the PEPFAR country team had implemented Site Improvement through Monitoring System (SIMS) visits in some sites visited during this assessment. One site specifically indicated that the process had been helpful. This MEASURE Evaluation assessment, however, focused on the "how" of PHFS implementation, rather than a SIMS-style intensive audit of PEPFAR program Core Essential Elements or a review of SIMS findings.

Conclusion

In Lesotho, support for QI training, coaching, supervision, and mentoring is key to the success of QI in PMTCT program implementation in facilities as well as in other HIV and health departments. In facilities where staff have bought in to the necessity and utility of QI approaches, 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. Applicability beyond PMTCT has become evident, but facility staff and members of the district health management teams emphasized the need for ongoing support to ensure sustainability and eventually adopt a culture of quality improvement and assurance. This support will substantially contribute to continuation of the near-zero numbers of mother-to-child transmission of HIV and (perhaps more important at this stage of Lesotho's epidemic) to increased retention in ART and viral load suppression, while maximizing the survival of exposed infants.

The general embrace of QI to improve service delivery and client outcomes has had a broad effect on PMTCT services in the country. In many ways, it is the commitment to or the ethos of quality that is the most important legacy of PHFS in Lesotho. Facility staff seem genuinely interested in improving and maintaining the quality of service delivery, despite many challenges.

Background

The Partnership for HIV-Free Survival was implemented in six countries in eastern and southern Africa between 2013 and 2016. PHFS 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: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. Although specific aims differed slightly by country, the initiative was designed to reduce mother-to-child transmission of HIV 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 that MEASURE Evaluation conducted in participating PHFS countries used a qualitative lens to examine key PHFS 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, child health, and nutrition activities, and (2) to capture good practices from PHFS implementation that can be scaled-up across the region, particularly pertaining to the QI approach and its contributions to epidemic control.

Fundamental PHFS approaches to QI were facility-level or department-level assessments of PMTCT services and outcomes, QI training for staff, on-site technical assistance, routine data collection and reporting, information sharing, and follow-up support. At the start of PHFS, each participating country created a practical and locally relevant set of metrics to track changes implemented to improve program performance.

In Lesotho, health facilities are managed either by the government or by the Christian Health Association of Lesotho, and all are considered part of the national system. There are some inconsistencies in quality of service delivery across the two providers' facilities, and across districts (including performance of regional laboratories) that may contribute to variation in the success of QI implementation. The PHFS steering committee based initial site selection on need (i.e., higher rates of HIV-positive infants), deciding on four demonstration sites in each of three districts—Maseru, Mohale's Hoek, and Thaba Tseka Districts—plus, eight scale-up sites, in Butha Buthe District. The ASSIST project ultimately rolled out its QI approach to all districts.

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 Ministry of Health 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 in the following common thematic areas across interviews: community engagement (community/client links), efficiency, the health system/HIV structure within which PHFS was functioning, innovation, integration of services, knowledge exchange, nutrition, partnership, QI activities, reach, the role of USAID, and site selection.

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