

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

Findings

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

- Mother-baby pairs
- Mother-baby care points
- Integration of services
- National policy
- Quality improvement
- Coaching
- Knowledge exchange

The findings are based largely on a rapid assessment conducted in Uganda in October 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-freesurvival-1>.

Core Components of PHFS in Uganda

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 Uganda, patient records for a mother and her baby were combined by simply stapling them together and filing them under the mother's ID. The combined records had a clear and positive effect on patient care and tracking, including reducing the time required for recording data. However, the overall burden of data collection remained high in facilities,

owing to the multiple registers used to record data for mothers and babies.

Mother-Baby Care Points

Recognizing the value of seeing mother-baby pairs in a single visit led to the development of designated "mother-baby care points" for HIV-positive mothers and their HIV-exposed infants. These care points proved to be a highly effective way to provide services to the mothers and babies enrolled in the facility's prevention of mother-to-child transmission (PMTCT) program. The care points helped create a practical partnership between healthcare workers, outreach/community teams, and mothers, which helped improve retention of mother-baby pairs in care and contributed to better health outcomes for the mothers and babies.

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 adequate infant feeding; 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 antenatal care; postnatal care; PMTCT Option B+; and nutrition assessment, counseling, and support (NACS). The objective was to ensure the full range of services for HIV-positive pregnant women, HIV-positive mothers, and HIV-exposed infants were available when they came for their clinical visits.

The integration of services eased time pressures on service providers and helped improve the quality of care and support they could 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). The integration of services was so successful that the Ministry of Health moved quickly to include this approach in the national policy for the operation of mother-baby care points.

Although PHFS did focus on improving data quality, the challenges of integrating patient record keeping were never fully addressed, in large part because of the mandated use of multiple government registers that needed to be completed for mothers and babies.

National Policy

One of the most important—and most successful—aspects of the PHFS program in Uganda was the early recognition by the Ministry of Health of the high value of key components of the approach and the accelerated inclusion of these components in national policy and standard operating procedures. These key components included mother-baby care points, combined patient records for the pair, and integrated care for the pair. The willingness of the Ministry of Health to move quickly to institutionalize the critical components of the PHFS approach meant that many health facilities in Uganda, including those not directly involved with PHFS, were able to adopt the core approaches and see the corresponding benefits in patient care and clinic operations.

Quality Improvement

PHFS was widely seen as a quality improvement (QI) project in Uganda, with a clear focus on improving the quality of life of pregnant women and mothers and decreasing the number of infants who became infected with HIV. Stakeholders at national, regional, district, and facility levels recognized early on that the QI approach was an effective way to improve their PMTCT programs, including routine nutrition assessments for participating women and babies.

At the facility level, the basic approach relied on QI teams, QI journals, and “change ideas” to identify, implement, track, and sustain quality improvements in service delivery and data collection. (A change idea in the PHFS QI model is a proposed action that, when implemented, is anticipated to improve an indicator outcome over a defined period.) The QI teams met 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 change ideas to address identified challenges or underperformance.

In high-performing sites, the sustained attention to quality improvement led to the development of an ethos or “culture of quality” that had a positive effect on all aspects of the care point. In one facility, the commitment to quality had led to the use of a regular patient survey that identified areas to improve the patient experience and the quality of service delivery.

Coaching

Facility-level activities were supported by QI coaches—engaged by University Research Company, LLC (URC) under USAID’s Applying Science to Strengthen and Improve Systems (ASSIST) project—and the district health management teams, who made regular visits to the hospitals and clinics participating in PHFS. 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 develop and implement solutions. In Uganda, facility staff had high praise for the quality and contributions of the coaches and for the professional rapport they were able to develop with the coaches.

As the capacity of QI teams within facilities grew and matured, mentorship and monitoring by the coaches continued to be an important component of the QI approach. This mentorship was effective even in facilities where key staff had gained the knowledge and skill in implementing QI practices to serve, effectively, as on-site coaches. In certain sites, there was a telling counterfactual: when competent coaching was less available, the quality of PMTCT implementation declined.

Knowledge Exchange

PHFS learning sessions were held at district, regional, and national levels. Participants placed a high value on these sessions, regardless of level. The ability to learn from peers had a significant impact on the participants’ understanding and appreciation of QI, in general, and how it could be used to improve performance and outcomes at the facility level. The sessions were also a forum for generating specific ideas for activities or actions to address underperformance. In addition, the sessions bred a healthy sense of competition between facilities that contributed to the enthusiasm of the staff and their commitment to QI activities.

PHFS stakeholders in Uganda also played an important role in international knowledge exchange, including the provision of peer-to-peer technical support to the PHFS program in Lesotho in 2015.

Conclusion

Within the six-country Partnership for HIV-Free Survival, Uganda was the fast mover. Stakeholders from government and nongovernment organizations, even those with more of a focus on the community level, moved quickly to implement and support activities at the facility level. When the activities began to show results, the Ministry of Health took steps to institutionalize key components of the PHFS approach (e.g., care points, paired records, and integrated care) so that facilities across the country could strengthen their PMTCT programs.

The strong commitment to QI, epitomized by the hard work—and the joint work—of QI teams at the facility level and the QI coaches who supported them, played a pivotal role in identifying and sustaining efforts to improve patient outcomes for mothers and babies alike. The fact that PHFS facilities saw a significant decline in the number of HIV-infected infants and children is a testament to the combination of the Option B+ approach to PMTCT and a sustained commitment to quality improvement activities.

The success of PHFS in Uganda has also contributed to the integration of QI activities in other development projects funded by the US government. For example, the Regional Health Integration to Enhance Services in Eastern Uganda (RHITES) project in Eastern Uganda and Southwestern Uganda has not only included QI as a core activity, it is leveraging the expertise developed under PHFS by using QI team members in facilities to train and mentor colleagues working in other services within the clinic/hospital.

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 the 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 Uganda, PHFS was implemented in 22 demonstration sites and 56 scale-up sites in six districts (Jinja, Manafwa, Namutumba, and Tororo in the Eastern Region; Kisoro and Ntungamo in the Western Region). Key partners included ASSIST (URC), Food and Nutrition Technical Assistance Project (FANTA) (FHI 360), Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) (JSI), The AIDS

Support Organization (TASO), the Uganda Ministry of Health, and USAID. The launch of PHFS activities coincided with the rollout of the Option B+ approach to PMTCT in Uganda. In the six PHFS districts, the overlap of PHFS and Option B+ activities and approaches was a powerful and effective combination.

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 included 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 into 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.