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

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 South Africa highlighted by a legacy evaluation of partnership activities. The findings are based largely on a rapid assessment conducted by MEASURE Evaluation in South Africa in January 2018. The core components follow:

- Government engagement
- Continuous quality improvement
- Mentoring
- Knowledge exchange
- Integration of services
- Mother-baby pairs
- Nutrition

The assessment was conducted by MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and 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 South Africa

Government Engagement

Government engagement with PHFS in South Africa was strongest at the provincial, district, and subdistrict levels. PHFS implementing partners—such as the Centre for Rural Health at the University of KwaZulu-Natal and South to South (S2S) at Stellenbosch University—had solid relationships with government colleagues in the Departments of Health at these levels. These were symbiotic relationships between the implementing partners and their government counterparts that created a culture of quality improvement (QI) and data use at the facility level. Government engagement with PHFS activities at district and subdistrict levels had a strong practical focus on facility performance and patient outcomes. The targeted training and technical assistance provided by PHFS partners supported and sharpened this focus while also helping raise the profile of QI more generally.

The name "PHFS" was rarely used to identify or describe the project when it was active in South Africa. The work was seen more generically as an integrated approach to QI and prevention of mother-to-child transmission (PMTCT) of HIV, focused on improving performance and outcomes.

Practical and productive engagement with government managers and implementers is a compelling legacy of PHFS in South Africa. Government counterparts who participated in the program continue to use core knowledge and skills that were part of the partnership activities, including, for example, straightforward QI approaches such as Plan-Do-Study-Act (PDSA), the cause-and-effect ("fishbone") diagram, and the Five Whys.[1] The approaches were taught and have continued to be useful when a primary healthcare facility is implementing the standards of patient care included in the country's Ideal Clinic program. Ideal Clinic is a nationwide initiative launched by the national Department of Health shortly after the start of PHFS, which uses QI practices to make wide-ranging improvements to clinic operations: administration, clinical policies and practices, infrastructure, staffing, and supply chain.

Continuous Quality Improvement

PHFS, which was modeled after interventions pioneered by 20,000+ in South Africa—a partnership to reduce perinatal transmission of HIV—is widely seen as a QI project with a clear focus on delivering effective services for HIV-positive pregnant women, HIV-positive mothers, HIV-exposed infants, and a decreasing number of HIV-positive infants. Stakeholders at all levels recognized that the QI approach is an effective way to improve PMTCT programs and felt it was a worthwhile investment of their time and energy.

[1] PDSA, the fishbone diagram, and the Five Whys are proven QI tools that have been widely implemented in multiple sectors. They are straightforward tools that can be used easily and productively by frontline staff. For example, Five Whys asks participants to iteratively ask the question "Why?" to determine the root cause of a problem that implementers are trying to solve.

At the facility level, the implementing partners relied on straightforward and proven QI approaches to help teams identify problems, challenges, and possible solutions. The partners introduced tools such as PDSA, the fishbone diagram, and the Five Whys; they worked with facilities to organize, train, and mentor QI teams; they provided support to improve data systems, including the development and use of run charts to track progress; and they worked with facilities to identify and implement opportunities to improve quality.

The focus was on continuous quality improvement (CQI), which charged facility managers and QI teams with sustaining successes and identifying new opportunities to improve service delivery and patient outcomes. The more dynamic nature of CQI also meshes with the activities and milestones required to reach and maintain Ideal Clinic status.

Mentoring

Initial and follow-up training played an important role in building the knowledge and skills of staff members at participating PHFS sites. However, there was a strong consensus among district, subdistrict, and facility staff that the QI mentoring provided by coaches from the PHFS implementing partners (e.g., Centre for Rural Health and South to South) was even more important than the training. Facility staff placed a high value on the practical, on-the-job aspects of mentoring, which they saw as valuable in helping them translate QI theory into sustained practice.

An equally high value was attached to mentoring at the subdistrict and district levels for Department of Health staff who are responsible for managing and supporting primary healthcare facilities. Mentoring was important, because PHFS approaches were relevant to the rollout, management, and continued improvement of Ideal Clinics.

Knowledge Exchange

Facility staff benefited from opportunities to share knowledge and experiences with their peers at different health centers. The ability to learn from each other had a significant impact on people's understanding of how QI could improve performance and outcomes at the facility level.

The South Africa Department of Health's decision to introduce weekly "nerve center" meetings at facility, subdistrict, and district levels in 2017 reinforced the value of the PHFS learning sessions. These weekly reviews of clinic performance across a set of key indicators, including eight PMTCT indicators, are another opportunity to review and share data and identify opportunities for improvement within facilities, across facilities in a subdistrict, and across subdistricts.

Integration of Services

In recent years, health facilities in South Africa have taken an increasingly integrated approach to service delivery, including integrated services within maternal and child health (MCH). The ongoing rollout of the Ideal Clinic program, which is premised on the added value of integrated services, is a clear demonstration of the country's commitment to this approach. PHFS was an early and strong proponent of integrated PMTCT services: antenatal care, postnatal care, PMTCT Option B/B+, and nutrition. The objective was to ensure that the full range of services for HIV-positive pregnant women, HIV-positive mothers, and HIV-exposed infants would be available when they came for their clinical visits.

Integration in the Ideal Clinic program (i.e., Integrated Clinical Services Management) is designed to ease time pressures on service providers and help improve the quality of care and support they can deliver, which in turn contributes to better patient experiences, better patient engagement, and better patient outcomes. In the context of PMTCT, service integration—as implemented under PHFS and Ideal Clinic—has contributed to better treatment retention, improved nutrition knowledge, and fewer HIV-positive infants.

Mother-Baby Pairs

PHFS helped demonstrate the benefits of linking HIV-positive mothers and their HIV-exposed infants as pairs for their regular clinical visits. Seeing mother-baby pairs at a single visit—as opposed to separate visits for mother and baby—was recognized as a more efficient and effective way to see these patients. In addition, integrating patient records made it easier for clinic staff to understand and track the health of both mother and baby and ensure benchmarks were being met (e.g., PCR testing in line with national protocol). South Africa also recognized the broader value of pairing mothers and babies for clinic visits and now sees all mothers and babies as pairs, regardless of their HIV status. This approach underlies the MCH "stream" in the Ideal Clinic program being deployed across the country.

The caveat in South Africa is that mothers and babies are typically seen as pairs only until the baby is 14 weeks old, because of other demands on the mothers' time. After that, most mothers rely on alternative caregivers (e.g., grandmothers) to take the baby to his or her regular appointments. Because of the competing demands on mothers' time, all PHFS countries struggle to see pairs over a longer term, but South Africa is more open about the realities and challenges of this situation. Healthcare workers recognize the advantages of extending the time when mother-baby pairs are seen together (e.g., ongoing treatment counseling for the mothers), but there is an implicit understanding that seeing pairs for a shorter period did not diminish the value of the approach.

Nutrition

At the facility level, nutrition was an integral component of the PHFS approach. In general, there was an emphasis on encouraging exclusive breastfeeding among HIV-positive mothers, given the high percentage of mothers who introduce supplemental feeding around 14 weeks after birth. In addition, there was expanded counseling and support on proper nutrition practices for child development and a healthy lifestyle. With small numbers of undernourished people presenting at participating facilities and high rates of overweight and obesity in South Africa, identifying and treating undernutrition was a low priority, even though it is a core component of the NACS (Nutrition Assessment, Counseling, and Support) work under PHFS.

At a strategic level, the nutrition component of PHFS was not particularly robust. PHFS was seen by most stakeholders as primarily a QI project, which limited its ability to link with other, broader nutrition activities in participating provinces. For example, nutrition is a health priority in KwaZulu-Natal, but there were no serious efforts to link PHFS with the nutrition activities or metrics in the province, including actions to address the high levels of stunting.

Legacy

In South Africa, implementing partners were able to leverage comparable activities that were already under way in the country. For example, 20,000+, which was implemented in KwaZulu-Natal with a focus on data use and quality improvement in PMTCT, was essentially a precursor to the PHFS approach and many of the same people who worked with 20,000+ shifted to PHFS activities. Similarly, work being done by South to South in QI improvement helped shape the implementation of PHFS activities in the Eastern, Northern, and Western Cape.

The straightforward approach used by PHFS in South Africa, including widely available, open-source QI tools and methods, was seen as a positive aspect of the approach, because it was more accessible than other proprietary systems. In addition, the practical focus on results (e.g., better data quality, better data use, and better patient outcomes) resonated with the PHFS stakeholders. Declines in the number of HIV-positive infants and children at participating facilities is a testament to the combination of the Option B/B+ approach to PMTCT and a commitment to QI activities. However, continued poor performance in other areas—e.g., stubbornly low rates of exclusive breastfeeding for six months and late initiation of antenatal care—show the importance of comprehensive and continuous QI efforts over the long term.

In the provinces where it was active, PHFS made an important contribution to to the dialogue about, and the implementation of, QI in health facilities. PHFS showed it is possible to effectively integrate basic QI practices in day-to-day operations in ways that the Ideal Clinic program is now doing more broadly. The success of PHFS activities in South Africa was based on its ability to leverage similar work already being done in the country. The legacy of PHFS in South Africa is that other initiatives are leveraging its experiences to build a sustainable approach to QI and PMTCT work.

Background

PHFS was implemented in six countries in eastern and southern Africa between 2012–2016. It was a collaboration among USAID, PEPFAR, WHO, and UNICEF to accelerate the uptake of the WHO 2010 guidelines on HIV and infant feeding in the 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, treatment uptake and retention among HIV-positive pregnant women and mothers, and overall mother-baby care.

In South Africa, PHFS was implemented at sites in four provinces: Eastern Cape, KwaZulu-Natal, Northern Cape, and Western Cape. Key partners were the Centre for Rural Health (University of KwaZulu-Natal), FHI 360, IHI, Provincial Departments of Health, South to South (Stellenbosch University), and USAID.

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 mother, newborn, and child health and nutrition 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 QI approaches that PHFS used 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.

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 Department 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/patient links), efficiency, existing 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.

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. FS-18-266