



REPUBLIC OF KENYA



KINGDOM OF LESOTHO



REPUBLIC OF MOZAMBIQUE



REPUBLIC OF SOUTH AFRICA



UNITED REPUBLIC OF TANZANIA



REPUBLIC OF UGANDA

THE PARTNERSHIP FOR HIV-FREE SURVIVAL (PHFS)

Launch Meeting
Pretoria, South Africa
11–14 March 2013



Acknowledgments

The Partnership for HIV-Free Survival (PHFS) was launched in Pretoria, South Africa on 11–14 March 2013. The PHFS coordinating committee would like to thank the Governments of Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda for their participation in this meeting, their commitment to the partnership, and their ongoing dedication to HIV-free survival for HIV-exposed infants in their countries, and across the globe. The committee would also like to express its gratitude to the Government of South Africa for hosting the launch of this important initiative.

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Acronyms

| | |
|--------|--|
| ANC | antenatal care |
| ART | antiretroviral therapy |
| ARV | antiretroviral drug |
| ASSIST | Applying Science to Strengthen and Improve Systems |
| BF | breastfeeding |
| CHW | community health worker |
| COP | country operating plan |
| DOH | Department of Health |
| EBF | exclusive breastfeeding |
| eMTCT | elimination of mother-to-child-transmission (of HIV) |
| FAQs | frequently asked questions |
| FANTA | Food and Nutrition Technical Assistance III Project |
| FBP | Food by Prescription |
| HCW | health care worker |
| HIV | human immunodeficiency virus |
| IATT | Interagency Task Team |
| IHI | Institute for Healthcare Improvement |
| LIFT | Livelihoods and Food Security Technical Assistance Project |
| M&E | monitoring and evaluation |
| MAM | moderate acute malnutrition |
| MDG | Millennium Development Goal |
| MOH | Ministry of Health |
| MNCH | maternal, newborn, and child health |
| MTCT | mother-to-child-transmission (of HIV) |
| MUAC | mid-upper arm circumference |
| NACS | nutrition assessment, counseling, and support |
| NGO | nongovernmental organization |
| OGAC | Office of the U.S. Global AIDS Coordinator |
| PDF | post-script document file |
| PDSA | plan-do-study-act |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PHFS | Partnership for HIV-Free Survival |
| PMTCT | prevention of mother-to-child transmission (of HIV) |
| QI | quality improvement |
| SAM | severe acute malnutrition |
| SUN | Scaling Up Nutrition |
| U.S. | United States |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| URC | University Research Corporation, LLC |
| USAID | U.S. Agency for International Development |
| WASH | water, sanitation, and hygiene |
| WHO | World Health Organization |

Executive Summary

In 2010, the World Health Organization (WHO) published both revised guidelines for the prevention of mother-to-child transmission of HIV (PMTCT)—*Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Recommendations for a Public Health Approach*—and the accompanying *Guidelines on HIV and Infant Feeding*. These were based on landmark evidence (from 2009) demonstrating that a dramatic reduction in postnatal mother-to-child transmission (MTCT) rates could be achieved if three key tasks were achieved: 1) HIV-infected mothers exclusively breastfed for the first six months, 2) they continued breastfeeding (BF)—while introducing complementary foods—until at least 12 months, and 3) mother-infant pairs had access to antiretroviral drugs (ARVs) during this period. According to the research, adherence to these guidelines would reduce vertical transmission during the postnatal period from 15% to 1% or less.¹

While many countries have adopted the 2010 guidelines, and training materials are proliferating, there is still limited experience in scaling up the postnatal continuum of PMTCT and nutrition care. More specifically, uptake of the WHO guidelines by countries has been slow, and health care systems have struggled to support the necessary integration of PMTCT; maternal, newborn, and child health (MNCH); and nutrition for mother-infant pairs. In most resource-limited settings, mothers still do not receive adequate knowledge, skills, and support to guarantee HIV-free survival for their infants during their first two years of life. In particular, *retention* in care is poor, with a significant portion of mother-infant pairs being lost to follow-up during the early postnatal period.

The Partnership for HIV-Free Survival (PHFS) is an initiative that aims to accelerate the adoption and implementation of the 2010 WHO Guidelines in the six member countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. The partnership was conceived by WHO and the United States President's Emergency Plan for AIDS Relief (PEPFAR), and is positioned under the Child Survival Working Group of the Interagency Task Team (IATT) on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children. UNICEF is also a key partner, along with four nongovernmental organization (NGO) technical partners: the Institute for Healthcare Improvement (IHI), University Research Corporation (URC) (through the Applying Science to Strengthen and Improve Systems [ASSIST] Project), HEALTHQUAL, and FHI 360 (through the Food and Nutrition Technical Assistance III Project [FANTA]). Importantly, the PHFS is owned and led by the ministries of health in these six countries.

The *overarching objectives* of the PHFS are: 1) to achieve universal breastfeeding and improved nutrition of mother-child pairs and 2) to ensure that all breastfed infants exposed to HIV are protected through ARVs. Subsumed under these overarching objectives are the following *specific aims*: 1) across six countries (within target populations), to achieve more than 90% coverage of elimination of MTCT (eMTCT) services, thereby reducing MTCT from 15% to 1%, and 2) across six countries (within target populations), to achieve more than 90% coverage of nutrition assessment, counseling, and support (NACS) programming. The PHFS will not introduce *new* PMTCT or nutrition programs. Instead, it seeks to *accelerate* the progress of *existing* national programming using quality improvement (QI) methodologies and a multi-country learning platform established to share successful ideas, models, and interventions.

Partners will apply QI methods in a small number of highly functional sites to gain technical learning, with a focus on improving service quality and efficiency. Using data to demonstrate the effect of proposed “change ideas,” they will select those that are successful, and scale them up rapidly in their respective districts and countries. The learning platform will serve as a vehicle for spreading successful ideas and other lessons from the front line of individual sites to other member countries.

¹ R.L. Shapiro, et al. “Antiretroviral Regimens in Pregnancy and Breast-Feeding in Botswana.” *New England Journal of Medicine* 362 (June 2010). <http://www.nejm.org/doi/full/10.1056/NEJMoa0907736#t=articleDiscussion>.

NACS, the PEPFAR-sponsored framework for nutrition assessment, counseling and support, exists in each of the six member countries and offers an opportunity to create a comprehensive continuum of nutrition care and a structure for retaining mother-infant pairs in care for the first two years of life. All six PHFS countries will use the NACS framework as a platform for integrating PMTCT, MNCH, and nutrition services.

Following several months of preparatory work, on 11–14 March 2013, the PHFS was launched in Pretoria, South Africa, with representatives from the six member countries, among others, in attendance. A total of 116 participants spent four days working together intensely to develop and agree on the concept and principles of the PHFS; set common and country-specific “aims”; identify the primary and secondary drivers of HIV-free survival; agree to illustrative indicators; and, finally, develop draft work plans for implementing the PHFS in their respective countries.

At the launch meeting, there was widespread agreement that to achieve these aims, a radical departure from the status quo is required. As noted by one participant on the last day of the meeting, “The PHFS presents us with a unique opportunity to dramatically increase the number of HIV-exposed infants that remain HIV-free, and that survive to grow into healthy, productive adults.” The six member countries of the PHFS have the potential to become pioneers for accelerating global progress toward HIV-free survival.

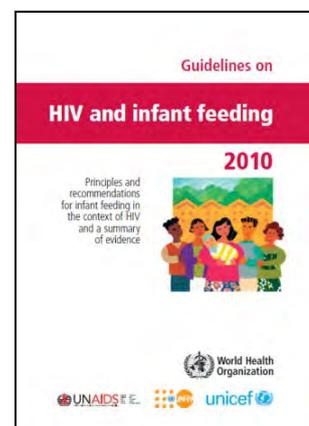
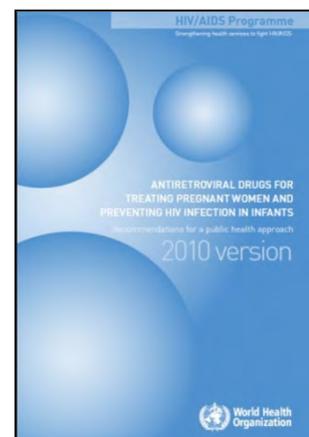
Background

In 2010, WHO released updated guidelines on PMTCT, including guidance on HIV and infant feeding. While many of the recommendations in the 2010 document remained consistent with the previous (2006) guidelines, there were some significant changes. Since the previous guidance, new evidence had emerged (in 2009) demonstrating that ARVs significantly reduce the risk of HIV transmission through breast milk. More precisely, research demonstrated the possibility of reducing vertical transmission during the postnatal period from 15% to 1% or less.²

Based on that evidence, the 2010 guidelines emphasized the importance of providing lifelong antiretroviral therapy (ART) to HIV-infected pregnant women who meet the criteria for such treatment, and recommended the use of two ARV prophylactic options for women not eligible for ART. Additionally, mothers were advised to exclusively breastfeed for the first six months, and, where ARVs are available, WHO recommended that mothers known to be HIV-infected breastfeed until their child is 12 months of age, while introducing complementary foods at six months.

Importantly, within the context of ARVs for PMTCT, breastfeeding was recommended as the optimal feeding practice for all HIV-infected women in countries where significant numbers of children still die from diarrhea, pneumonia, and malnutrition. The term “HIV-free survival” was coined to emphasize not only the importance of eliminating MTCT, but, just as importantly, the promotion of breastfeeding for child survival.

While impressive advances have been made in reducing antenatal and perinatal transmission (of HIV), the postnatal period (0–24 months) has remained problematic. Uptake of the WHO guidelines by countries has been slow, and health care systems and community outreach services have struggled to



² Ibid.

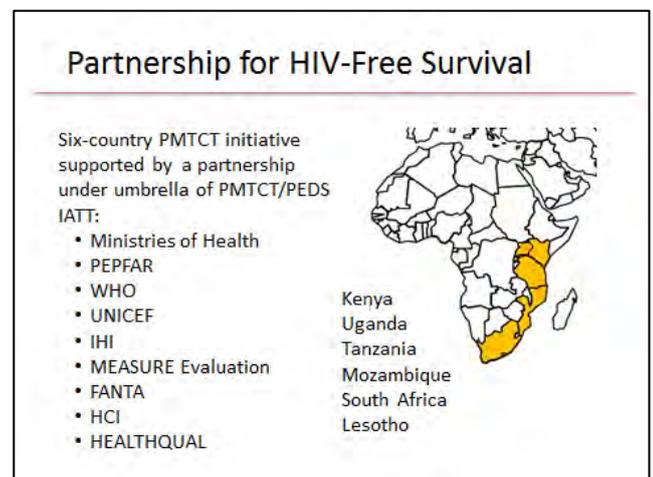
support the necessary integration of PMTCT, MNCH, and nutrition for mother-infant pairs. To date, systems remain lacking in most resource-limited settings, and mothers do not receive adequate knowledge, skills, and support to guarantee HIV-free survival for their infants during their first two years of life.

The PHFS was conceived by WHO and PEPFAR to accelerate the adoption and implementation by countries of WHO's 2010 guidelines, with the ultimate goal of increasing HIV-free survival initially in six countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. Other countries may join the PHFS in the future.

NACS is the framework that the partnership will utilize to ensure a continuum of nutrition care and support for HIV-infected mothers and their infants during those first two critical years of life. Technical support for the PHFS will be provided by IHI, URC, HEALTHQUAL, and FHI 360. Under URC, the ASSIST project will provide support, and under FHI 360, both FANTA and the Livelihoods and Food Security Technical Assistance Project (LIFT) will provide support.

The participating countries are assembling multidisciplinary steering committees (five are already established), led by their respective Ministry of Health (MOH), and including WHO, UNICEF, relevant technical support partners listed above, and other relevant country implementing partners. A draft version of an operational manual (for the preparation and implementation of the PHFS) has been jointly developed by WHO, PEPFAR, and IHI for consideration by the participating countries. This manual is designed to be adapted to individual country contexts and can be found at the following link: [PHFS Operational Manual](#).

In essence, the PHFS is intended to boost existing national efforts and capabilities for the seamless integration and improved effectiveness of PMTCT, MNCH, and maternal/infant nutrition services. The PHFS launch meeting of March 11–14 represents the official start of this vital initiative. This report documents the proceedings and summarizes key findings, conclusions, and next steps.



Objectives

The following objectives were established for the meeting:

1. Develop a common understanding of aims, methods, and measures of the PHFS
2. Understand the state of partner countries in implementation of current WHO guidelines
3. Describe the role of QI using NACS as a platform to support the objectives of the PHFS
4. Provide country teams with an opportunity to work together to define roles and responsibilities in the implementation of PHFS activities
5. Provide a clear set of action points and follow-on PHFS activities for the implementation of country work plans

Participants

There were a total of 116 participants at the four-day meeting to launch the PHFS. The majority of participants came from the six member countries, with the following number of participants from each: Kenya (2), Lesotho (12), Mozambique (13), South Africa (20), Tanzania (11), and Uganda (13). The remaining participants came from Malawi, Rwanda, Nigeria, and the United States. A complete list of participants appears in the post-script document file (PDF) above.

It should be noted that Kenya had intended to send a larger contingent of representatives. However, the timing of the launch conflicted with the country's national elections. Therefore, only two were able to attend. These two participants plan to replicate key sessions of the launch meeting with the rest of their team upon their return to Kenya.

Those participants not coming from member countries consisted of staff from technical partners (IHI, FHI 360 [FANTA and LIFT], URC [ASSIST], and HEALTHQUAL), as well as the U.S. Agency for International Development (USAID), the U.S. Department of State, WHO, and UNICEF. Country teams were made up of representatives from the ministries of health and WHO, along with NGO implementing partners and technical partners mentioned above.

Meeting Process

A wide range of workshop formats and methodologies was used to ensure full and active participation of country teams and technical partners in the launch, orientation, and working group processes.

Approximately one-and-a-half days of the four-day meeting were dedicated to orienting participants to the history, rationale, and overall aims of the PHFS, as well as to the roles of partnership members. The remaining time was dedicated to planning and decision making by country teams (working in their respective groups), so that upon their return to their countries, they could immediately launch their country-specific partnerships.

The planning and decision-making process was structured using QI techniques. Countries created process maps of their health systems, identified primary and secondary drivers of HIV-free survival, and practiced developing change packages for testing. They also identified illustrative indicators, at the output, process, and outcome/impact levels, in addition to evaluation (outcome/impact) questions for each country. A dedicated session on the learning platform was conducted using the World Café methodology generating a list of preferred mechanisms for learning, as well as priority themes for inter- and intra-country learning.

While the four-day meeting began with a tentative agenda, the plan was adjusted daily to reflect issues raised and needs expressed by the participants each day. In particular, more time was allotted to working on country work plans and decision making regarding next steps.

Day One Proceedings

Opening and keynote remarks

Dr. Nneka Mobisson-Etuk, Executive Director of IHI in South Africa, acted as overall moderator for the four days, with assistance from Dr. Nonhlanhla Dlamini, Head of Child, Adolescent and School Health for South Africa's Department of Health (DOH), on Day One only.

Paul Mahanna, USAID/South Africa

Mr. Mahanna, the acting Health Director for USAID/South Africa, opened the meeting by thanking the South African national DOH for hosting this meeting. He noted the significant financial support that PEPFAR has allocated to acceleration of PMTCT and nutrition programming, in particular toward the implementation of the 2010 WHO PMTCT, HIV, and infant feeding guidelines.

Mr. Mahanna said that this is a dynamic time for HIV and nutrition, and a time of innovation and cautious optimism. Mr. Mahanna then acknowledged Dr. Thurma Goldman, Senior Advisor for PMTCT and Pediatric HIV at the Office of the U.S. Global AIDS Coordinator (OGAC), and thanked her for being present.

Yogan Pillay, Department of Health, South Africa

Dr. Pillay, the Deputy Director-General of the DOH of South Africa, welcomed guests from the various countries to South Africa, noting his enthusiasm for the launch of the PHFS. He articulated the DOH's commitment to the initiative and the need to bring other stakeholders in South Africa on board as well. He also raised the question of how the PHFS might link with other multilateral initiatives, such as Scaling Up Nutrition (SUN). Dr. Pillay pointed out not only the focus on the "1,000-day window" (pregnancy through age two), but coincidentally, the 1,000 days before the deadline for meeting the 2015 Millennium Development Goal (MDG) targets, which he hopes that the PHFS will help achieve.

History of the PHFS initiative



Nigel Rollins, WHO

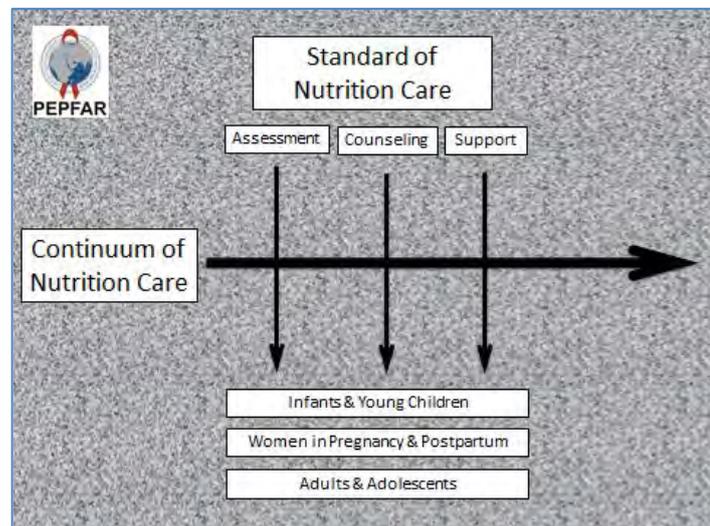
Dr. Rollins summarized the key changes in policy and guidance emerging from the 2010 WHO PMTCT guidelines and the accompanying HIV and infant feeding guidelines. Importantly, these guidelines reflect 2009 evidence demonstrating that, for the first time, with access to ARVs, it is possible to reduce postpartum vertical transmission to extremely low levels (e.g., 1%). Another major change was that countries were advised to support one approach or another (i.e., breastfeeding or replacement feeding) and to develop systems that support the selected option. He noted that policies, interventions, and programs (including cost-effectiveness) should be evaluated on their ability to promote HIV-free survival among all children and the health and survival of mothers, and not just avert HIV transmission.

Establishment of the PHFS within PEPFAR programs



Tim Quick, USAID/PEPFAR

Dr. Quick related the history behind integrated HIV and nutrition programming, citing the first international conference on the topic in Durban in 2005; the evolution of Food by Prescription (FBP) programming in Kenya; and eventually the formation of NACS programming, which exists in various forms in 16 countries. He described the "standard of acute and chronic nutrition care" promoted by NACS, with a focus on mother-infant pairs during the first 1,000 days and adults in care and treatment programs. Dr.



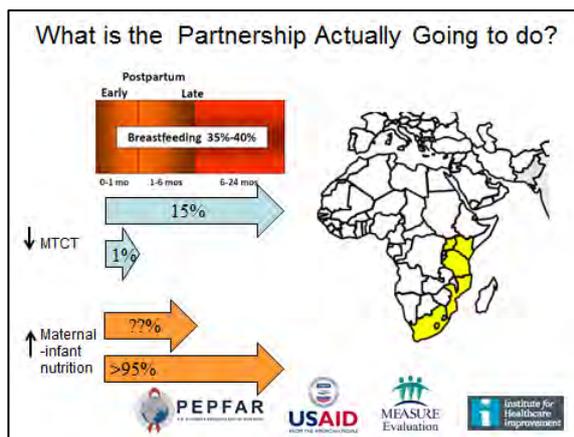
Quick noted that the release of the WHO 2010 HIV and infant feeding guidelines presented an opportunity to enhance support for PEPFAR's HIV and nutrition goals. This was the genesis of the PHFS, which coincided with the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive*.³ The six countries at this meeting have the potential to become pioneers for accelerating progress toward HIV-free survival.

³ Joint United Nations Programme on HIV/AIDS (UNAIDS). 2011. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf.

Review of partnership design

Pierre Barker, IHI

What is the PHFS? Dr. Barker addressed this question, and summarized the aims, design, and timeline of the PHFS. Importantly, he suggested that the PHFS is an opportunity for the six member countries to significantly reduce maternal transmission of HIV. The overall aim of the partnership is to improve HIV-free survival in affected countries in sub-Saharan Africa by decreasing postnatal transmission of HIV and improving maternal and infant nutrition. The QI activities will enable teams to test a series of changes with support to accelerate the scale-up of the interventions at a district and national level. A structure of technical support has been created in the form of partners, including IHI, HEALTHQUAL, FHI 360 (FANTA and LIFT), and URC (ASSIST), but the countries themselves are responsible for implementation.



Overview of NACS in relation to the PHFS

Serigne Diene, FHI 360 (FANTA)

Dr. Diene gave an overview of the NACS approach and described the phased implementation in 16 countries to date. He noted some of the achievements of NACS, particularly in terms of integrating nutrition into national HIV responses, and cited lessons and challenges thus far. Importantly, while health facilities are a good entry point for PLHIV nutrition services, NACS must be integrated with community-based health services/outreach to be truly effective. Finally, Dr. Diene described plans for scale-up of NACS and further health system strengthening to support NACS going forward.

Basics of quality improvement design

Pierre Barker, IHI

Dr. Barker explained that the basic goal of QI is to close the gap between our performance today and the performance needed to eliminate MTCT. QI is about understanding the psychology that helps people change, and trying *different* approaches to solving a problem. Dr. Barker explained where QI fits within the realm of health systems strengthening and how the partnership will use QI methods to reach its PMTCT and nutrition goals. Finally, he provided details on the QI process: understanding systems, identifying change ideas, implementing the “plan-do-study-act” (PDSA) cycle, and using data to continuously measure feedback. The process for scaling up across sites, districts, and, ultimately, the six countries was also described.

COUNTRY PRESENTATIONS

Nneka Mobisson-Etuk, IHI

Five of the six countries presented their pre-launch templates, which they had developed with the help of IHI over the past several months. As noted earlier, the majority of the Kenya delegation did not attend the meeting due to the time conflict with the national elections. The two representatives from Kenya who were present participated in the remaining country-specific work sessions, but did not present their initial template. Topics covered in the templates included: the state of PMTCT and NACS in their countries (including which PMTCT “option”⁴ [see Table 1] was selected and current BF trends), the objectives of the PHFS in their country, the regions/ districts they have selected for the PHFS, steering committee members, and agreed-to country indicators.

⁴ HIV and Infant Feeding 2010: An Updated Framework for Priority Action. WHO Guidelines. http://www.who.int/maternal_child_adolescent/documents/9241590777/en/

Expert discussion on infant feeding & ARV coverage at the facility level



Nigel Rollins, WHO

Dr. Rollins explained the rationale behind the WHO 2010 recommendation that national authorities promote a single infant feeding strategy for all HIV-infected mothers (i.e., BF or replacement feeding). He noted that training of health care workers (HCWs) is not enough to change BF practices. Five distinct factors influence the way that HCWs support mothers and the probability of mothers receiving ARVs and adequate support for BF. These are: 1) knowledge of HCWs; 2) HCWs' beliefs and values; 3) efficiency of the system; 4) attitudes of the community; and 5) willingness of mothers to hear, believe, receive, and do. Dr. Rollins provided evidence from various studies demonstrating how these factors influence infant feeding and HIV-free survival outcomes. Finally, he briefly discussed the soon-to-be-released, revised WHO recommendations (2013) on the use of ARVs, with details on Option B+.

Table 1. Three options for PMTCT programmes

| | Woman receives: | | Infant receives: |
|------------------------------|---|---|--|
| | Treatment (for CD4 count ≤350 cells/mm ³) | Prophylaxis (for CD4 count >350 cells/mm ³) | |
| Option A^a | Triple ARVs starting as soon as diagnosed, continued for life | <i>Antepartum:</i> AZT starting as early as 14 weeks gestation <i>Intrapartum:</i> at onset of labour, sdNVP and first dose of AZT/3TC <i>Postpartum:</i> daily AZT/3TC through 7 days postpartum | Daily NVP from birth through 1 week beyond complete cessation of breastfeeding; or, if not breastfeeding or if mother is on treatment, through age 4–6 weeks |
| Option B^b | Same initial ARVs for both ^c : | | Daily NVP or AZT from birth through age 4–6 weeks regardless of infant feeding method |
| | Triple ARVs starting as soon as diagnosed, continued for life | Triple ARVs starting as early as 14 weeks gestation and continued intrapartum and through childbirth if not breastfeeding or until 1 week after cessation of all breastfeeding | |
| Option B+^c | Same for treatment and prophylaxis ^b : | | Daily NVP or AZT from birth through age 4–6 weeks regardless of infant feeding method |
| | Regardless of CD4 count, triple ARVs starting as soon as diagnosed, ^c continued for life | | |

Note: "Triple ARVs" refers to the use of one of the recommended 3-drug fully suppressive treatment options.

^a Recommended in WHO 2010 PMTCT guidelines

^b True only for EFV-based first-line ART; NVP-based ART not recommended for prophylaxis (CD4 >350)

^c Formal recommendations for Option B+ have not been made, but presumably ART would start at diagnosis.

GROUP EXERCISE ON PMTCT AND INFANT FEEDING



Deborah Ash, FHI 360 (FANTA)

Dr. Ash facilitated an exercise designed to get participants thinking about how to interpret and apply the 2010 WHO guidelines at the level of the individual HCW and mother. The following questions were posed to participants, who worked in small groups to form responses:

Q1: What should the HCW say or do if she learns that an HIV-infected mom is mixed feeding?

Q2: Is it still important to promote and support exclusive breastfeeding (EBF) among HIV-infected women who are receiving ART?

Q3: Do HIV-infected moms really need to stop BF, especially if they are on lifelong ART?

Q4: Which HCWs are best able to support mothers and to give them confidence to want to recommend HIV-infected mothers to breastfeed while receiving ART?

A summary and list of responses from working groups appear in the PDF above. Note: WHO has developed a long list of frequently asked questions (FAQs) similar to the questions posed above. These questions and their answers can be found at the following link: [WHO Q&A on infant feeding in an HIV context.](#)

Introduction to process mapping



Maureen Tshabalala, IHI

Dr. Tshabalala defined process mapping and explained how it is useful in creating a visual tool to analyze a series of activities. Process mapping has a variety of uses, including uncovering system barriers; identifying bottlenecks, duplication of efforts, and inefficiencies; and analyzing their causes. It is particularly useful for exploring alternative ways to improve services. Two examples of process maps were provided: mapping clients seeking care in a health facility and mapping the steps in PMTCT care, antenatal care (ANC), and labor.

COUNTRY TEAMWORK: PROCESS MAPPING



Applying the concepts explained in the previous session, each country used process maps to address the following question: *What is the current state of eMTCT in-country programming?* More specifically, participants were asked to develop process maps in their respective countries for: 1) postnatal HIV prevention, testing, and treatment for mothers and infants; and 2) routine, postnatal nutrition care for mothers and infants. A gallery walk was conducted to end the session, allowing the six countries to learn from each other's work. In general, participants found the process of developing their maps to be a powerful means of understanding the weaknesses and gaps in their services. Process maps for the six countries and a summary of the discussion held can be found in the PDF above.



Country reflections from Day One



To close the first day's proceedings, participants from each of the six countries articulated one *thing that they had learned* and one *challenge* that they foresaw with regard to moving forward with the PHFS.

Day Two Proceedings

Review of Day One



Tin Tin Sint, UNICEF

Dr. Sint summarized the key points from the presentations and country team reflections on Day One. She also briefly discussed the Child Survival Working Group of the IATT, and its relevance to the PHFS. Finally, Dr. Sint offered an overview of the SUN initiative, and noted its significance for NACS.

Getting us aligned – Setting aims



Sarah Olver, IHI

The *specific aims* of the partnership were reviewed and stated as follows⁵:

1. Across six countries (within target populations), achieve more than 90% coverage of eMTCT services, thereby reducing MTCT from 15% to 1%.
2. Across six countries (within target populations), achieve more than 90% coverage of NACS programming.

Ms. Olver also described the QI cycle of PDSA and the criteria for a good “aim statement.” This session ended with guidance to country teams on how to set aims for the PHFS in their respective countries.

COUNTRY TEAMWORK: SETTING AIMS



Country teams practiced establishing aims by developing at least one aim and presenting it to plenary for critique. The aims varied across countries; some focused at the national level while others were

⁵ These specific aims were fine-tuned following the conference. Therefore, the wording here is slightly different than the wording in the presentation.

directed at the district and site levels. There was an effort/struggle to cover both HIV transmission and nutrition in one aim, as well as tension between being aspirational yet realistic. Countries all articulated their desire to make these aims measurable and achievable. Country-specific aims are listed in the PDF above.

Drivers of HIV-free survival

Pierre Barker, IHI

Dr. Barker discussed the theory of change and the factors that contribute to making change happen. He explained the QI process of developing driver diagrams, and identifying the primary and secondary drivers that get us to the “aim” that we identified in the previous session. Once drivers are identified, change ideas (or possible solutions) to those drivers are developed. QI is very adaptable; changes will be rapid at first, and take place more slowly in later stages. While primary drivers are likely to be similar across countries, secondary ones may be somewhat different. Primary drivers for the PHFS should cover four general areas: community, facility, data systems (QI), and learning.

COUNTRY WORKING GROUPS: PRIMARY AND SECONDARY DRIVERS OF HIV-FREE SURVIVAL

Country teams were asked to review the proposed primary drivers for the overarching partnership, articulate whether or not they agree with them, and then develop their own secondary drivers accordingly. All of the countries agreed to *a standard set of primary drivers*, with the exception of Tanzania, which made slight modifications to its list. Each country came up with its own *context-specific* list of secondary drivers (health system design features). A wide variety was identified. However, there were some common ones across the countries; they are listed below. The complete list of secondary drivers for each country appears in the PDF above.

| Primary system drivers | | Secondary drivers (health system design features) |
|------------------------|--|--|
| 1 | Provide effective, client-centered care for HIV-infected/exposed mother-child pairs | <ul style="list-style-type: none"> • Improve human resource capacity – knowledge and skills on NACS, PMTCT, infant feeding, etc... • Improve service delivery standards (policies, procedures, guidelines, terms of reference, job aids, etc... • Increase availability of commodities, supplies, and equipment. • Improve adherence and retention of mother-infant pairs. |
| 2 | Develop community engagement and access to care | <ul style="list-style-type: none"> • Improve use of volunteers and support groups, strengthen referral systems, and establish improved systems for mother-infant follow-up. • Use mentor-mothers, community dialogue, community feedback mechanisms, and strategies that build awareness and knowledge among communities. • Improve linkages between clinics and communities. |
| 3 | Develop culture of and capacity for continuous improvement (including effective leadership and management) | <ul style="list-style-type: none"> • Improve data management systems. • Build capacity for understanding, using and learning from data. • Improve feedback loop (between central and clinical levels, and clinic to community). • Engage communities in change activities. • Document and share “improvement” lessons. |

Principles of measurement

Nigel Livesley, URC (ASSIST)

Dr. Livesley reviewed issues related to different types of data requirements. In most cases, data are intended to be used for management decision-making purposes, particularly toward improvement. Measuring for improvement requires looking at data *during*, not only before and after, interventions. There are different ways to look at data; it’s important to look at it sequentially and frequently (over

time) so that learning happens in real time, not just at the end. The run chart, depicted in the PDF above, is one of many tools that can be useful in this respect.

Global PMTCT M&E indicators

Amie Heap, USAID/PEPFAR

Ms. Heap described the history of measuring NACS efforts, and noted that NACS indicators are meant to cover high-level efforts. Following consultations from 2009 to 2012, a list of indicators was agreed to in 2012. Ms. Heap reviewed the PEPFAR Next Generation Indicators and pointed out some of their deficiencies. During the development of these indicators, consultations were held in NACS countries in an effort to ensure that they were relevant to needs. There are three thematic areas of indicators: 1) nutrition care, 2) PMTCT/infant feeding, and 3) food security. None of the indicators are mandated, so they can be adapted to country-specific needs. Each country has created a tailored NACS framework by applying a series of questions (contained in the PDF above) to the standard list of NACS indicators. The complete list of indicators appears in the PDF above, and will soon be available on the [UNAIDS Indicator Registry](#).

Special interest lunches

Three special interest lunches were held with three different groups of stakeholders:

1. Group 1: The U.S. Government group – USAID and OGAC
2. Group 2: The NGO Group – URC, IHI, and FHI 360
3. Group 3: UNICEF, WHO, and the ministries of health

Summaries of the three discussions appear in the PDF above.

Building your indicator set

Pierre Barker, IHI

Dr. Barker discussed the method of building an indicator set by tracing the “process of care” and noting what needs to be measured at each step in the process. The session was then used to review the draft illustrative indicators for the PHFS, covering indicators related to HIV, nutrition, and access/attendance, among others in the continuum of care. These indicators are still under development and will be released in the coming weeks.

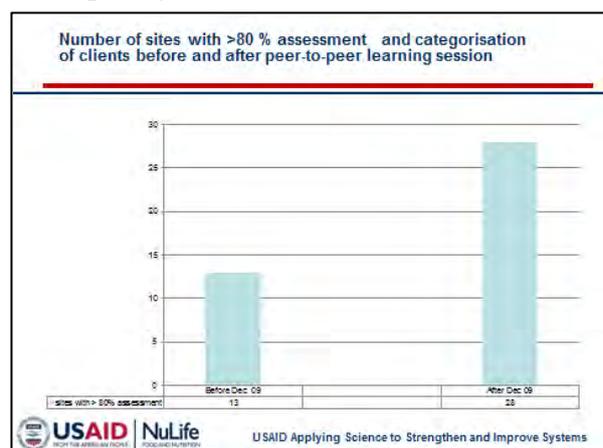
COUNTRY WORKING GROUPS: ESTABLISHING ILLUSTRATIVE INDICATORS

Countries were asked to: 1) consider the draft PHFS indicator set, 2) note which ones they are currently collecting, 3) note frequency of collection, and 4) develop plans to fill the data/indicator gaps. Countries generally agreed with the range of indicators proposed, though they noted that the exercise was challenging without indicator definitions (numerators/denominators) available to compare to their existing country indicators. Some of the proposed indicators are already being collected across the six countries, some in slightly modified versions. Frequency of collection still needs to be reviewed. Only two countries currently have an indicator that relates to HIV-exposed infants being breastfed with the mother on ART. A table depicting the illustrative indicators and individual country indicators appears in the PDF for Dr. Barker’s presentation above.

Building QI capacity – URC (ASSIST) and HEALTHQUAL

Nigel Livesley, URC (ASSIST) 

Dr. Livesley explained the role of ASSIST with regard to providing QI support to each of the PHFS countries. In Uganda, for example, they use QI to ensure that nutrition assessment was being conducted; in Niger, a massive reduction



in postpartum hemorrhaging was achieved using QI. The pace of progress for expanding the use of QI varies between sites and countries. Dr. Livesley also discussed various factors related to developing QI capacity, and how ASSIST can support each of these areas. Finally, he described the peer learning model, which moves learning from one site/location to another via peer-to-peer meetings with the goal of exchanging lessons. In Uganda, the number of sites with more than 80% nutrition assessment increased dramatically after QI and peer-to-peer learning were applied.

Bruce Agins, HEALTHQUAL 

Dr. Agins explained the origins of HEALTHQUAL and its work in New York State. The HEALTHQUAL team currently works in a variety of countries, using an approach that emphasizes QI and performance measurement. They provide coaching to national coaching teams in the countries where they work, and they emphasize developing a culture of improvement. Quality must be both bottom-up *and* top-down, which requires leadership. Dr. Agins described a national QI intervention in Namibia where ART adherence was low due to food insecurity and alcohol consumption. Using QI, a list of relevant interventions was generated and they used communities of practice to spread learning.

Wrap-up of Day Two

Nigel Rollins, WHO

Dr. Rollins reviewed the progress made over the first two days, with emphasis on the work achieved thus far by the country teams. Aims, driver diagrams, and illustrative indicators had been developed, and the process of developing a common understanding of the PHFS was under way. He noted that the partnership has a complex vision and commitment, particularly considering the immense diversity across the six countries. Dr. Rollins expressed his firm belief in this concept, and its vision, though acknowledged that it will be difficult to bring it all together. He encouraged participants to keep in mind that the PHFS has the potential to significantly improve the lives of HIV-affected women and children in these six countries and beyond.

Day Three Proceedings

Review of Days One and Two 

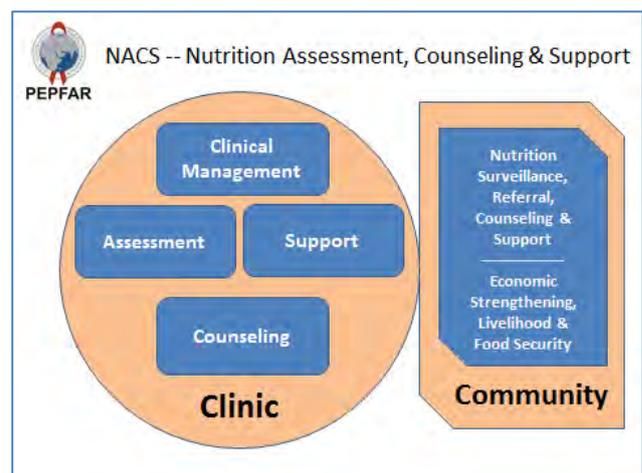
Nneka Mobisson-Etuk, IHI

Dr. Mobisson-Etuk reviewed progress from the first two days, reiterating the process of developing aims, and primary and secondary drivers. She talked briefly about the illustrative indicators for the Partnership and then explained the agenda for day three.

OPEN MIKE: QUESTIONS, CONCERNS, AND COMMENTS 

In this “open mike” session, participants were invited to ask questions and comment generally on their impressions of the meeting thus far. This session evolved into an opportunity for participants to express their concerns and confusion around the core utility of the PHFS. Questions such as “*How does this partnership add value to what is already being done?*” and “*How precisely how does it intend to make a difference?*” were posed.

Responses and comments were provided by both donors and technical partners. But perhaps more importantly, countries such as South Africa and Uganda, which have already seen success from applying the QI method in a limited number of districts, shared their experiences and inspired participants who were newer to the approach. The complete list of questions, responses, and comments can be found in the PDF above.



Overview of NACS and integration into the PHFS



Simon Sadler and Tina Lloren, FHI 360 (FANTA)

Mr. Sadler and Dr. Lloren explained that NACS is an evolving approach, with each implementing country at a different stage of development. At the core of NACS is the assessment and classification of clients' nutrition status. Based on this, nutrition counseling is conducted, which can be delivered in group or individual settings. The “support” piece consists of referral to therapeutic or supplementary feeding; food security, economic strengthening, and livelihoods programming; and water, sanitation, and hygiene (WASH) support.

COUNTRY WORKING GROUPS: TELL US ABOUT NACS IN YOUR COUNTRIES



Two questions were posed to the country teams:

1. What does NACS (in your country) look like in a health facility providing MNCH services?
2. What does the “S” (support) component of NACS look like in your country?

All of the countries reported that they conduct anthropometric assessments measuring height, weight, and mid-upper arm circumference (MUAC) at the facility level, and many also measure and refer at the community level. Using the anthropometric data, they classify those who are malnourished into severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) categories, but due to shortages of counselors, most conduct individual counseling for the SAM and MAM clients only, *not all clients*. Dietary assessment (e.g., using 24-hour recall) is done in some of the countries. Nearly all of the countries noted weaknesses in the “counseling” piece, and some noted poor skills among HCWs on recording, understanding, using, and reporting nutrition data. Systems are in place in most countries, but the quality of nutrition assessment is lacking. With regards to the “S” (support) piece of NACS, countries reported a broad range of interventions, including referral for therapeutic and supplementary feeding, as well as food security, economic strengthening, and livelihoods support. Full responses from each country are listed in the PDF above.

LIFT – Promoting the “S” in NACS

Jacky Bass, FHI 360 (LIFT)

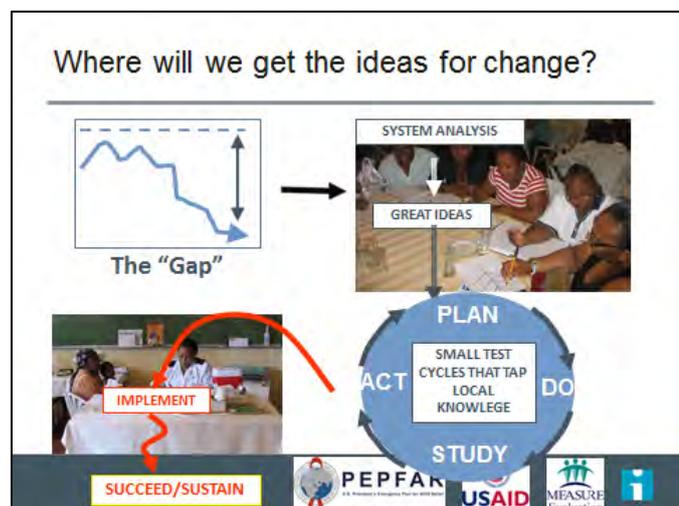
Ms. Bass explained that LIFT is focused on the “S” (support) component of NACS. LIFT aims to facilitate linkages between health facilities and communities, and focuses on referrals for food security, economic strengthening, livelihoods support, and WASH. LIFT does not provide services; it helps map and strengthen referral networks for existing support. This presentation appears in the PDF entitled *Overview of NACS and integration into the PHFS* on the previous page.

Change package development – Local learning for local spread



Maureen Tshabalala, IHI

Ms. Tshabalala revisited the driver diagrams (containing aims and primary and secondary drivers), and explained the next step of generating “change ideas.” Change ideas emerge as a result of analyzing systems and, in particular, gaps/problems within those systems. With change ideas identified, the next step is to apply the PDSA cycle to the idea, testing it to see if it generates improved outcomes. Data are key to this process, since improvement must be quantifiably measured to confirm success and to warrant a decision to



scale up the change idea. Ms. Tshabalala gave examples of how different change ideas have been tried, data analyzed following the change, and then the best ideas selected. She cited examples from [Tried and Tested: Models for the Scale Up of HIV Prevention, Treatment, and Care from South Africa and Beyond](#).

COUNTRY WORKING GROUPS: DEVELOPING CHANGE IDEAS



Three questions were posed to the country teams:

1. *What is one change idea you have?*
2. *How will you share successes and failures?*
3. *How will you document your change ideas that you test at the country level?*

Using the previous sessions (on process mapping and drivers of HIV-free survival) as a foundation, participants worked in their country groups to brainstorm change ideas that could be tested. Some of the change ideas included trying one-stop service provision and same-day service and attempting to conduct training on a more continuous basis. Ideas for documenting and sharing lessons included using leveraging existing monitoring and evaluation (M&E) systems and utilizing national MOH websites. One country's participants suggested using their national PMTCT dashboard to post aims, indicators, outputs, and outcomes. As importantly, they viewed this approach as an opportunity for bringing nationwide attention (within the health sector) to PMTCT and maternal and infant nutrition. Each country's change ideas are listed in the PDF above.

Cross-country learning platform



Patty Webster, IHI

Ms. Webster presented the concept of a jointly designed learning platform for shared learning within and across the six countries. She described some of the goals of the learning platform as: 1) sharing best practices, tools, pitfalls, and barriers; 2) sharing evidence (data) related to which changes work; and 3) creating a universal package of changes to spread. The learning platform philosophy is "all teach, all learn" with lessons generated from frontline practitioners.

COUNTRY WORKING GROUPS: CREATING A PLATFORM FOR LEARNING



The World Café approach was used to capture thoughts, ideas, and responses to the following three questions:

1. *What do you want to learn from other countries?*
2. *How do you want to learn together (i.e., what mechanisms for shared learning [and data] do you prefer to use?)*
3. *What key areas of interest would be worth diving into for deeper learning?*

A vast array of ideas was generated in response to all three questions. The collective responses are detailed in the PDF above.

External evaluation strategy



Karin Lane, USAID; Valerie Flax, MEASURE Evaluation; Ana Djapovic Scholl, USAID; and Carolina Mejia, MEASURE Evaluation

The four presenters began by noting that the PHFS is primarily concerned with the question: "How do we care for mother-infant pairs, keeping infants HIV-free for their first two years of life?" They discussed the two key issues that the PHFS intends to tackle: 1) achieving EBF goals per national guidelines and 2) ensuring all breastfed infants exposed to HIV are protected by ARVs. The stages of learning in QI were described with respect to evaluation, including outputs (QI indicators), process evaluation, and outcome/impact evaluation. And finally, examples of evaluation questions at the process and outcome/impact levels were provided.

COUNTRY WORKING GROUPS: GENERATING EVALUATION QUESTIONS

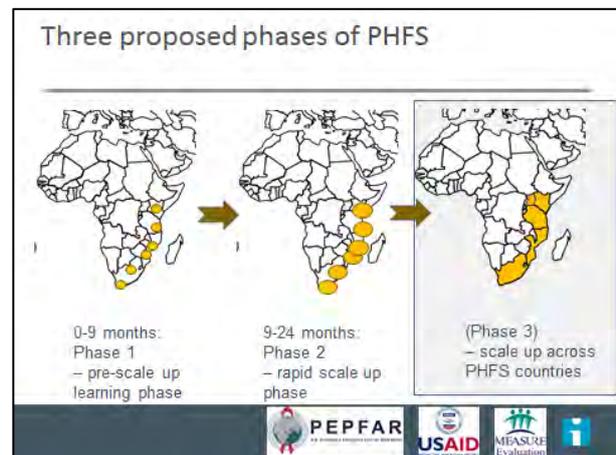
Country teams worked together to generate the priority questions that they would like to see included for PHFS evaluations. The list of evaluation questions generated by each country can be found in the presentation for the previous session.

Next Steps

Pierre Barker, IHI

Dr. Barker reviewed the proposed PHFS timeline and explained the four phases:

- Phase 0:** Preparatory (where we are now)
- Phase 1:** Learning (getting great ideas, learning what works, and building the capacity and will for scale-up)
- Phase 2:** Scaling up (expect district-wide results and learning taking place across districts and countries)
- Phase 3:** Scale-up across countries



This timeline is suggested, but countries may move at different speeds. Detailed suggestions for next steps at the sub-district level, along with recommended “dos” and “don’ts” for getting started are included in the presentation.

Day Four Proceedings

Review of Days One, Two, and Three

Amie Heap, USAID/PEPFAR

Ms. Heap reviewed progress from Days One, Two, and Three. She covered the initial conceptualization of the PHFS; setting aims and drivers of HIV-free survival; developing principles of measurement; and, finally, constructing change packages and looking at what happens next to take the initiative forward in each of the countries.

COUNTRY WORKING GROUPS: ACTION PLANNING

Country teams spent approximately three hours working together to generate action plans for their return home after this meeting. A common template was used to plan next steps, and each country presented its plan to plenary in the afternoon. Each country documented its proposed action steps and corresponding outputs, responsible persons, resources required, and timeline for implementation of their country plans. All country plans, except that of Kenya, can be found at the following links: [Lesotho](#), [Mozambique](#), [South Africa](#), [Tanzania](#), and [Uganda](#).

Review of next steps

Nigel Livesley, URC (ASSIST) 

Dr. Livesley reiterated the overarching goal of the partnership: to create a health system that is better at keeping mothers and babies alive and well their first two years of life. This means ensuring that they are covered by ARVs and getting the right nutrition support for this entire postnatal period. As noted earlier, at the beginning (Phase 1), the focus is on learning, then rapidly scaling up within countries (Phase 2), and, finally, scaling up across the six countries and beyond (Phase 3). The partnership is about to enter Phase 1. It will be critical that teams select well-functioning sites from which they can move forward with technical learning. The poorer functioning sites will not be ignored. They will come on board during scale-up, but first change ideas at sites with relatively minimal administrative and logistics challenges need to be tested.

Closing remarks

Tim Quick, USAID/PEPFAR

To close the four-day meeting, Dr. Quick reviewed key concepts and principles of the PHFS that were discussed over the course of the four-day meeting. He reiterated that this partnership is about mainstreaming “QI and learning” into each country’s larger PMTCT and MNCH programming. Each country may go about this in a different way, but all participants hope that they will all learn from one another. Finally, Dr. Quick reviewed the five originally stated objectives of the PHFS launch meeting, and declared a collective success in achieving each one. He also reiterated the highly relevant South African proverb that opened the meeting: “If you want to go fast, go alone; if you want to go far, go together.”



Conclusion

Synthesis of key findings

The Partnership

- The PHFS has two *overarching objectives*: 1) achieving universal BF and improved nutrition of mother-child pairs and 2) ensuring that all breastfed infants exposed to HIV are protected through ARVs.
- Subsumed below these objectives, the PHFS has two *specific aims*: 1) *for mother-infant pairs within targeted populations, achieve more than 90% coverage of eMTCT services, thereby reducing MTCT from 15% to 1%, and 2) for mother-infant pairs within targeted populations, achieve more than 90% coverage of NACS programming.*⁶
- The PHFS does not introduce any *new* PMTCT or nutrition programs. Its focus is to improve the quality of *existing* programming and services, and sharing successful change ideas among sites, districts, and countries.
- This six-country partnership must be owned and led by the countries’ ministries of health and their respective district management teams to be successful. The NGO partners will proactively provide technical support and coordination among the countries.
- The 2010 release of the WHO HIV and infant feeding guidelines presented an opportunity to enhance support for PEPFAR’s HIV and nutrition goals. This was the genesis of the PHFS, which coincided with UNAIDS *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive*.
- The aim of the PHFS is to accelerate the adoption and implementation by countries of the WHO 2010 guidelines, with the ultimate goal of increasing HIV-free survival in the six member countries and beyond.
- These are not pilot projects. Scale-up is built into the implementation plans, and the QI cycle and learning platforms are the methods for making scale-up happen.
- The PHFS is not a PEPFAR-only project. It was initially conceived as a WHO/PEPFAR initiative, and UNICEF has since come on board as a key partner. The PHFS is positioned under the broader umbrella of the IATT working group on PMTCT and, in addition to the six countries that attended the launch, it is expected that other countries will become part of the PHFS in the future.

⁶ These specific aims were fine-tuned following the conference. Therefore, the wording here is slightly different than the wording in the presentation.

HIV-free survival and the WHO 2010 guidelines

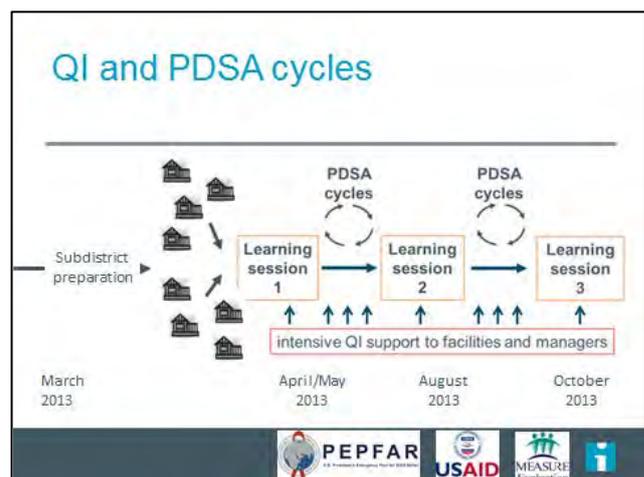
- HIV prevalence in many countries is stable or decreasing, but MTCT rates, as well as maternal and neonatal mortality rates, remain unacceptably high.
- HIV-free survival means not only keeping infants HIV-free, but also promoting better infant feeding practices and key MNCH interventions to keep them from dying of common childhood illnesses. There needs to be a shift in focus from eMTCT only to an all-encompassing *HIV-free survival*.
- Policy, interventions, and programs (including cost-effectiveness) should be evaluated on their ability to promote HIV-free survival among all children and the health and survival of mothers, not just on HIV transmissions averted.
- The WHO HIV and infant feeding guidelines make evidence-based recommendations on how to reduce transmission through breast milk to negligible rates (i.e., less than 1%). While many countries have adopted the 2010 guidelines, and training materials are proliferating, there is still limited experience in scaling up the postnatal continuum of PMTCT, MNCH, and nutrition care. More specifically, facility- and community-level implementation of the WHO guidelines has been slow.
- Country presentations at the launch meeting explained that while antenatal services are relatively well functioning, postnatal care is severely lacking. In particular, *retention* in care is poor, with a significant portion of mother-infant pairs being lost to follow-up in the early postnatal period.
- To date, HCWs and mothers lack the knowledge and confidence to translate the WHO guidelines into practice. Similarly, as revealed during group exercises during the launch meeting, even at the highest levels of policy making and program management, interpretation and translation of the guidelines into “practice” is still challenging.

NACS

- NACS offers an opportunity to create a comprehensive continuum of nutrition care and support, and a framework for retaining mother-infant pairs in care for at least the first two years of life. All six PHFS countries will use the NACS framework as a platform for integrating PMTCT, MNCH, and nutrition services.
- Promotion of BF must make use of community outreach and the array of factors that influence BF at the level of the community and the family. NACS has the potential to achieve this given its emphasis on linkages between health facilities and their surrounding communities.
- When describing existing NACS services, nearly all of the countries noted weaknesses in the “counseling” piece and due to shortages in trained staff, only those diagnosed as SAM and MAM receive counseling. Some countries highlighted poor skills among HCWs in recording, understanding, using, and reporting nutrition data. Systems are in place, but the quality of nutrition assessment is lacking.
- The PHFS will inform and strengthen NACS and MNCH services. Conference participants repeatedly noted the importance of getting mothers on ART and EBF for the first six months of life, in addition to continued BF while introducing complementary foods from 6 to at least 12 months of life.

Quality improvement and the learning platform

- QI and the learning platform are the means by which the partnership will achieve its aims.
- QI is about closing the gap between performance today and the performance needed to achieve the partnership’s PMTCT



and nutrition goals. QI is intended to identify and address gaps in the performance of health systems.

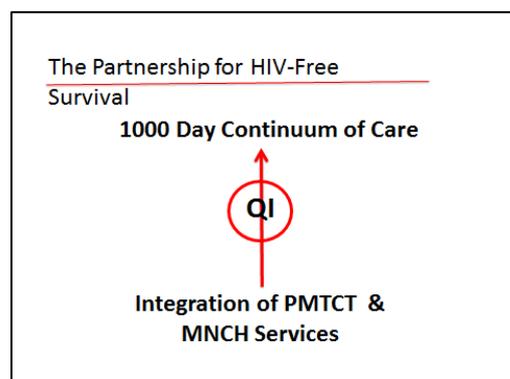
- QI is also about understanding the psychology that helps people change, and trying *different* approaches to solving a problem (vs. putting more resources behind existing methods). A cultural shift is required to embrace the QI method.
- Positive experiences with QI in Uganda and South Africa were shared with the other countries. They recounted their achievements with QI and peer-to-peer learning, and the need to use it repeatedly, in cycles, to see a difference. They described QI as seeing the problem from the frontline perspective, not from experts in the capital cities or regional headquarters. The South Africa team explained how it has already made their work easier, and the changes were scaled up quickly and sustained.
- Participants found process mapping to be a powerful, and enlightening, experience. It highlighted the challenges and complexities to be addressed in their health systems, but was also very motivating as well.
- Building “will” takes time; not everyone changes immediately. At the initial stages, there will be “early adopters,” but there will also be “laggards.” Participants agreed that they can’t let the laggards deter them.
- The learning platform offers an opportunity to establish a variety of learning mechanisms, both in country and among countries, to facilitate the rapid spread of successful change ideas, as well as other lessons learned.
- As part of the learning platform, an M&E community of practice has already been established, and has begun to discuss upcoming priorities. Other thematically focused groups are expected to form learning communities in the upcoming months.

Technical support

- IHI will lead management of the multi-country learning platform and support HEALTHQUAL and URC in providing QI technical support as needed in the six countries. Technical support on NACS and integration of PMTCT and nutrition services is the responsibility of FHI 360 (FANTA and LIFT).
- The precise role of each technical partner will vary from country to country, depending on its presence on the ground and existing relationships between PHFS stakeholders.

Monitoring and evaluation

- The overarching question identified by the partnership was: “How do we look after mother-infant pairs during their first two years of life?” In line with its overarching aims, the M&E framework will measure the partnership’s success in: 1) ensuring that all breastfed infants who are exposed to HIV are protected through ARVs per national guidelines and 2) achieving BF goals per national guidelines and improving the nutrition of mother-infant pairs.
- The PHFS M&E framework will encompass measurement at the output, process, and impact levels. QI focuses on outputs and processes. Science tells us that coverage needs to be very high, i.e., more than 90%, to have a sustainable impact on indicators like transmission of HIV and child survival. Therefore, high standards need to be set for the partnership in terms of scaling up improved systems.
- Countries constructed a diverse range of evaluation questions to measure the success of the PHFS. These will be further discussed and solidified in the coming months.
- Data on PMTCT is relatively well documented, while nutrition data are lacking. This partnership presents a massive opportunity to measure key indicators such as adherence to the WHO



guidelines over time (e.g., mothers on ART who are EBF and BF over time, from 0 to 24 months), and the effect of different interventions on these indicators.

- There are no reporting requirements for the PHFS. Sharing of data on indicators is voluntary, and only for the purposes of learning from one another.

Concerns and challenges

HR capacity: Limitations in HR capacity were repeatedly noted as a concern. Participants struggled to understand how they could mainstream QI and learning, without overburdening their already overstretched staff and systems. It was noted by those with QI experience that ultimately QI would reduce the burden on existing staff, so the initial investment should be worthwhile.

Turnover: The high turnover of clinical staff was raised as potentially prohibitive for effectively implementing the QI process in a short period of time. The partnership will have to be prepared to train and *re-train* on QI to accommodate rapid turnover. QI experts present noted that on-the-job training in QI is common as new staff are plugged into QI teams and collaboratives and thereby trained on-site.

Timeline: During the report-back of country work plans, all countries noted that the timeline for Phase 1 (i.e., nine months) was overly ambitious. They explained that implementation could not begin until there was sufficient buy-in and formal approval from their respective ministries and other in-country stakeholders. Likewise, in setting programmatic aims, there was tension between being ambitious and being realistic. Countries teams articulated their desire to construct aims that were both measurable and achievable.

Budgets: Country participants expressed their concern about implementing the PHFS within the limitations of their existing budgets. A USAID representative reiterated that the PHFS is not “outside” of the work already being done. It’s about enhancing that work by improving efficiency and quality, and then scaling up that improvement. To achieve that, members will need to look at funding opportunities across the NACS Acceleration and PMTCT Acceleration Funds, existing pipelines, and 2013 country operating plan (COP) funding, and, very soon, participants can fill gaps in the 2014 COPs. It’s also important to keep in mind that QI changes are not always costly, and some changes can be implemented at no cost at all.

Reliability of funding: Participants expressed concern that the uncertainty in Washington around the U.S. federal budget might affect the release of PHFS funding. Participants were assured, however, that the PHFS is part of the 2010 budget that has already been approved. This funding is *not* contingent on the outcome of the Washington, DC, sequestration process. Also, USAID expects that PHFS funds from PEPFAR will help leverage money from other donors.

Coordination: Country participants expressed confusion around the roles and responsibilities of the multiple PHFS stakeholders. In certain countries, it was still not clear which of the technical partners would be providing QI support. Planning in this realm is ongoing, and will happen in earnest once partners return to their countries and solidify their in-country work plans.

Conclusion and next steps

The PHFS launch meeting ended with each country acknowledging its rapid progress over the course of the four days, both toward developing an understanding of the concept, aims, and principles of the partnership and toward drafting concrete work plans for moving forward.

There was widespread agreement that to achieve a significant reduction in postnatal transmission of HIV, and a corresponding increase in maternal and neonatal nutrition coverage, a radical departure from the status quo will be required. The PHFS presents a unique opportunity to do things differently, to learn from change ideas that are proven successful, to apply the learning at scale, and to spread that

learning over multiple countries. The six countries at the launch meeting are in many ways pioneers for accelerating global progress toward HIV-free survival.

Below are several useful points of reference for moving forward:

- The *suggested* timeline and next steps for countries, including sub-district kick-offs, appear here: 
- Agreed timelines, tasks, and responsibilities for each country, except Kenya, appear here: [Lesotho](#), [Mozambique](#), [South Africa](#), [Tanzania](#) and [Uganda](#).
- As of March 22, several multi-country learning initiatives are in the works, including an M&E working group (and list serve), and a series of face-to-face and virtual learning events. Details are available here: 

Finally, the PHFS has a complex vision and noteworthy aspirations. There is, however, significant diversity across the six-country membership, requiring that each country adapt the concept to its own needs and priorities. Most importantly, the partnership requires that each country embrace the opportunities presented by the QI method and the learning platform. In particular, this entails the sharing of data and lessons openly so that successes can be scaled up rapidly, and the goal of increasing HIV-free survival can become a reality over the next two years.

