REPUBLIC OF SOUTH AFRICA

KINGDOM OF LESOTHO

REPUBLIC OF MOZAMBIQUE

THE PARTNERSHIP FOR HIV-FREE SURVIVAL (PHFS)

Southern Regional Meeting
Maputo, Mozambique
October 23–24, 2013

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Acknowledgments

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Acronyms

ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral drug
ASSIST	Applying Science to Strengthen and Improve Systems
CCR	children at risk clinic (in Portuguese)
CDC	U.S. Centers for Disease Control and Prevention
CHW	community health worker
CTT	community tracking tool
eMTCT	elimination of mother-to-child-transmission (of HIV)
FANTA	Food and Nutrition Technical Assistance III Project
GAAC	Community-Based Support Group for Adherence (in Portuguese)
HCT	HIV counseling and testing
HIV	human immunodeficiency virus
IHI	Institute for Healthcare Improvement
LIFT	Livelihoods and Food Security Technical Assistance Project
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
PCR	polymerase chain reaction
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
U.S.	United States
UNAIDS	Joint United Nations Program on HIV/AIDS
URC	University Research Corporation, LLC
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

The Partnership for HIV-Free Survival (PHFS) was conceived by the World Health Organization (WHO) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to accelerate the adoption and implementation of the WHO 2010 prevention of mother-to-children transmission (PMTCT) guidelines, and accompanying HIV and infant feeding guidelines, with the ultimate goal of increasing HIV-free survival. The Partnership was launched in March 2013, with six participating member countries—Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda.

While all six PHFS countries have now adopted these guidelines, operationalizing them remains a major challenge. Uptake by countries has been slow, and health care systems have struggled to support the necessary integration of PMTCT; maternal, newborn, and child health; and nutrition services for mother-infant pairs. In particular, retention in care remains poor in all countries, with a significant portion of mother-infant pairs being lost to follow-up during the early postnatal period.

The southern regional PHFS meeting took place seven months after the Partnership launch in Pretoria, with participation from three of the six member countries—Lesotho, Mozambique, and South Africa. This two-day encounter provided a supportive venue for sharing data, expressing challenges, and reaching out to one another for solutions to common problems. Primary topics for discussion included: (1) retention of mother-infant pairs, (2) implementation of nutrition assessment, counseling, and support (NACS), (3) knowing the HIV status of every mother-infant pair, and (4) ensuring optimal antiretroviral therapy coverage for every mother-infant pair.

Country teams also reported their progress along the quality improvement (QI) care path, and noted plans for enhancing data systems, testing change ideas, and using data to demonstrate change and increased buy-in. With regards to the QI process:

- Lesotho has recently completed QI training and is in the early stages of its QI path. In the coming months, the team will focus on building will among stakeholders to engage in the QI process and focus on developing its QI capacity, drawing on technical support from partners as much as possible to ensure a strong foundation.
- Mozambique has the advantage of an existing national QI program in the majority of PHFS provinces to use as a foundation. As the team has learned, however, this comes with its own set of challenges, and makes coordination and collaboration with the Ministry of Health vital to their success. As Mozambique continues to roll out the QI process, a primary task is to assimilate plans and systems into existing national strategies.
- South Africa also benefits from a pre-existing national QI system, and strong local capacity for QI. Given their use of a collaborative model, referred to as the *the eMTCT Quality Improvement Learning Collaborative*, they have the potential for greatly accelerated scale-up and spread. As the PHFS evolves in South Africa, urgent priorities include demonstrating its added value to the Department of Health and improving coordination between partners on the ground.

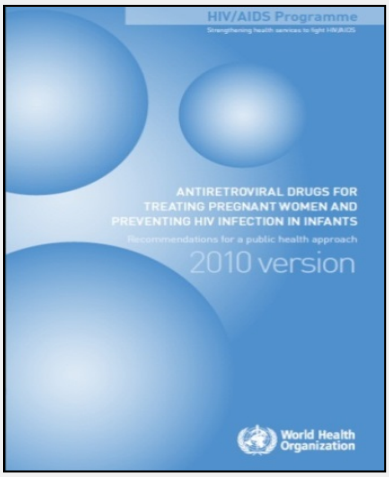
During this regional PHFS meeting, country teams were repeatedly reminded not to view their work in isolation and not to underestimate the importance of their efforts. The PHFS is "joining the dots" of what is being learned on the global journey toward HIV-free survival. U.N. agencies and donors are watching closely and looking to the PHFS for both results and lessons on how to operationalize the 2010 WHO guidelines. Given its size (six countries) and unique methodology (QI), the PHFS has the distinct potential to drive global policy over the next two years and beyond.

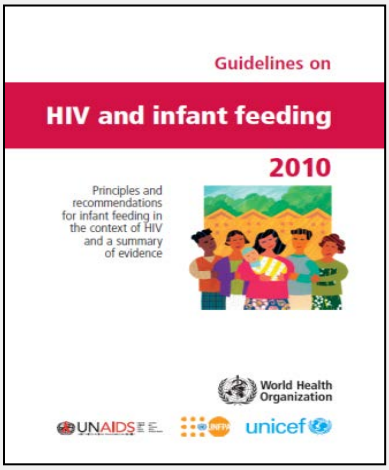
Finally, members were reminded that the clock is ticking, and the next six months (of the initial two-year start-up phase) are crucial to achieving the project's medium- and longer-term benchmarks for success. Building will among stakeholders, developing QI capacity, strengthening data systems, demonstrating results, and keeping pace with existing national QI programs will be the focus of the coming months.

Background

The Partnership for HIV-Free Survival (PHFS) was conceived by the World Health Organization (WHO) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to accelerate the adoption and implementation by countries of the WHO 2010 guidelines (see box to the right), with the ultimate goal of increasing HIV-free survival.

The PHFS was officially launched in Pretoria, South Africa in March 2013, with participation of six member countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. The Partnership grew out of a recognition that (1) there had been significant success in reducing the transmission of HIV from mother to child during the antenatal and perinatal periods of pregnancy, but that postnatal transmission rates, via breast milk, were still alarmingly high; and (2) infants born to HIV-infected mothers were at higher risk of mortality due to traditional causes of infant mortality such as diarrhea, pneumonia, malaria, and malnutrition.





WHO 2010 Guidelines

In 2010, WHO released updated guidelines on prevention of mother-to-children transmission of HIV, including guidance on HIV and infant feeding.

Since the previous guidance in 2006, new evidence had emerged (in 2009) demonstrating that antiretrovirals 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.

Fortunately, the landscape of prevention of mother-to-children transmission of HIV (PMTCT) is gradually changing. With the *Global Plan towards the Elimination of New Infections among Children by 2015 and Keeping their Mothers Alive*, by the Joint U.N. Program on HIV/AIDS (UNAIDS), and the gradual adoption of the 2010 WHO updated guidelines, many countries have moved to options B or B+ in order to ensure that mothers and infants receive maximum antiretroviral (ARV) protection during pregnancy and throughout the postpartum period.[1]

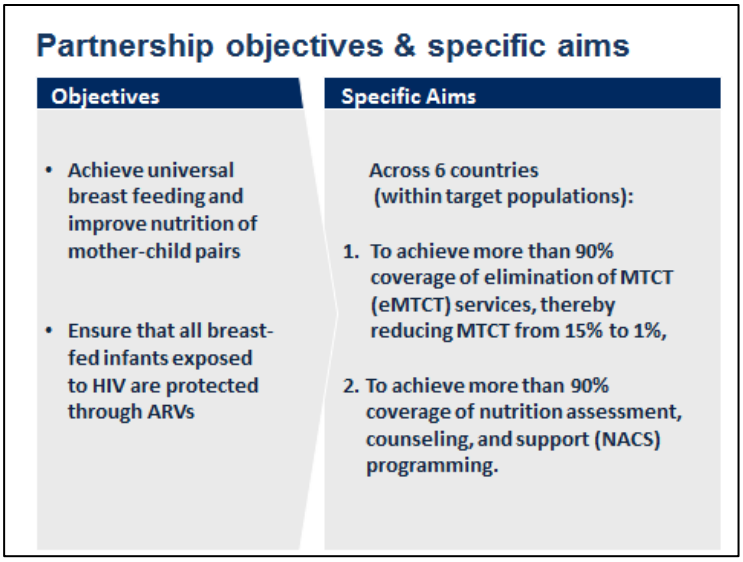
With WHO guidelines in place, and countries adjusting national policies to adhere to those guidelines, a primary challenge that remains is to ***bridge the gap*** between what's possible under the WHO guidelines (i.e., 1% or less postnatal transmission) and the current unacceptable postnatal transmission rates in the PHFS countries (as high as 15% without interventions).

Uptake of the WHO guidelines by countries has been slow, and health care systems and community outreach services have struggled to support the necessary integration of PMTCT; maternal, newborn, and child health; and nutrition services 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 improve the likelihood of HIV-free survival for their infants during their first two years of life. While impressive

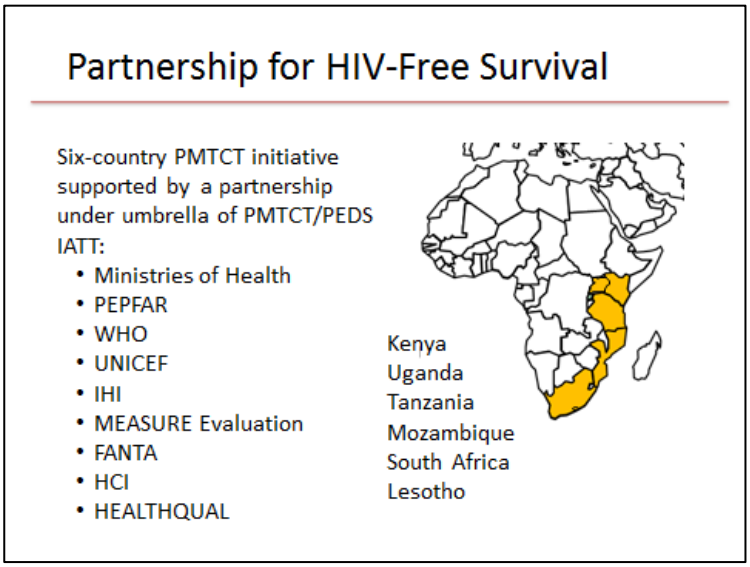
[1] Option A, B, and B+ are the three treatment options described in the WHO 2010 guidelines entitled *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Recommendations for a Public Health Approach.*

advances have been made in reducing antenatal and perinatal transmission (of HIV), reduction in transmission during the postnatal period (0–24 months) has lagged behind.

Closing this gap between "what we know is possible" and "our current reality" is the overarching goal of the PHFS, and the reason that the quality improvement (QI) methodology has been selected as its implementation tool (see QI Refresher later in this document). Through use of QI methods and the establishment of a cross-country learning platform, the Partnership intends to improve implementation of the WHO 2010 guidelines, and thus accelerate reductions in mortality and HIV infection among infants exposed to HIV.



The specific objectives and aims of the Partnership are listed in the graphic to the right. The U.S. Agency for International Development (USAID)/PEPFAR-sponsored nutrition assessment, counseling, and support (NACS) programming provides the framework and programming platform for integration and expansion of PMTCT and maternal and infant nutrition support during pregnancy and up to two years of life. This continuum of postnatal care is intended to support mother and infant during their period of greatest vulnerability—the first 1,000 days of from conception.



Importantly, the PHFS is *led* by the Ministry of Health in each of the six member countries. At its core, the PHFS is intended to boost *existing* national efforts and capabilities for the seamless integration and improved effectiveness of PMTCT; maternal, newborn, and child health; and maternal/infant nutrition services. Technical support is provided by the Institute for Healthcare Improvement (IHI), University Research Corporation (URC), HEALTHQUAL, and FHI 360. Under URC, the Applying Science to Strengthen and Improve Systems (ASSIST) project is providing support, and under FHI 360, both the Food and Nutrition Technical Assistance III Project (FANTA) and the Livelihoods and Food Security Technical Assistance Project (LIFT) are providing support.

This southern regional PHFS meeting took place seven months after the Partnership launch in Pretoria with participation from three of the six member countries—Lesotho, Mozambique, and South Africa. The Eastern Regional PHFS Meeting took place the following week in Entebbe, Uganda. This report documents the proceedings and summarizes key findings, conclusions, and next steps from the southern regional meeting.

Objectives of the Meeting

The following objectives were established for the meeting:

1. Understand the state of member-country implementation and learn from each other's best practices through sharing evidence
2. Provide teams with an opportunity to work together to update their implementation and testing plans from other countries' experiences
3. Assemble best practices and challenges for sharing across all PHFS countries
4. Lay out specific plans for the next six months

Participants 

There were a total of 69 participants at the two-day regional meeting. The majority of participants came from the three member countries in the southern region, with the following number of participants from each: Lesotho (11), Mozambique (33), and South Africa (12). The remaining participants came from the United States, Switzerland, and Denmark. A complete list of participants appears in the post-script document file (PDF) above.

Those participants not from member countries consisted of staff from technical partners (IHI, FHI 360/FANTA, FHI 360/LIFT, URC/ASSIST, and HEALTHQUAL), as well as USAID, the U.S. Centers for Disease Control and Prevention (CDC), and WHO. Country teams were made up of representatives from the ministries/departments of health, UNICEF, nongovernmental organization (NGO) implementing partners, and technical partners mentioned previously.

Meeting Process

The meeting utilized a wide range of workshop formats and methodologies to ensure full and active participation of country teams and technical partners. In particular, sessions rotated between introductions, presentations, and small-group discussions to share learning from the various countries. In some cases, mixed-country groups were assembled (to ensure learning *between* countries), and in other cases, country-specific groups were used, mostly to facilitate work plan development.

Session topics were focused on particularly challenging themes, e.g., retention of mother-infant pairs, with the intent of eliciting ideas and lessons, and sharing them across the three participating countries. Opportunities to provide technical support on various topics, including QI and NACS, were also built into the sessions. IHI, FHI 360/FANTA, FHI 360/LIFT, URC/ASSIST, and HEALTHQUAL led those sessions.

A storyboard/poster session was conducted in the evening of the first day, with the intent of updating one another on in-country progress, and sharing lessons, ongoing challenges, and learning to date. A dedicated session on the learning platform was also conducted, eliciting feedback on what has worked, what has not worked, and what participants would like to see change over the upcoming six months. The final session provided country teams with the opportunity to examine the ideas gleaned over the two-day meeting and incorporate them into updated work plans.

Day 1 Proceedings

Opening and Keynote Remarks

Rosa Marlene Manjate, Mozambique Ministry of Health

Dr. Rosa Marlene Manjate, the National Vice-Director of Public Health, extended a warm welcome to all of the PHFS partners on behalf of the Mozambican Ministry of Health (MOH). She noted that Mozambique has nearly 1.7 million people living with HIV and lamented the difficulty that the health care system has had in supporting and caring for these citizens properly. Dr. Manjate described some of the extraordinary challenges faced by the health sector, including technical difficulties and lack of capacity.

She appealed to health care colleagues in all of the three PHFS countries to continue working to improve service provision for people living with HIV, and importantly, she urged participants to view people in a holistic manner, not as a person on antiretroviral therapy (ART), a person with tuberculosis, or those with other such labels. Clients, including infants, must be served in an integrated manner, and this includes addressing concerns around nutrition. She also noted that it's crucial for women to access maternal and child health services early in their pregnancy, and for them to be provided with the ART and nutrition support necessary to avert vertical transmission of HIV.

As a country, Mozambique has made a significant investment in QI since launching its own national QI strategy, which covers all aspects of health, including PMTCT and nutrition. She acknowledged that the goal of HIV-free survival cannot be attained in Mozambique by the government alone; rather, it requires collaboration and sharing between countries and partners. Finally, Dr. Manjate appealed to all of the partners present to continue their support, cooperation, and provision of technical expertise so that the quality of health services for all people in this region will be improved.

Ms. Juno Lawrence-Jaffer, USAID Mozambique

On behalf of the USAID mission in Mozambique, Ms. Lawrence-Jaffer thanked Dr. Manjate for her presence and her poignant comments about the situation in Mozambique. She also conveyed regrets from Dr. Tim Quick and Ms. Amie Heap of USAID/PEPFAR in Washington D.C. who could not attend due to the recent U.S. Government shutdown.

By way of review, and for the participants who did not participate in the PHFS launch in Pretoria earlier in the year, Ms. Lawrence-Jaffer gave an overview of the Partnership's conceptual origin and history. She noted that this meeting provides the members with an opportunity to review individual and collective progress toward the partnership goals six months into the program; to examine successes and remaining challenges; and most importantly, to update and strengthen country-specific work plans based on learning during the regional meeting.

> "At its core, this Partnership is designed to capture and promote best practices in implementing the WHO 2010 guidelines on infant feeding, and to enhance the efforts of the six PHFS countries towards HIV-free survival."
>
> *– Ms. Juno Lawrence-Jaffer, USAID Mozambique*

PHFS Introduction and Overview 

Nneka Mobisson-Etuk, IHI South Africa

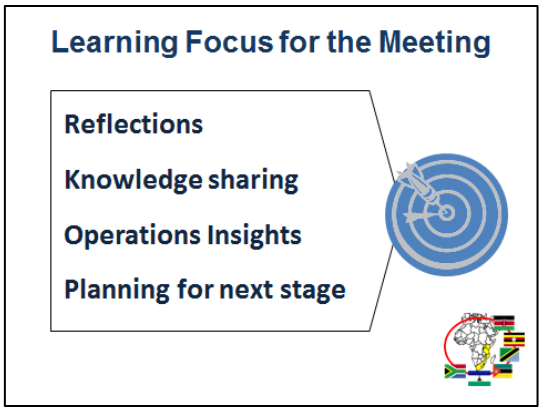
Dr. Mobisson-Etuk was the overall moderator for the meeting. She welcomed participants and guests, then explained the purpose of the meeting: to provide an opportunity to share the experiences and learning that had taken place since the Partnership was launched seven months prior.

Dr. Mobisson-Etuk urged participants to consider the meeting as a safe haven for sharing what had worked and what had not, along with any and all feedback they might have regarding the Partnership itself. She emphasized that one important outcome from the meeting would be an action plan to guide country-specific activities until the group comes together again in six months. Participants were encouraged to use the action plan template (see PDF) to register ideas that they gleaned during the sessions, so that they could later be incorporated into their country plans.

Dr. Mobisson-Etuk reminded the group that each of the countries are at different stages in implementing the PHFS, but that country participants had much to learn from one another over the next two days. The session plans were specifically constructed to allow for cross-country learning (discussions with mixed-country groups), and for country-specific planning (discussions with country teams) so that learning could be immediately incorporated into country plans.

Dr. Mobisson-Etuk reviewed the agenda for the upcoming two days and summarized the tasks and expected outputs, as listed below. For the detailed agenda, click on the PDF.

1. **Operations:** To learn about progress in other countries, challenges, and potential solutions to enhance ongoing operations and to share with teams back home.
2. **The four step "care path" (*break-out sessions*):** To discuss on-the-ground progress and focus on plans for testing/tracking change ideas and data.
3. **Story board reception:** To share and learn from the specifics of country activities.
4. **Next steps for cross-country exchange:** To share and learn from the specifics of country activities.
5. **Sustainability/Scale-up:** To begin planning for scale-up and "spread" design.
6. **Team action planning:** To develop robust plans for activities in each country.



Putting the PHFS's Role into Perspective

Nigel Rollins, WHO

Dr. Rollins provided additional context regarding the role of the Partnership in the global arena of HIV, PMTCT, and child survival. He emphasized that participants should *not underestimate* the importance of their work. Organizations such as WHO and UNICEF are particularly interested in what each PHFS country team is doing and how that work is being linked to national planning in each country.

In recent years, the Interagency Task Team on PMTCT has acknowledged the need for linking and positioning PMTCT within the broader realm of child survival programming. The goals of the PHFS encapsulate this shift in thinking, and high-level members of the Interagency Task Team (including U.N. agencies and donors) are looking to the PHFS for both results and lessons on how to operationalize the 2010 WHO guidelines to achieve HIV-free survival.

Furthermore, the Global Steering Group of the *Global Plan towards the Elimination of New Infections among Children by 2015 and Keeping Mothers Alive* has recently prioritized five countries in moving towards the elimination goal. Three of those countries—Mozambique, Tanzania, and Uganda—are PHFS members, providing the Partnership with a strategic opportunity to inform national elimination plans, and to lead progress on a global scale.

Finally, Dr. Rollins stressed that the PHFS country teams should not view their work as isolated, independent projects. The PHFS is "joining the dots" of what is being learned; it will be up to UNICEF, WHO, and others at the policy level to ensure that this learning spreads across the globe. While the Partnership is not *currently* driving policy, it does have the *potential* to do so.

Session 1—Unpacking Operations and Project Management

Bruce Agins, HEALTHQUAL and Puni Mamdoo, South to South

Before delving into the primary focus of this session, Dr. Agins and Dr. Mamdoo asked each of the country teams to deliver a three-minute update on PHFS-related progress in their country.

Lesotho: Lesotho has adopted Option B+ for their treatment approach. The PHFS team has selected three districts in which to implement the PHFS, which include 15, 12, and 14 facilities in those districts. They have formed QI teams at the sites who have recently been trained in the QI methodology. They also developed a plan for carrying out the PHFS and recently begun discussing that plan with various partners. Nutrition surveillance training has also taken place, and the team is currently discussing relevant indicators for nutrition and PMTCT. Finally, it was decided that the Food and Nutrition Coordinating Office will release a quarterly bulletin to inform the various stakeholders of the Partnership's progress.

Mozambique: Mozambique has adopted Option B+. The PHFS team has selected three provinces in which to operate, and within those provinces, they've chosen four districts with a total of eight participating health facilities. PHFS-specific indicators were identified in April and the operational plan for the PHFS has been finalized and approved. QI training of the teams has taken place in three of the four districts thus far; the remaining district is in Gaza province, and teams there will receive training next month. Data collection took place in one province; the other two (Gaza and Sofala) will begin to collect data soon.

The Government of Mozambique had a national QI strategy in place prior to the inception of the PHFS, so a primary task for the PHFS has been to assimilate plans into existing strategies. The existence of the national strategy provides a foundation for the PHFS and has led to early success with rolling out the Partnership.

South Africa: South Africa has adopted Option B for their treatment approach. The PHFS is being integrated into the existing QI work taking place throughout the country. This integrated effort is referred to as the *eMTCT Quality Improvement Learning Collaborative*. The QI work in South Africa aims to accelerate existing eMTCT (elimination of mother-to-child-transmission of HIV) programs and has already demonstrated significant success. The PHFS is working in four districts with 33 participating facilities. QI teams have been formed; they have had several learning sessions; and have a national monitoring and evaluation dashboard with the eMTCT and nutrition indicators being used. NACS is an integral part of the PHFS, and NACS program staff have participated in the PHFS learning sessions.

Next, each country took a turn recounting their experience as it related to one of the topics listed in the following table and then led a discussion on that topic.

Country responsible for leading discussion	Discussion topic
Mozambique	Harmonization and integration with MOH programming
South Africa	Improving PMTCT: Learning sessions and testing changes
Lesotho	Communicating with stakeholders and linking to communities

Team Mozambique—Harmonization and Integration with the Ministry of Health

The first step taken by the Mozambique team was to establish a steering committee that included representation from the maternal and child health, nutrition, and PMTCT departments/sectors within the MOH, as well as the national QI initiative. There was also participation from bilateral partners, including the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), CDC, HEALTHQUAL, URC, FANTA, among others. Together, this group put together a plan of action that began with examining existing (national) QI activities and looking for ways to integrate the PHFS.

One major challenge during this period was a health care workers strike which lasted more than two months. Another challenge was that the national strategy was already ongoing, and there was pressure to integrate the PHFS quickly. And finally, there were numerous conflicts in timing given all of the different MOH activities running simultaneously. This was particularly difficult since the rollout of respective trainings often involved the same staff.

Despite these operational challenges, the existence of an existing national QI strategy is generally viewed as an advantage by the Mozambique PHFS team, and integration of indicators and processes has been successful to date.

For the mixed-country group learning exercise, the Mozambique team posed the following questions for small-group discussion:

1. *What challenges have you faced in the harmonization and integration of the PHFS?*
2. *What are the solutions you have developed to deal with them?*

Responses from the mixed-country groups are summarized below:

Challenge: South Africa and Lesotho both reported relatively poor communication and coordination between the PHFS partners, particularly between the three NGOs in South Africa.
Solution: Both countries are working to strengthen these aspects and are considering the establishment of a coordinating body, such as the one in Mozambique.

Challenge: Lesotho didn't conduct stakeholder mapping to understand who should be involved in PHFS. As a result, the players involved aren't necessarily the right ones.
Solution: There are plans to hold a stakeholders meeting, review membership, and encourage more buy-in.

Pay Attention to Who and What!

This learning event presents an extraordinary opportunity. Pay attention to *ideas* and *experiences* that are mentioned, and to *who* expresses them. Track that person down at lunch or during breaks and be proactive to learn more about what they said.

– Bruce Agins, HEALTHQUAL

Challenge: There is concern that the PHFS brings with it additional work for district- and facility-level staff, and it is not yet seen as a way to improve their efficiency and effectiveness.
Solution: Teams were encouraged to discuss this further throughout the meeting.

Challenges: Mozambique and Lesotho reported that their data collection systems were unreliable.
Solution: Teams were encouraged to request technical assistance from the relevant partners in their countries—e.g., HEALTHQUAL and URC/ASSIST respectively.

Challenge: Both Mozambique and South Africa cited challenges related to alignment and integration of the PHFS into the pre-existing national QI priorities and systems. In Mozambique, this has been especially difficult given that there are various MOH agencies/departments involved (e.g., PMTCT, HIV/ART, etc.) and they operate in separate silos. In South Africa, the national PMTCT program already has a QI component built in, so there is concern from within the MOH that the PHFS is a duplication of effort.
Solution: The Mozambique team continues to coordinate closely with the relevant MOH agencies and sectors. The South Africa PHFS team brought members of their national nutrition team to this meeting to help them understand the aims of the PHFS, foster better communication, and show them that it is not meant as a stand-alone initiative, but to support existing Department of Health efforts. The PHFS in South Africa has also sought to achieve buy-in at the facility level first, and to work their way up from there.

Challenge: Both Mozambique and South Africa noted that buy-in from the various levels of the health sector has been a challenge.
Solution: In South Africa, the PHFS teams have found that once success is demonstrated using the QI method, buy-in follows naturally. At the national level, it also helps that the PHFS has selected indicators that are aligned with the national program and already on the monitoring and evaluation dashboard.

Challenge: There is poor integration of services at the point of entry to the facility; clients are coming in for one service, e.g., antenatal consultation, but may have missed their HIV counseling and testing (HCT) appointment, and there is no common tracking tool to pick this up.
Solution: An integrated, holistic screening process at the point of entry would ensure that mother and baby are up-to-date on all of their consults, and if not, gaps can be identified and referrals be made on the spot.

A Good Idea is a Hard Thing to Stop!

An interview with Puni Mamdoo of South to South, one of the PHFS partners in South Africa.

Click on the video icons below for footage of that interview.

 At the health clinics in South Africa, there were systems in place to have mothers receive HIV counseling and testing (HCT) as part of their postnatal visit. However, after having their routine maternal and child health consult, including the palpation of the baby (and where they were informed of the gestation of the baby), they often left the clinic, discouraged by long lines and less interested in the HCT aspect of the consultation.

 Using the QI method, clinic staff came up with the idea of rearranging the order of the services so that the palpation, which is what the mothers really wanted, came at the end of the visit.

 The health care workers knew the context and understood what the patients were coming for. The plan-do-study-act (PDSA) technique provided a framework for eliciting ideas, testing them, and then measuring whether they worked. In the end they arrived at a solution that worked for the mothers, and that improved HCT rates.

Challenge: Training on QI and the PHFS are done once, but newly arriving staff are unaware of the initiative.
Solution: Build QI and PHFS components into the job orientation program for all new health facility staff, including that of community-based health workers and volunteers, so that they start their job well-informed and understanding what's expected.

Team South Africa—Improving PMTCT: Learning Sessions and Testing Changes

The PHFS in South Africa is implemented in 33 facilities, including some hospitals. The team is trying to integrate the PHFS into existing programs, and has focused most intensely at the facility level. In KwaZulu Natal they are fortunate because the local Department of Health has taken a keen interest in the PHFS, so in that district there is good buy-in.

South to South is one of the three PHFS technical partners in South Africa. They focus on early antenatal booking as a vital aspect of PMTCT. At one of the recent learning sessions facilitated by South to South, FHI 360 was present and discussed maternal and infant nutrition. Many of the participating clinic staff heard about the importance of nutrition in maternal health for the first time. During this discussion, it was noted that although children were coming in for their immunizations on time, many malnourished children weren't identified, even though there was supposedly a comprehensive nutrition assessment tool in place.

Following the learning session, staff returned to their home clinics with the goal of investigating this aspect and found that nutrition assessments were being conducted correctly in *only one* of the nine clinics. This was partly because the assessment tool was somewhat sophisticated and intended to be applied by an experienced nutrition advisor. Unfortunately, these advisors were not always on hand at the clinic. The team determined that the current system was not effective, nor scalable, since it relied on staff that were not always present. The PHFS teams are currently exploring modifications to systems in order to address these problems.

For the mixed-country group learning exercise, the South Africa team posed the following question for small-group discussion:

> *How can we improve retention of mother-baby pairs over time?*

Ideas from the mixed country groups are summarized below:

- Retesting of mothers and babies at six weeks, and then quarterly, is extremely important for improving retention. It's also important to have a tracking system to record the result, and to involve community health workers in this process.
- Use a "one stop" health care model to ease the travel time/cost and child care burden on clients.
- Provide client education on what to expect from health care services, using morning health talks, orientation on arrival, etc. This should include setting realistic expectations regarding what the clinic can and can't do.

South Africa Enacts Re-Testing Policy

In South Africa, a new policy requires that infants are tested for HIV at six weeks, and then every 12 weeks for as long as the mother is breastfeeding. This policy was a response to the finding that infants of HIV-negative mothers (i.e., infants of mothers who tested negative during pregnancy), were sero-converting during breastfeeding.

This is likely because the mothers had sero-converted after being tested. At a learning session in Kwa Zulu Natal, clinic staff examined whether these re-tests were taking place and the systems in place to ensure them. They used QI to bring re-testing rates closer to their targets of 70% the first year, and 80% the second.

- Keep mother-infant pairs together for 18 months, then transfer the pair together to ART.
- Mozambique uses community-based mother support groups. These groups have a link with the health facility; the groups receive a list of people who didn't come to visits so they can conduct follow-up.
- Mobile clinics offer PMTCT and ART services on a monthly basis to access hard to reach communities.
- In Mozambique, a program called Community-Based Support Group for Adherence (GAAC in Portuguese) arranges people living with HIV into groups of six, and one individual from each group picks up their medication. This saves in travel time/cost, child care, etc. and promotes adherence through accountability between the group members.
- In South Africa, there is something called "Reengineering Primary Health." There are three levels of health care and the primary health care team is headed by a nurse and a team of community health workers (CHWs) that do home visits, partly to enhance retention. The teams are not established everywhere in South Africa, but the intent is that they will be eventually.

Team Lesotho—Communicating with Stakeholders and Linking Communities

In Lesotho, the Partnership members include ministries and implementing partners. They have a monthly PHFS meeting and they have recently developed a template for monthly reporting on PHFS progress. The MOH operates only at the facility level, and at the community level there are village health workers who contribute to MOH work by conducting growth monitoring and other services within the communities.

Two-way communication between the village health workers and health facilities remains a significant challenge. They are, however, in the process of developing a reporting tool for village health workers that will facilitate the flow of information back to the facility. In general, communication between community and facilities, and from districts up to national level, is slow, and since there is no PHFS focal point at the district level, communication can be complicated.

For the mixed-country group learning exercise, the Lesotho team posed the following question for small-group discussion:

> *How do we operationalize two-way communication between the community and the facility? In particular, if someone at the community level refers a client to a facility, how do we ensure that the client actually received the services?*

Ideas from the mixed country groups are summarized below:

- In Mozambique, health committees made up of community leaders, religious leaders, and practitioners of traditional medicine meet once per month to discuss the health situation in their communities and make suggestions on improvements. Representatives from the health facility are also present.
- In South Africa, there is a system of multisectoral committees (covering health, education, agriculture, etc.) that liaises with the health center.
- In Lesotho, they have home caregivers who act as a bridge between the community and facility. When clients miss appointments, the home caregivers find the client and facilitate the client's return to the facility for follow-up.
- In South Africa, the health committees in the community are connected to a community caregiver, and the community caregiver has regular meetings with the health facility manager to ensure a two-way flow of information.
- In South Africa, the Reengineering Primary Health Care mentioned in the previous section intends to enhance the position of the CHWs, who play a key role in communicating vital information between

the facility and community. For example, they send out teams of CHWs to investigate when they discover certain health problems are coming up at the facilities.

- It's best to first examine what kinds of groups or committees already exist in the community and build on that, instead of creating something new.
- While these CHWs are vital to maintaining links between the community and the health facility, providing remuneration/incentives is an ongoing problem in all of the countries. All three countries have community-based volunteers in place, but they have different mechanisms for retaining them. In South Africa and Lesotho, the MOH provides incentives directly and in Mozambique, NGOs provide incentives. Turnover remains high among these workers.
- Lesotho has a patient tracking tool and system to ensure mothers and infants adhere to PMTCT and other relevant consultation schedules.
- Intensive counseling is recommended to encourage mothers to adhere to their consultation schedule.
- Tracking mother and infant in pairs could be helpful. At the moment, the mother stays in care, but often the infant drops out. Clipping the cards (of the mother and infant) together could help.
- Engage community leaders who are active to help make referrals.
- It's important to have a two-way referral slip so that the second slip (the copy) is sent back to the person/group that made the referral and confirms that the client received the service.
- The GAAC in Mozambique, mentioned in the previous section, can act to bridge the gap between the health facility and the community. Similarly, the community health committee and co-management committees are comprised of community leaders and can play this role. The GAAC is a new concept in Mozambique. This role was historically filled by home-based care workers from NGOs.
- In Mozambique there is a system of multi-purpose primary agents (APE in Portuguese). These agents follow standardized health protocols, use referral slips, and do community management of diarrhea and other common problems. There are now approximately 2,500 of these quasi-governmental staff and they are currently paid by the MOH with donor funding.

The Need to Demonstrate Progress

Justin Mandala, FHI 360, URC/ASSIST

Mr. Mandala provided insight on the perspective of the donor and the commitment of the PHFS to empirically demonstrate progress. He commented that given its size (six countries) and methodology (QI), the PHFS has a unique and extremely important role to play on the global eMTCT stage. With membership to this Partnership comes a significant amount of responsibility, and over the next six months, the group will need to start demonstrating what has been achieved.

Ultimately, PEPFAR will measure the PHFS's success against two primary indicators: (1) how many women were put on ART, and (2) how many were retained in care. While there are many indicators that the Partnership is interested in improving on, the Partnership cannot lose sight of the bottom-line indicators that the donor will use to assess the project.

Breakout Session One

Introduction—Nigel Rollins, WHO

Participants were asked to select one of the two breakout sessions to attend. The sessions were held simultaneously and included presentations and in-depth discussions.

1. **Ensuring Nutrition Assessment, Counseling and Support (NACS)**, *facilitated by Clinton Sears, FHI 360/LIFT II*
2. **Retention of Mother-Infant Pairs**, *facilitated by Amy Stern URC/ASSIST and Justin Mandala, FHI 360, URC/ASSIST*

Dr. Rollins noted that retention in care is a complex issue. As well, there are a wide range of issues to be considered under nutrition assessment and counseling. What's offered under these two areas (retention and NACS) will vary between facilities, districts, and countries. But when it comes to QI, there are certain common questions that need to be asked at all Partnership sites: *What will be the data that is used on a regular basis? What will be the data collected when sitting with the mother?* and *How will the data be aggregated at the end of the month to use for QI?*

The biggest challenge (and opportunity) as a cross-country learning platform is figuring out how to measure and monitor retention for use in a QI methodology, and figuring out what will be the NACS data that is used for a QI methodology. These are the underlying questions the participants were asked to keep in mind during the two breakout sessions.

Report Back on Session One Breakouts

Ensuring Nutrition Assessment, Counseling, and Support (NACS)

Nigel Rollins, WHO

Dr. Rollins asked each country to present 2-3 data elements that they agreed upon from the NACS discussion group. After each country reported, he offered technical feedback on each data element.

Mozambique: The indicators selected by the Mozambique team were discussed at length in country and have been pre-tested. All were chosen because they were already part of the national QI strategy. There are four sets of indicators:

1. % of exposed children that receive nutrition assessments, and mothers of exposed children that received assessments. These indicators are collected every three months for exposed children for their first 18 months of life. *Critique: Good, very practical. Easy to measure since they are based on absolute numbers.*
2. % diagnosed with severe acute malnutrition or moderate acute malnutrition, for exposed children and mothers of exposed children *Critique: Good, very practical.*
3. Of those eligible for supplementary or therapeutic products, % receiving those products. Again for exposed children and mothers of exposed children. *Critique: Good, very practical.*
4. % exclusive breastfeeding at six months.

How Many QI Data Elements Make Sense to Measure?

Mozambique started QI in 32 facilities under the national program. To date each facility follows 5-7 data elements monthly. The areas covered are broader than just PMTCT, and include ART, nutrition, etc.

They don't yet know what is possible for one facility to handle, but for the moment they have prioritized just 5-7 out of a total of 88 indicators that are monitored and evaluated through the national system. This is the number that they thought they could practically handle given each facility would have to collect and analyze it themselves on a monthly basis. They also decided that they would not follow *every* client, but instead select and monitor a limited sample.

Lesotho

1. % of underweight pregnant women at the health facility level, measured monthly. *Critique: To interpret underweight during pregnancy is almost impossible. Need much more specificity and it has to be possible to measure at a primary health facility.*
2. # of underweight children under two years of age at the health facility and at community levels, measured monthly.
3. % of children under six months who are exclusively breastfeeding, measured monthly.

South Africa

1. % of children exclusively breastfeeding at 14 weeks.
   Critique: Very good because it's measured at a specific point in time. It's a data element that can be measured repeatedly over time and easily compared. It has an easily defined numerator and denominator.
2. Growth monitoring of infants less than two years of age.
   Critique: This is too complicated since it involves interpreting "changes" in nutritional status. Growth faltering is challenging to measure for QI. Many countries find it too difficult to measure height; they are therefore using mid-upper arm circumference (MUAC) since it's a single measure. Instead, consider measuring the number of children with low MUAC, or low weight-for-height using a designated cut-off.
3. Maternal nutrition status—something that screens for obesity and underweight.
   Critique: You won't be able to measure micronutrient status. Also, to interpret underweight in pregnancy is almost impossible. You could look at BMI at 3 or 6 months postpartum.

General Comments by Dr. Rollins

For any of these indicators, there needs to be more specificity; i.e., a precise statement of the measurement and how often it will be collected. And, it must be practical and within the capacity of the primary health care staff to measure, analyze, and interpret.

Most countries have a much longer list of PMTCT and nutrition indicators collected for patient care and for health system monitoring. The indicators discussed during this session refer to the subset that will be monitored monthly for QI purposes only.

Reminder of the 14 PHFS Data Elements

In the months leading up to the PHFS launch, and over the past six months, in-depth discussions were held between the six PHFS country teams, USAID, CDC, the monitoring and evaluation staff, and technical partners to arrive at a list of 14 data elements that will be tracked by the PHFS. See the PDF above for a complete list of PHFS data elements.

Retention of Mother-Infant Pairs

Amy Stern and Justin Mandala, FHI 360, URC/ASSIST

There was general agreement that retention is poor across all three countries. The exact magnitude of the problem is difficult to express. Three key reasons for poor retention were cited as follows:

- Poor coordination between the antenatal care (ANC) system and PMTCT/HIV/ART services
- Stigmatization
- Migration of people to and from different geographic areas

A long discussion ensued about how to measure retention. Participants need to know: *Are mother-infant pairs who are supposed to be in care, actually retained in care?* Most of the discussion was focused on determining the denominator of this measurement. Some of the categories of individuals who should populate the denominator include:

- All HIV-positive women who come for ANC

- All pregnant women who test positive in HCT
- Exposed infants where the mother is not yet identified as HIV-positive [2]
- HIV-positive infants with mothers lost to follow-up

Next, the group discussed how to collect the data to populate the denominator. For example,

- In Lesotho, data would need to come from three registers: ANC register, delivery register, and maternity and postnatal register.
- In South Africa, data would need to be collected from the ANC register, HCT register, and maternity register, as well as the register for mothers that have tested positive.

Comments from Dr. Rollins:

- One option is to use the number of women collecting their ARVs monthly as a proxy for retention in care (i.e., numerator).
- Feeding practice at that time would need to be known.
- For option B+ countries, receipt of ARVs would be independent of feeding practices, since the mother will be on ARVs for life. But for option B countries, it is essential to know the mother's feeding practices.
- One important question is: *Can we achieve the processes in the clinic to collect these numbers from the various registers on a reliable basis?*

This discussion about retention is now taking place in many countries. WHO, UNAIDS, and UNICEF are proposing the following *draft* public health indicator for retention:[3]

> % of HIV-infected women who come back to the clinic at six months postpartum.

No one knows how easy it will be to collect. Basically, if the woman comes through the door, this is a proxy for retention. It's not exact, but it's a reasonable starting point for getting some information about retention over time. Work is currently under way by the U.N. agencies to finalize this draft indicator.

Evening Storyboards

Each country was asked to develop and present their storyboard on progress to date for their respective in-country Partnerships. The storyboards also included topics such as: what the country team is most proud of; successes and challenges to date; what they've learned along the way; and plans for the upcoming quarter. The template and instructions for completing each country's story can be found on the PDF above.

Highlights from each country's storyboard presentation are described next, along with the full presentation on the PDF links.

[2] This refers to infants who sero-convert during breastfeeding with mothers who tested negative during pregnancy, i.e., the mother sero-converted *after* testing.

[3] It's important to realize that there are indicators for public health purposes, ones for QI, and others designed for research purposes. For research, there would be extraordinary sources for measuring. For QI there is a need to be more practical.

Lesotho:

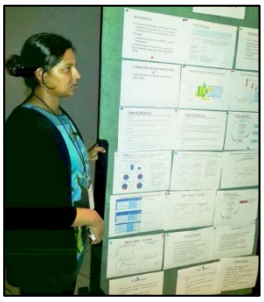
"We've been working hard to sensitize people at different levels about the concept of the PHFS. We want them to understand that this is not a new program that's running parallel and that it's actually here to strengthen the PMTCT program that we already have."

"We have something called a community tracking tool (CTT) that is very useful. When we have mothers that have missed their appointment, we write the names of those people in the CTT and the community health worker gets a slip of paper with that mother's name on it. They go to the community and find her, explain the issue and give her the slip. When the mother comes to the clinic with the slip, we note it in the CTT. Using the CTT we can see if our follow-up is effective."

Team Mozambique:

"The MOH was developing a QI strategy for national rollout, starting with a pilot in three provinces, and it was using HIV and NACS indicators. The team that was rolling out the national QI strategy was the same team that we would use to roll out the PHFS, so we saw this as an opportunity to integrate everything at once. "

"We have just one methodology and one unified data collection system. This is one of the biggest successes we've had because the Partnership is not seen as something separate or different—it's all integrated, and it's viewed as coming from the MOH, not from the outside. Integration definitely comes with its challenges, but in the long run, the combined system will be more effective and sustainable."



South Africa:

"One of the big successes is that we've set up a data management system that allows the facilities themselves to examine their performance. South to South helped build their capacity (at facility and sub-district levels) to compile the data, analyze it, and interpret it. We trained the staff and did intensive mentoring. The mentoring is what really makes the difference; building a relationship was the most important thing. People don't care how much you know, until they know how much you care. They have to trust you first."

"One of the issues was that we needed more Department of Health representation on the initial PHFS task team. This led to poor coordination, and even between the local partners, we didn't often know what each other was doing. There is a call now for better communication; that hopefully starts at this meeting. We are interested in learning more about the steering committee that's used in Mozambique."

Site Visit to Option B+ Health Facility in Bagamoio, Mozambique

Facilitated by Dr. Eduarda Gusmão, Mozambique MOH and Dr. Dulce Nhassico, FANTA Mozambique

On the morning before the regional meeting, the Mozambique PHFS team hosted a site visit to the Bagamoio health facility to share experiences on the implementation of Option B+. There were nine participants, including PHFS team members from South Africa and technical assistance partners from the United States and Mozambique.

The visit was hosted by the facility director and nurse responsible for PMTCT, and facilitated by Dr. Eduarda Gusmão of the MOH and Dr. Dulce Nhassico of FANTA. The group visited ANC services and a Children at Risk clinic (CCR in Portuguese). The ANC nurse shared her experience with implementing Option B+ as well as her experience with the one stop model. The nurses associated with the CCR services shared their experiences implementing the Nutritional Rehabilitation Program and the monitoring of children born to HIV-positive mothers. The nurses from both programs spoke of the day-to-day challenges they face, as well as their successes to date.

Below are some of the points noted, key reflections, and recommendations made by site visit participants:

Points noted

- Polymerase chain reaction (PCR) coverage at six weeks is around 47% and is higher in Maputo.
- Children with HIV, tuberculosis, and malnutrition are all integrated in the CCR clinic.
- 30–40% of mother-baby pairs are lost to follow-up.
- There are problems with recording cases of severe acute malnutrition.
- There is an ANC register in addition to a client card (held by the client) that records the client's details and all services received. These records make it easy to collate data and to monitor nutrition services to clients.

Key reflections

- Referral and follow-up of clients is a real challenge even within the health care facility. Just *telling* clients to go to a particular area for service does not guarantee that they will reach the site. To overcome "loss to follow-up in treatment" of clients, the site has a system whereby a health worker accompanies the client to the site to which they are referred, and hands the client over to the next point of service.
- An adherence support group of six mothers, called GAAC, aims to reduce the number of times an ART client needs to return to the clinic for services. Each month, a different member of the group takes a turn visiting the clinic to pick up medication for those in the group. The system also uses a focal person from the clinic to meet with the six mothers to ensure adherence. This focal person meets with various GAAC groups over the course of the month. GAAC is a national strategy and is being implemented for adults at the HIV clinic, but does not involve HIV-infected children, or pregnant or lactating women.
- The one stop model is an interesting concept for reducing the burden on PMTCT clients.
- The health facilities had good documentation systems; an important asset for QI efforts.
- The nutrition register was well-organized, clustering all the relevant information in one small box, making it easy to track clients longitudinally.

Recommendations from site visit participants

- The community follow-up of clients to ensure adherence should be scaled-up.
- Nutrition assessment should be conducted for all women using MUAC, and not only women that appear undernourished.
- Most "Road to Health Booklets" had weights plotted but no interpretation documented on the card. It would be helpful to complete the cards with this information.

DAY 2 Proceedings

Open Microphone—Review of Day 1

Dr. Mobisson-Etuk invited participants to share some of the highlights of the previous day, i.e., one thing that they learned from the proceedings. Comments are paraphrased below:

> "The most important thing is building a relationship. People don't care how much you know, until they know how much you care. They have to trust you first."
>
> *– South Africa storyboard presentation*

- Since the launch of the PHFS in Pretoria, we've realized that all of our countries have similar challenges and that we can learn how to solve them from one another.
- We learned about the model in Lesotho where mothers and infants are retained in pairs in maternal and child health for 18 months. We have several questions about how this works.
- We learned about Mozambique's mothers' adherence groups, where they collect ARVs for one another and support one another. We'd like to learn who is leading this from the clinic side and how it's organized.
- The Mozambique steering committee sounds like an effective coordination mechanism. We'd like to learn more about who the members are and how it was set up.
- In South Africa they've had success with improving retention; we'd like to hear more about that.
- In Lesotho, we have a lot of challenges with data collection and communications between the facility and community. We look forward to hearing more from South Africa on how they are overcoming these challenges.

QI Refresher

Pierre Barker, IHI

Given that approximately half of the participants at this meeting did not attend the PHFS launch in Pretoria, Dr. Barker provided a refresher on the value of QI (the full presentation is available via the PDF above).

Dr. Barker noted that the Millennium Development Goals (MDGs) are on the agenda of all of the countries, and the group should be particularly interested in MDGs 4, 5, and 6 (on child mortality, maternal health, and HIV). The "countdown site" (http://www.countdown2015mnch.org/) provides data on all countries as they pertain to goals 4 and 5.

Dr. Barker took the group through an exercise examining data from the South Africa MDG countdown. The data tells a story—it describes good progress against several health indicators, and relatively poor progress in others. The Partnership can use such data to compare where they are to where they want to be.

The overarching problem of interest to the Partnership is coverage along the maternal and child health and nutrition continuum of care, particularly as it relates to nutrition and to the protection of HIV-exposed infants. The Partnership aims to improve ART coverage of infants exposed to HIV via their mothers' breast milk, and to do that, they need to solve two problems:

1. Make sure mothers and infants come to the clinic
2. Achieve reliable implementation of PMTCT and nutrition services

There are roughly 10 steps along the continuum of care that need to be done right in order to arrive at the elimination of mother-to-child transmission of HIV. Ninety-five percent of mothers need to be identified,

95% of them tested, 95% put on ART, 95% retained on ART, achieve 95% adherence, as well as other nutrition-related steps. Science shows that 95% is needed to get large scale efficacy of programs.

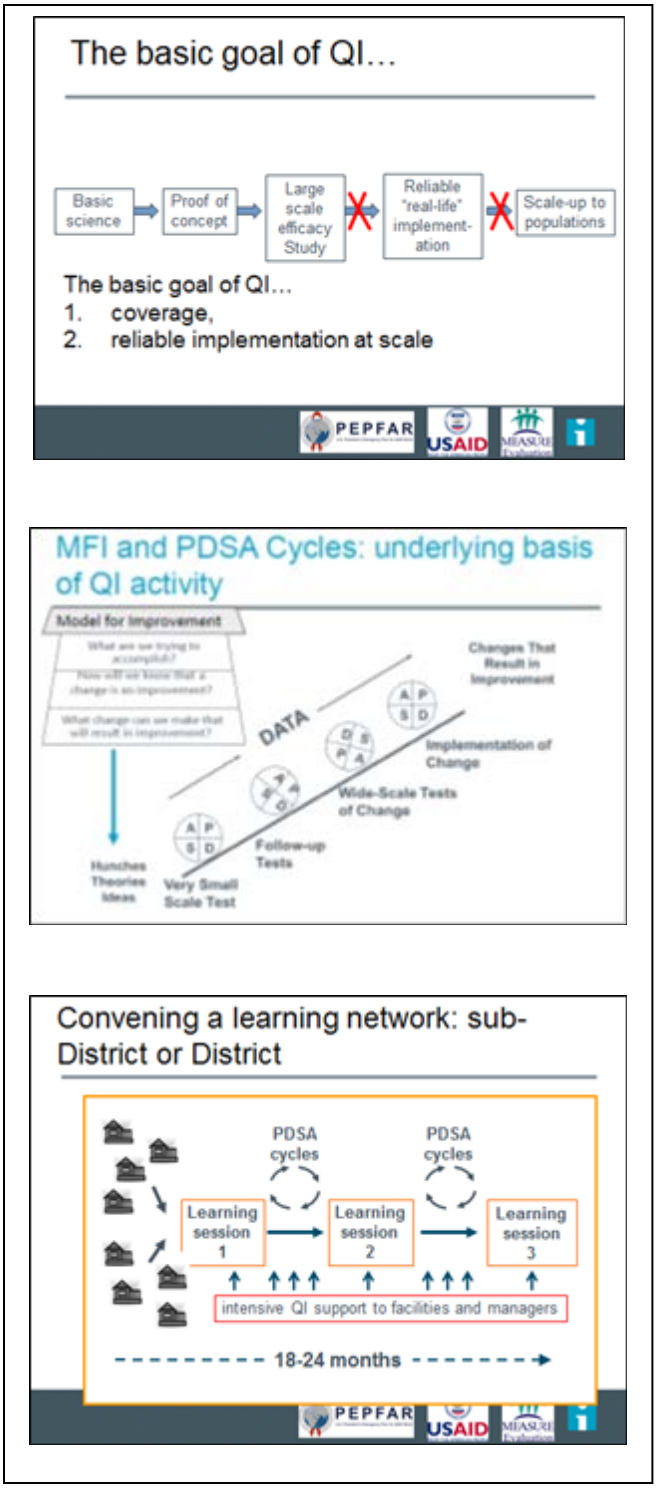
The problem that arises is that in reality, there is *not* reliable implementation of PMTCT and nutrition services (see the first red X in the first graphic to the right). In South Africa, this is achieved in antenatal care, but postnatal is not nearly there.

Evidence from WHO and its resulting guidelines are in place, the task of the Partnership is to get around the "blockage" which can be summarized as "context" or "real life," and which is unique in every country, district, and health facility. QI helps in discovering how to address challenges in each health system and finding answers so that progress can be made.

For example, in South Africa, something similar to the PHFS was used to get perinatal transmission from 7–10% down to 2–3%. They used QI to overcome context-related blockage. This was an extraordinary achievement and serves as inspiration to the PHFS teams.

In QI there are three questions to ask in order to come up with hunches, theories, and ideas for change (see middle graphic at the right):

1. *What are you trying to accomplish?* (i.e., *What is the problem you are trying to solve?*)
2. *How will you know that a change is an improvement?* (i.e., *What data elements will be used to indicate improvement?* These are the 14 data elements that were agreed to since the launch in Pretoria.)
3. *What changes can be made that will lead to an improvement?* (i.e., *What ideas can be tested?*)



The Partnership engages in plan-do-study-act (PDSA) rapid cycles to generate and test ideas that come from "inside knowledge," instead of relying only on guidelines handed down from above. Then they have learning sessions between the cycles to help spread what is learned (see the bottom graphic). The rapid-cycle PDSA technique is common to nearly all of the various QI methodologies that exist. The beauty of

frontline, rapid-cycle PDSA is that within weeks, an idea can be planned and tested to know whether it works—it doesn't take months or years to get an answer.

Breakout Session Two

Participants were asked to select one of the two breakout sessions to attend. The sessions were held simultaneously and included presentations and in-depth discussions.

1. **Knowing HIV Status of Every Mother-Infant Pair**, *facilitated by Victor Boguslavsky, URC/ASSIST*

2. **Ensuring Optimal ARV Coverage for Every Mother-Infant Pair**, *facilitated by Bruce Agins, HEALTHQUAL*

1. Knowing the HIV Status of Every Mother-Infant Pair

Victor Boguslavsky, URC/ASSIST

Jennifer Reddy of 20,000 Plus Partnership and Puni Mamdoo of South to South set the context for the discussion by presenting on this topic, sharing their experiences and data from their respective provinces in South Africa (see the box on the next page for details on Kwa Zulu Natal).

Summary of Discussion—Justin Mandala, FHI 360, URC/ASSIST

Mr. Mandala briefly summarized the presentations and discussion from this session as follows:
South Africa uses QI to improve re-testing of mothers and infants; to minimize the amount of time that women are in the clinic; and to improve the likelihood of them completing all of the service steps when they come for their consultation.

Key learning that emerged from the discussion includes the following:

- Ensure a clear understanding of the problem. You can't know where you are going until you understand what's not working.
- Having a really strong QI team is key. It should be multi-disciplinary and include doctors, nurses, community representatives, health workers, etc.
- Ensure the perspective of the client is represented on the team (i.e., an "expert patient"); this can often be very different from the rest of the team.
- Training in QI is not enough. Continued support and mentorship is critical to building skills and confidence in the QI process.
- Expect a lag-time between introducing/training on QI and getting results. It takes a long time (up to six months or a year) before newly trained staff understand, believe in, develop capacity, and can use QI effectively. Be patient and persistent; it will eventually pay off.
- QI requires good data quality and effective data use. Everyone on the QI team needs to be able to understand the data and know how to make decisions using it.

HIV Retesting in Pregnancy

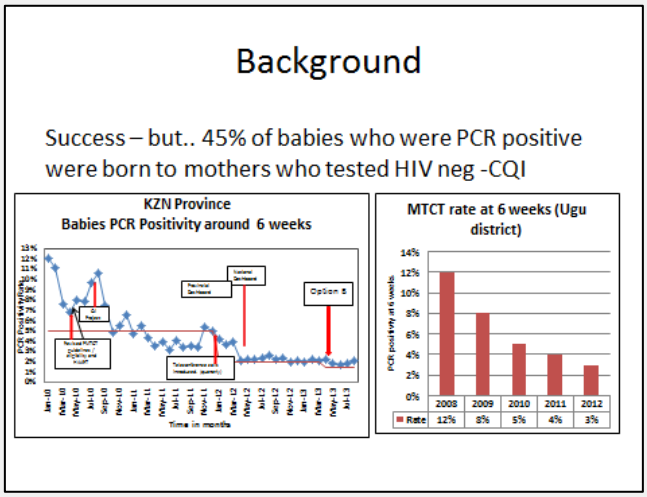
Dr. Reddy showed the power of looking at routine public health data over time. The graph below on the left shows the success of the facility that engaged in QI, in comparison to the district-wide data on mother-to-child transmission rates.

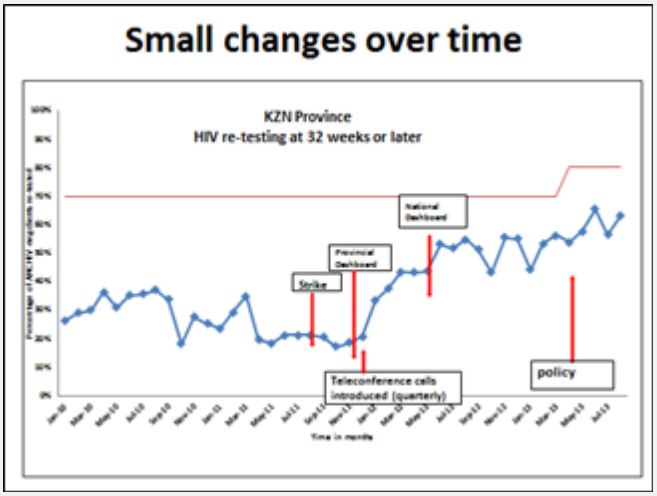
While they *were* successful in reducing transmission rates, they found that 45% of babies who were PCR positive were born to HIV-negative mothers. The districts set targets for re-testing and again used data to monitor performance. The red bar running horizontally across the graph on the right (at 70%) allows staff to see how they are performing against the 70% retesting target over time.

The peaks and valleys in data coincide with events such as a health sector strike, release of new guidelines, and initiation of quarterly phone calls (for QI), etc. In Kwa Zulu Natal, they did not have the luxury of physically bringing everyone together, so for them, collaborative learning took the form of conference calls with program managers from the 11 districts to share ideas that were working.

Some of the successful ideas were:

- Explain to the clients what is happening (i.e., that infants are sero-converting even when mothers are testing HIV-negative, so there is a need for re-testing). The re-test date was recorded on the client card and clinic records so that when they should be coming back was recorded in the system.
- Bundle several activities, including retesting, at six weeks since mothers usually come in reliably on that date.
- Schedule consultations as close as possible to the immunization dates to prevent unnecessary trips to the clinic.





2. Ensuring Optimal ARV Coverage for Every Mother-Infant Pair

Bruce Agins, HEALTHQUAL

Dr. Nidia Abdula of the Mozambique team set the context for the discussion by presenting some of the challenges that the Mozambique team has faced in providing optimal coverage of mother-infant pairs. She also recounted some of their successes with respect to applying the QI methodology. See the two PDFs above for her presentation in English and Portuguese respectively.

Summary of Discussion—Saskia Guerrier, HEALTHQUAL

Discussion focused on the importance of providing optimal ARV coverage, and began with a presentation from Mozambique on the challenges that they face.

The two principal goals of the session were to: (1) share implementation strategies, and (2) share how national teams can help support hospitals and clinics on the ground. The following points were made.

- An important first step is to undergo a mapping process. For this, it's important to have all of the stakeholders in the same room since each will all have a different perspective on the problem and possible solutions.
- Turnover among staff is a huge challenge; those trained in QI leave, which stagnates the process. As a solution in Mozambique, they send a multi-disciplinary QI team to facilities for one week to make recommendations and provide support. In Lesotho, they made sure that some trained staff were permanent (versus rotating between clinic and hospitals) so that they would have consistency on the QI team and not need to keep retraining the rotating staff. They also provided extra incentive for staff to stay longer in some of the less appealing facility locations, again for consistency in staffing.
- Mozambique uses a tool that allows local health facilities to monitor their progress against each activity on a weekly basis so that problems can be corrected quickly.
- In South Africa, a lot of emphasis is placed on onsite mentoring and coaching. Having a QI champion who is in charge (or influential) at the facility is also key. They engage in task sharing and task shifting to overcome staffing constraints at the sub-district level.

Comments from Dr. Barker and Dr. Agins

Change is not easy. The Partnership is in the business of changing from a system that doesn't work very well, to one that works extremely well. It takes more than a mandate, request, or guidelines to actually enable change. It takes having the tools, the framework, and providing the specific technical support needed to create an environment for change.

Finally, it's worth noting that in many of the PHFS countries, there are strong monitoring and evaluation systems in place (or being rolled out) at the national level. The PHFS teams will need to think carefully about how to ensure (and leverage) those systems so that QI is well-integrated and receives adequate support to function.

Four Attributes of an Idea that Spreads

1. It needs to be better than what you're currently doing.
2. It has to be very simple.
3. It must be relevant to your context.
4. You have to be able to test it out.

Shared Learning from the Breakout Sessions

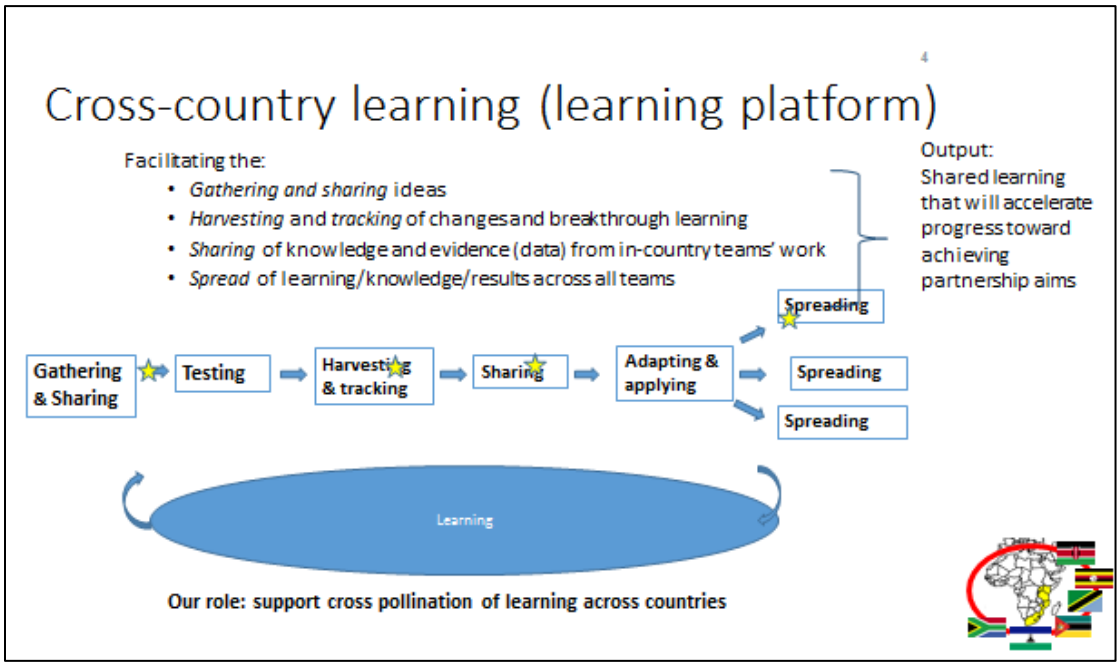
By way of review, country teams cited some of their key learning from the two breakout sessions.

- Involvement of community leaders and representatives is extremely helpful to the QI process. They provide a unique perspective not found when only health care workers are included.
- The Partnership needs to reach 95% perfection on the six QI data elements in order to achieve success.
- Partnership members should construct run charts to demonstrate improvement so that facility staff can easily see the changes.
- QI works best when health workers, community leaders, and clinical staff are put together in one room to identify problems and come up with change ideas. This has been very successful in South Africa.
- There is a gap between the guidelines and real-world implementation, and there will always be a delay in getting to the performance required by the guidelines.
- Involvement of traditional healers can be a useful way to encourage pregnant women to get ANC early in pregnancy. In Lesotho, they only go to the clinic when they are showing, so the team would like to try engaging healers and other influential people to convince mothers to come earlier.

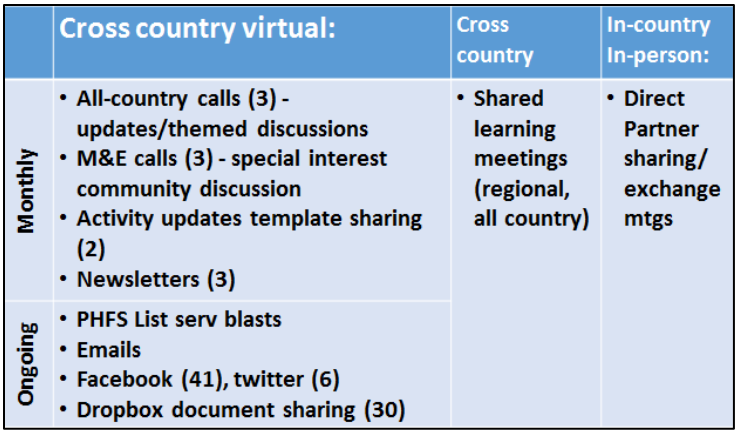
Cross Country Planning

Patty Webster, IHI

Ms. Webster posed the question: *Based on what we've learned during these two days, how do we want to learn from this meeting forward?* She reviewed the concept of the learning platform, the basis for cross-country learning (see graphic below), and likened it to the cross pollination done by bees and butterflies. The function of the cross-country learning platform is to harvest the learning taking place in one country and facilitate the spread of that learning across the region.



At the PHFS launch in Pretoria, participants were asked for ideas on how they wanted to learn from one another. A list of learning methods was generated (detailed in graphic to the right), many of which have been tried over the past seven months. This session was used to gather the group's feedback on what has been working, what has not been effective, and what the group would like to change moving forward. These questions were posed to the mixed-country groups:



- *Are you committed to the shared learning goal?*
- *Do you want to continue with the learning mechanisms we have?*
- *Are there things you would like to change?*
- *What kinds of content would you like to share?*

PHFS Website—Coming Soon!

The cross-country learning platform will soon launch a PHFS website to facilitate the sharing of best practices, change ideas, data, case studies, research, and anything else that member countries would like to use it for. If desired, it can use a "push notification" so that anyone registered will be notified when something new is posted. The site will be hosted by WHO. Concerns around privacy can be addressed by ensuring that part of the site is password secure. The website can be designed as private (for members only), open to the public, or a combination of both.

Report Back on Learning Methods Moving Forward

General:

- Yes, the group is committed to continue with the mission of shared learning.
- In-country learning can be as valuable as cross-country.
- The abundance of communication (e.g., calls, emails, etc.) helps keep the momentum of the Partnership.
- It would be helpful to establish a master calendar of events. If they knew of an event six months in advance, they could make plans to travel to district or central offices to access high-speed internet for a given event. That way more staff could be involved.
- It would be helpful for people in similar positions/jobs to be able to learn from one another.
- Have a key PHFS contact person for each country who is responsible for disseminating information.
- The monthly phone calls have been useful, but suggest holding them quarterly instead.

Technology:

- Internet access is a barrier to those in the more rural areas. A newsletter is preferable (instead of webinars and calls) since they can be received by email and printed.
- Facebook and twitter are not allowed in some workplaces, so these won't be feasible for some.

- The monthly calls have a lot of background noise, so participation is difficult. Poor internet access (for Skype) is also a constraint.

Language:

- Ensure that key documents are translated to Portuguese for the Mozambique team.
- Newsletters are better than calls and webinars since they can be translated into Portuguese and easily circulated.

Data sharing:

- There is a need to exercise caution around the sharing of data. Some members need approvals from their ministries before data is shared externally.
- Suggest generating write-ups of success stories, best practices, and change ideas from different countries, particularly when they address challenges that are common across countries.
- It would be helpful to share more NACS data.
- It's very important to share site-level data, since experience/success at one site can change the way an entire region delivers care. Fear of sharing needs to be overcome.
- The sharing of data is sensitive in some countries, but barriers can be overcome by working with local administrations and advocating for a policy that allows for data to be shared. Sharing data is vital to helping each other and to the success of the PHFS.

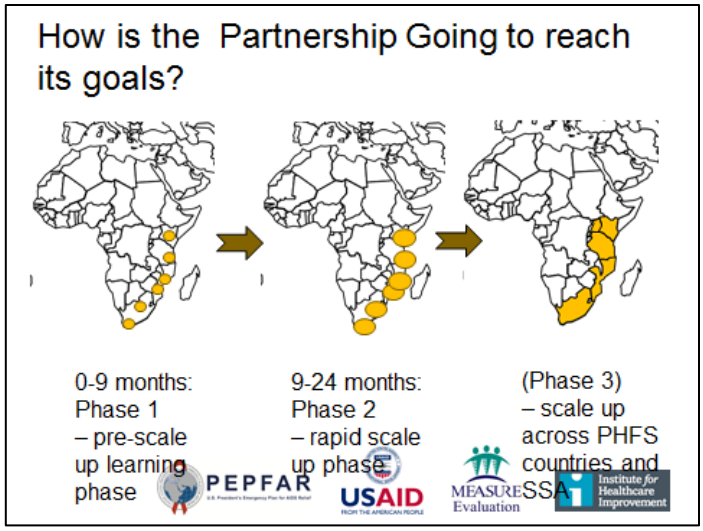
Are We Learning from Monthly Learning Calls?

- Just under half (22) of the participants in the room knew about the monthly PHFS phone calls.
- 15/22 participated in the calls.
- Of those who *didn't* know about the calls, 12 would have liked to participate.
- 8/15 would participate again.
- 9/15 learned something from the calls.
- 2/9 applied what they learned in their work.

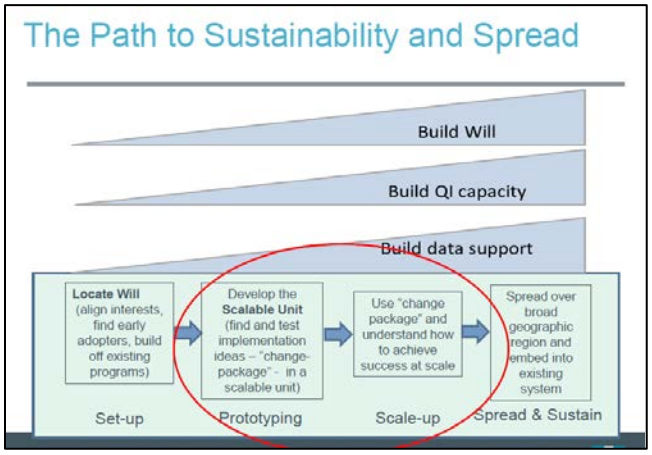
Designing for Success: Sustainability/Scale-Up

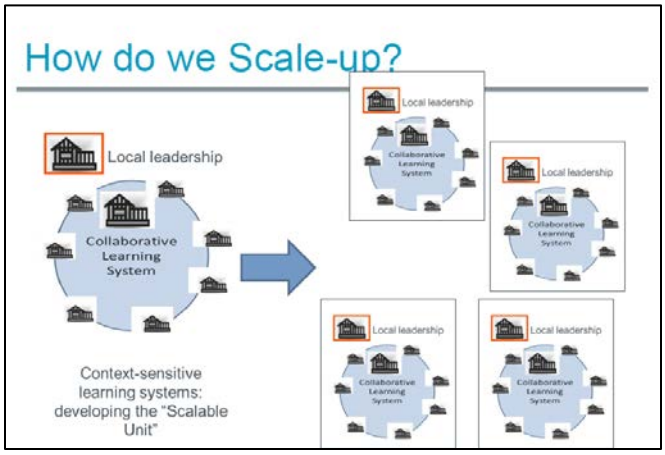
Pierre Barker, IHI

Dr. Barker noted that it's crucial to discuss scale-up and sustainability from the outset; it's part of the PHFS's design. The Partnership needs to be cognizant of its goal of scale-up from the very start of the project. The graphic to the right demonstrates the Partnership's goal and process of spreading and scaling up from individual sites to districts, provinces, and the national level in all six member countries.



Dr. Barker reviewed the path to sustainability and spread (see graphic on the left on the next page), which includes: building will, building QI capacity, and building data support. He next reviewed using a collaborative learning system to scale up rapidly (see graphic on the right on the next page). He emphasized that demonstrating results is key to spreading a good idea. Those with results can sell an idea, he rest just have opinions.





What is a QI Collaborative?

The concept behind a QI collaborative is to move ahead faster by learning together. The idea is to bring people together for learning sessions between PDSA cycles. This process needs to be imbedded into the district system, and it requires *intensive* QI support to involved facilities and managers. This support comes from NGO partners, like South to South and 20,000 Plus Partnership, as well as URC/ASSIST, HEALTHQUAL, and IHI.

In South Africa, the partners are using the collaborative model. All the involved facilities in a district come together 3–4 times over 18 months. They come together for two reasons: (1) to learn about QI methods and plan their first PDSA cycle, and (2) to learn how others have solved common challenges. In this way successful change ideas can be scaled up to the whole sub-district, district, and country very quickly. Mozambique and Lesotho may want to consider eventually moving to a collaborative model to accelerate adoption of successful ideas.

The following questions were posed to the mixed-country groups for discussion:

- *How ready is your data system? Do you trust the system? Is it accurate and timely?*
- *What is working and what is not working in building a set of measures to guide the progress of PHFS?*
- *What is your biggest challenge in terms of data systems, and what is your plan to support improved data over the next six months?*

Note: In responding to these questions, participants were focused on data systems, not indicators.

Report Back on Data Systems

Lesotho: Lesotho noted that they are just getting started. Their data systems are not yet ready, and they have a lot to do to prepare. They do expect, however, to make good progress in the next six months.

Challenge to Lesotho: Dr. Barker challenged the Lesotho team to come to the next meeting with run charts from their clinics so that they can start using the data.

South Africa: The South Africa team noted that the national indicator and data set is heavily controlled by the government, so there is little they can do to make changes there. They feel that the data is fairly reliable though.

Challenge to South Africa: Dr. Barker challenged the idea that they cannot influence change over the government data set. He noted that the reason that the antenatal data set (from South Africa) is so strong today is because there was a lot of pressure for the District Health Information System to expand the indicator set, and the government was responsive when it understood the need. He believes that the PHFS team *does* in fact have the ability to influence change.

Mozambique: Mozambique noted that many of its sites do not have the electronic patient tracking system. In those places, the data collection system is manual and not frequently updated. The register is also in a format that does not facilitate good client tracking. Fortunately, given that the PHFS indicators are part of the national QI indicators, Mozambique will have a very rich source of baseline data once collection is completed.

Challenge to Mozambique: Dr. Barker challenged Mozambique to put their data into run charts and start using it to test ideas over the next six months.

Two follow-up questions were posed to the groups:

1. *Do you have the QI capacity needed to scale up to get to the next stage?*
2. *What do you need in order to build the necessary QI capacity to get to the next stage?*

Lesotho: QI trainings were just held at all levels, including the district level. They are now ready to roll out the QI process; they are not clear yet what their challenges will be. What they really need at this stage is coaching, mentorship, and supportive supervision. Their process has only just gotten started.

South Africa: The South Africa team reports that they have sufficient support from various sources, including the QI unit of the government and NGO partners.

Mozambique: As noted earlier, one of the major challenges for the Mozambique team was to integrate QI into the Ministry's existing QI process. It's both an advantage and a challenge to have the existing QI system. Ultimately, it will allow the PHFS to scale up more quickly. Right now the challenge is to provide continuous, post-training support for each of the facilities. The plan is to provide a QI refresher every three months so that facility staff can share the challenges they face and get support to address them.

Tried and Tested

Tried and tested is a compilation of the models and tools that have been developed by frontline nurses and doctors across South Africa and in neighboring countries that are facing huge challenges with limited resources. You can download this book at:

Tried and Tested: Models for the Scale Up of HIV Prevention, Treatment, and Care from South Africa and Beyond

IHI hopes to produce a similar publication with learning from the PHFS in a year's time.

Those of us with results can sell an idea. The rest of us just have opinions.

– Pierre Barker, IHI

Who to Turn to for QI Tech Support

Lesotho
URC/ASSIST is the main source of QI technical support.

Mozambique
HEALTHQUAL is the source of QI technical support at the facility level and URC at the community level.

South Africa
The three local NGO partners are the primary source of technical support, and IHI provides secondary support.

Recommendations from Dr. Barker for all three countries:

- Both South Africa and Mozambique have strong underlying QI systems. Focus now on demonstrating success to get buy-in at all levels.
- Consider establishing a collaborative model, like the one in South Africa—this will accelerate scale-up and spread.
- If struggling with making improvements, and unsure what to do next, then don't hesitate to reach out for QI technical support. See the box at the right for relevant sources of support. The in-country steering committees need to clearly articulate each country's technical support needs so that the partners can understand how to help.
- Keep partners and government informed about PHFS progress, in particular successes, in order to have strong buy-in once ready for scale-up.

This PDF was presented at the Partnership launch in Pretoria and is a helpful overview of the PHFS design for those members who were not able to attend.

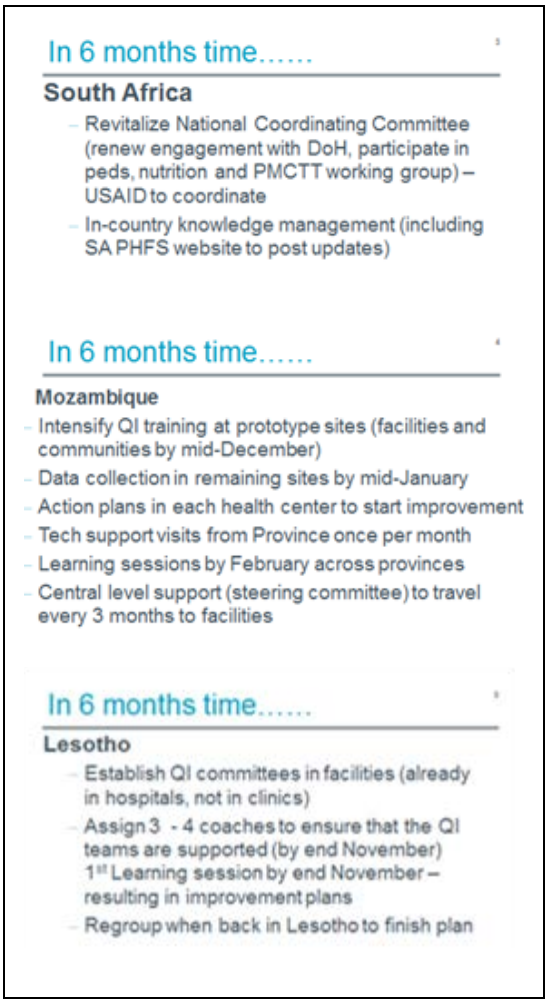
Country Work Plans

Country teams came together for one final session to compile their work plans based on the ideas they had gleaned during the two-day meeting. Below is a summary of their plans and draft commitments (see graphics), as reported. The completed templates for each country are not included in this report as they have not yet been finalized, vetted, and approved by the in-country steering committees.

South Africa:
The South Africa team intends to share PHFS progress with the nutrition and PMTCT working groups in their country. They also plan to have an in-country website (called web share) where they can share documents and ideas.

Mozambique:
Mozambique's focus to date has been to ensure that the PHFS is well integrated into the government's QI program. They have experienced slight delays in implementation but intend to have provided training to all of the facilities by mid-December. Once trained, they expect to conduct data collection in the remaining sites, analyze data, and establish plans for each facility. They expect to have action plans for each health facility by mid-January. They are also planning technical support visits to each of the eight facilities (at the provincial level) every month, and visits from the steering committee (central level) every three months. The first learning session is scheduled for February.

Lesotho:
Before getting started, they plan to form QI committees and assign 3 to 4 coaches to ensure committees are functional. The first learning session is planned for the end of November, and they expect the facilities to have their QI plans.



Final Wrap-Up

Pierre Barker, IHI

Dr. Barker thanked the participants for all of their hard work. The meeting demonstrated the power of collaborative learning. It will be important to have continuity over the coming months, so it would be helpful to have the same partners attend the next meeting in six months.

Reflecting on what Dr. Rollins said early in the meeting, Dr. Barker reiterated that the world is watching and waiting to see the results that the Partnership produces. The PHFS uses a unique method (QI), and is using it on a larger scale than ever before. This is a very important experiment that is aiming for an extraordinary result.

The clock is ticking, however, and the next six months are crucial towards achieving medium- and longer-term benchmarks of the project. If the country teams are able to achieve the tasks listed in their draft work plans, the Partnership is on track to meet the long-term goal at the end of two years. The following steps represent the focus of the next six months:

1. Develop change packages
2. Establish a solid data system
3. Develop competency in QI
4. Generate buy-in from the MOH for scale-up

Finally, Dr. Barker reminded participants that training alone is not enough to build QI capacity. QI cannot be learned only in the classroom; it must be learned by doing. Coaching and mentoring (every two weeks at a minimum) are recommended to build solid QI competency. Capacity can be further enhanced by taking advantage of the PHFS Facebook page, listserv, Twitter, and other cross-country learning mechanisms to build competency among teams.

Closing Remarks

Ana Cala, Mozambique MOH

The meeting was officially closed with final remarks from Dr. Cala, Chief of the Quality Improvement and Humanism Department of the Mozambique MOH. Dr. Cala congratulated the meeting participants on a successful event and moments of great sharing and learning. As hosts of the meeting, and on behalf of the Government of Mozambique, she reaffirmed her country's continued commitment to the PHFS, and to improving the quality of care for the mothers and infants in Mozambique and beyond.

Key Findings and Conclusions

Since the launch of the PHFS in March, the Lesotho, Mozambique, and South Africa teams have made tremendous progress toward achieving the long-term goals of the Partnership. Each is at a different stage in implementing PHFS activities and in overcoming its context-specific challenges:

Lesotho has recently completed QI training and is in the early stages of its QI path. In the coming months the team will focus on building will and developing its QI capacity, drawing on technical support from URC/ASSIST as much as possible to ensure a strong foundation.

Mozambique has the advantage of building on top of an existing QI foundation, given the pre-existence of the government's national QI program in the majority of PHFS provinces. As the team has learned, however, this comes with its own set of challenges, and makes coordination and collaboration with the MOH absolutely vital to their success. As Mozambique continues to roll out the QI process, a primary task is to assimilate plans and systems into existing national strategies.

South Africa also benefits from a pre-existing national QI system, and strong local capacity for QI programming. Given their use of a collaborative model—referred to as the *the eMTCT Quality Improvement Learning Collaborative*, they have the potential for accelerated scale-up and spread. As the PHFS evolves in South Africa, urgent priorities include demonstrating added value to the Department of Health and improving coordination between the partners on the ground.

While the details of their operational challenges may be unique, it became clear to participants early in the two-day meeting that there were also many themes (both barriers and opportunities) that they had in common. 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, the continued sharing and cross pollination of ideas was imperative.

Importantly, lessons shared between these three countries have been incorporated into revised work plans, with a commitment to next steps now documented and shared. The teams and technical partners look forward to sharing progress once again at the next regional meeting in six months' time.