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

Findings

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

- Mother-baby pairs
- HIV-exposed infant (HEI) days
- Integration of services
- Peer mothers
- Facility-level innovation
- Coaching
- Knowledge exchange
- Existing health system structures and staff
- Partnership

The findings are drawn largely from a rapid assessment conducted in Kenya in June 2017 by MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

Findings from assessments of PHFS in other participating countries are available on MEASURE Evaluation's website, here: https://www.measureevaluation.org/our-work/hiv-aids/evaluations-of-the-who-pepfar-partnership-for-hiv-free-survival-1.

Core Components of PHFS in Kenya

Mother-Baby Pairs

The value of linking HIV-positive mothers and their HIV-exposed infants as pairs was an early and important lesson from PHFS. Seeing the mother and child together, at a single clinical visit, and tracking their client records jointly are two key components of this approach. They are essential to reaching the global 90-90-90 goals of the Joint United Nations Programme on HIV/AIDS, which state that, by 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of those diagnosed with HIV will receive sustained antiretroviral therapy (ART); and 90 percent of those in treatment will have viral suppression. In Kenya, the health facilities in Kwale County that participated in PHFS enthusiastically adopted this approach to prevention of mother-to-child transmission of HIV (PMTCT) in mother-baby pairs. Clinics filed client cards for mothers and babies together, making it easy to track their status. In addition, facilities have specific clinic days each month for HIV-positive mothers and their babies (see below).

HIV-Exposed Infant Days

HEI days are a compelling and evolving innovation from Kwale County. These clinic days set aside for PMTCT clients are a more efficient and effective way to see mothers and babies. They include group education sessions with peer mothers and/or service providers. Mothers and babies receive all services during the one visit, meaning they do not have to make separate appointments. Mother-baby pairs do not have to come to the point of care on an HEI day, but they are encouraged to do so.

HEI days also give mothers an opportunity to share experiences with one another. These informal support groups keep mothers engaged and help motivate them to attend their regular appointments. Facility staff acknowledge that this approach has led to improvements in service quality, client satisfaction, and retention in care.

Integration of Services

Integration of health services for mother-baby pairs occurred at all PHFS sites in Kenya. Through the quality improvement (QI) process and learning sessions, PHFS facilities created a system to integrate routine antenatal and postnatal care, nutrition, and PMTCT services so PMTCT clients can receive all services in one visit. The integration of services contributed to a high percentage of mother-baby pairs being retained in care and, most important, very few HIV-positive infants.

Peer Mothers

Peer mothers have played an important role in PHFS work in Kwale County. They provide much-needed emotional and psychosocial support to HIV-positive mothers both in individual and group settings. They assist with pretest counseling and track clients who miss appointments and might otherwise be lost to follow-up. Their ability to share relevant personal experiences significantly enhances peer mothers' credibility with clients. The funding for the peer mother program, including the women's salaries, comes from Base Titanium, a Canadian mining company working in Kwale County. The county government has committed to fund the program when the support from Base Titanium ends.

Facility-Level Innovation

At the facility level, work improvement teams (WITs) were the key to QI of PMTCT services. Staff at each facility were encouraged to identify new, innovative ways to improve their services. With support both from ASSIST and their QI coaches, health facilities implemented a range of improvements, including better documentation of PMTCT monitoring data, more client-centered service delivery, and better follow-up with clients on ART adherence and retention.

Coaching

Facility-level activities were supported by regional-, district-, and county-level coaches, who made regular visits to the hospitals and clinics participating in PHFS. Coaches were trained professionals, who were affiliated with a PHFS implementing partner and/or government ministry or department of health. The coaches worked closely with the members of each facility's WIT, to reinforce the knowledge and skills required to identify areas for improvement, and develop and implement solutions. As the capacity of WITs within facilities grew and matured, the ability of the coaches to serve as mentors and external monitors remained important.

Knowledge Exchange

At regional learning sessions, staff from PHFS-designated health facilities shared their ideas with peers from other participating facilities. These sessions, which were both supportive and competitive, were effective in moving the innovation agenda forward: staff from different facilities wanted to learn from one another and then outperform their peers. During and after the learning sessions, participants adopted ideas from one another and adapted them to fit the needs of their communities and clients. The opportunity to meet, interact, and learn from one another—combined with support from the Kenya government, USAID's Applying Science to Strengthen and Improve Systems (ASSIST) project, and facility managers—made it possible to act on their "change ideas." (A change idea in the PHFS QI model is a proposed action that, when implemented, is anticipated to improve an indicator outcome over a defined period.) Acting on the change ideas, in turn, played a significant role in the success of PHFS.

Existing Structures and Staff

Another key to the success of PHFS in Kenya was the seamless integration of PMTCT improvement approaches in existing health structures in the county, including WITs, which had a history of QI work before PHFS began. These structures, along with support from the county government, have enabled PHFS approaches to continue in the original and scale-up sites beyond the end of the official PHFS program. Kenya's decentralized government structure, and the Kwale County governor's strong and progressive commitment to health, have created an environment with sufficient human and financial resources to implement PHFS activities in key sites. (Note: Kwale County spends 40 percent of its budget on health, and it has opened and staffed 15 new facilities since the start of PHFS.)

Partnership

In Kwale County, there was a clear partnership among stakeholders working on PMTCT. County health administrators, University Research Company, LLC (URC), Pathfinder, and local health facilities worked together closely to conduct QI activities, integrate health services, and share promising change ideas at learning sessions. The county health department also selected a subcounty representative for each health facility to serve as a QI coach. Through the ASSIST project, URC staff trained coaches in QI approaches and supported their ongoing engagement with the work improvement team at each PHFS facility. Stakeholders in PHFS activities widely acknowledged the importance of productive partnerships in improving client services and outcomes.

On a national level, ASSIST, as a member of the national PMTCT working group and in partnership with the Ministry of Health, helped develop a national QI framework that integrated experiences and strategies used in PHFS.

Conclusion

In Kenya, PHFS approaches appeared to have been implemented successfully in demonstration and scale-up sites. Stakeholders on all levels of the health system provided positive feedback on PHFS and recommended that PMTCT improvement activities be continued in existing sites and scaled up to additional health facilities in Kwale County and other counties. With limited human and financial resources, data-driven selection of sites can help spread PHFS-like approaches to areas with the highest rates of mother-to-child transmission of HIV.

In Kwale County, existing systems and structures allowed for easy integration of PHFS approaches in local health services. Several stakeholders mentioned that, before PHFS, strong PMTCT guidelines were already in place, but through PHFS, health facilities received supervision and support to implement the Option B+ protocol (lifelong ART) more effectively.
Moving forward with the improvement of PMTCT services in Kenya, it will be important to continue to support the PHFS components: QI activities, data collection, and data use for PMTCT indicators and outcomes. Programs should continue supporting supervision and support for QI through existing governmental health staff and platforms for sharing ideas and innovations across health facilities and other PMTCT partners.

Background

The Partnership for HIV-Free Survival was implemented in six countries in eastern and southern Africa between 2013 and 2016. PHFS was a collaboration among PEPFAR, UNICEF, and the World Health Organization (WHO) to accelerate the uptake of the WHO 2010 guidelines on HIV and infant feeding in participating countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. Although specific aims differed slightly by country, the initiative was designed to reduce mother-to-child transmission of HIV and increase child survival through improvements in breastfeeding practices, ART uptake and coverage among HIV-positive pregnant women and mothers, and overall mother-baby care.

Rapid assessments that MEASURE Evaluation conducted in participating PHFS countries used a qualitative lens to examine key PHFS activities and accomplishments. The primary purposes of these assessments were (1) to review the outcomes, and potentially the impact, of PHFS on PMTCT programs and related maternal, newborn, child health, and nutrition activities, and (2) to capture good practices from PHFS implementation that can be scaled up across the region, particularly pertaining to the QI approach and its contributions to epidemic control.

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

In Kenya, PHFS was implemented in 28 sites (16 original sites and 12 scale-up sites) in Kwale County, on the country's south coast. National-level partners were USAID, the Kenya Ministry of Health, and URC-ASSIST. On the county level, URC-ASSIST provided technical assistance for QI activities. Pathfinder was the implementing partner at the health facilities. Each worked with the county government to provide supervision and support to PHFS facilities in implementing relevant activities. Demonstration and scale-up sites were chosen based on the prevalence of HIV-positive mothers; for example, the 16 original PHFS sites accounted for 60 percent of the PMTCT caseload in Kwale County. Facilities were also selected to ensure the participation of different types of health facilities in the county, including dispensaries, health centers, and hospitals. Activities under PHFS began soon after the introduction of the Option B+ approach to PMTCT, and the partnership was able to build off this new approach. Given the links between the Option B+ approach and the PHFS activities, the combination was operated under the umbrella of PMTCT services and the name "PHFS" was not widely used or known.

Methods

For the country visits, MEASURE Evaluation developed an interview guide, with topics ranging from partnership structure, activity design, and perceptions of QI to implementation, tracking specific outcomes in identified program improvement areas, successes, and challenges. The evaluation teams gathered qualitative data on PHFS design, implementation, and scale-up/spread, through interviews and discussions with key stakeholders and partners and site visits to a selection of PHFS demonstration and scale-up health facilities.

Key stakeholders and partners were Ministry of Health representatives, subnational-level health representatives, the local USAID mission, PEPFAR implementing partners, and on-site health facility staff. When possible, the team photographed QI journals that facility teams maintained to track PMTCT indicators and outcomes. After a country visit, the evaluation team synthesized results in the following common thematic areas across interviews: community engagement (community/client links), efficiency, the health system/HIV structure within which PHFS was functioning, innovation, integration of services, knowledge exchange, nutrition, partnership, QI activities, reach, the role of USAID, and site selection.

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. FS-18-251

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