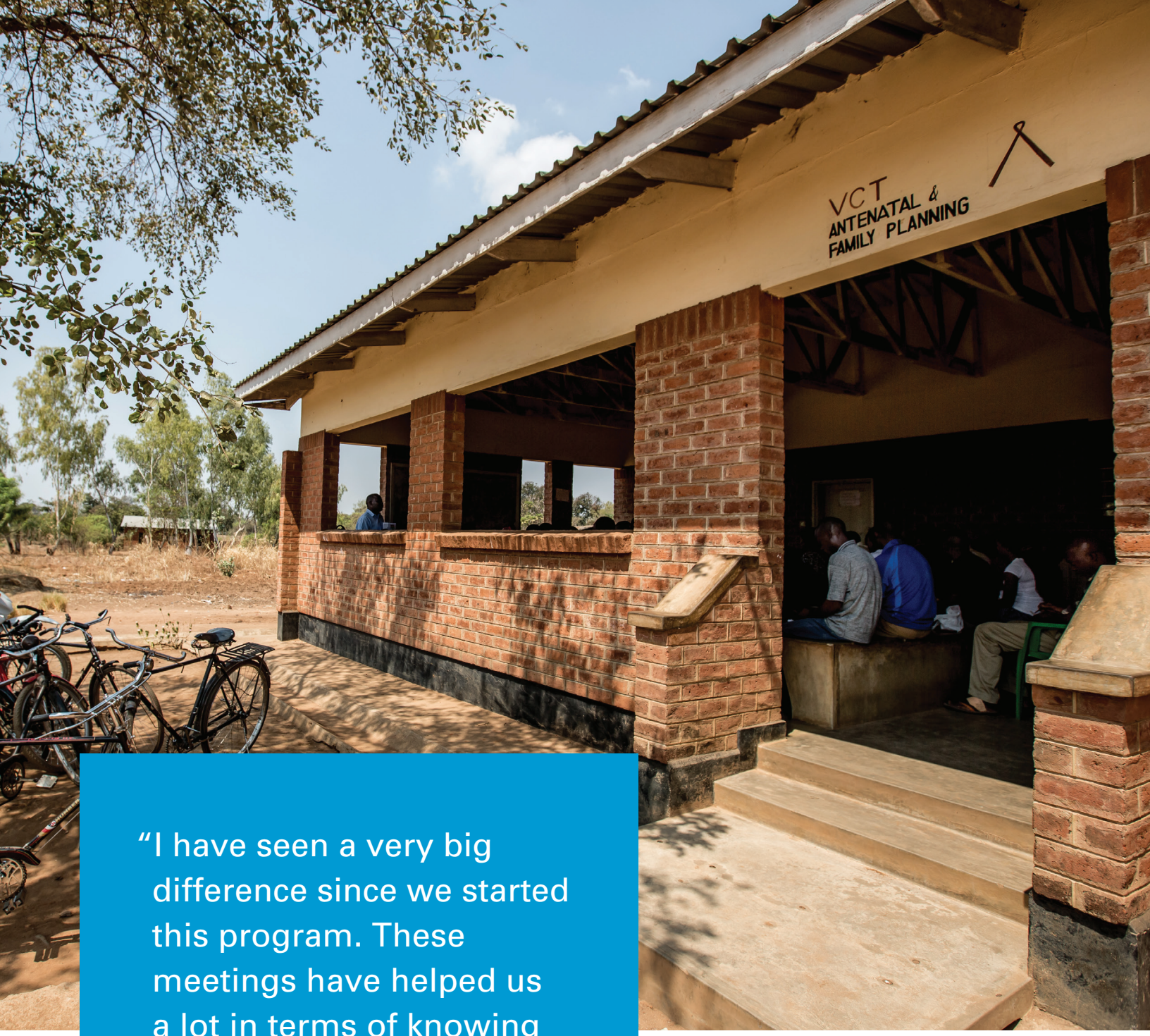
unicef

“TOGETHER, WE CAN IMPROVE”

A case study on joint community-facility review of PMTCT dashboards in Malawi

February 2016



"I have seen a very big difference since we started this program. These meetings have helped us a lot in terms of knowing about HIV and especially about women who are pregnant, and what needs to be communicated in order to prevent the transmission of HIV from mother to child."

Chief of Kakhome District

Introduction

Health-related data can help prioritize health interventions and monitor their effects.[1] However, data must be high quality and interpreted accurately, in order to adjust interventions for programme improvement.[2,3] Several studies have demonstrated that training facility-based personnel in use of health information for decision-making can improve data timeliness, completeness and accuracy.[4,5,6] However, few studies have explored how community actors can participate in and enhance the process of using data for programme improvement.

This case study is intended for programme managers and others who are interested in strategies for involving communities in the review and use of health information to help women and children stay in care and improve prevention of mother-to-child transmission of HIV (PMTCT) programme performance and outcomes. It reviews a pilot programme launched by the *Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women Initiative (OHTA)* to engage community leaders and facility-based staff in joint reviews of facility data to improve PMTCT programmes in three districts in Malawi. Led by UNICEF and funded by Sweden and Norway, the OHTA Initiative in Malawi works in collaboration with the National Government, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and other partners. For more information about the OHTA Initiative, visit http://childrenandaids.org/partnership/optimizing-hiv-treatment-access

Background

Malawi has made good progress towards the goal of eliminating mother-to-child transmission of HIV. In just four years, the country has halved the number of new infections among children—from 21,000 in 2010 to 10,000 in 2014. However, getting to zero still remains a challenge and ensuring that HIV infected pregnant and breastfeeding women enrol in and stay on treatment—one pill once a day—is a critical part of the solution. In 2014, only 64 per cent of pregnant women with HIV in Malawi received antiretroviral medicines for PMTCT, and about one-third discontinued their treatment[7]—also known as 'loss to follow-up'—at some point along the continuum of care. Because treatment interruptions during pregnancy or breastfeeding increase the risk of passing the virus to the infant, preventing these gaps is a key concern of PMTCT programmes.

Given the high rates of loss-to-follow up in Malawi and in many other high-burden countries, there is a strong push to identify how best to support women enrolled in PMTCT programmes so that they do not drop out of care. A recent review commissioned by UNICEF and supported by the Governments of Sweden and Norway concluded that better community-facility linkages can significantly improve PMTCT outcomes. The review identifies eleven promising practices in *community-facility linkages* that are associated with increased service uptake, adherence to drug regimens and retention in PMTCT, antiretroviral treatment (ART) or maternal, newborn and child health (MNCH) care.[8]

The review recommended that efforts to engage communities build on existing structures and resources to ensure local ownership and sustainability. One of the promising practices identified was engagement of community leaders; the review found that "purposeful community leader engagement is associated with increased service uptake, male partner involvement and positive shifts in community attitudes."

The Intervention

In order to address loss-to-follow up in facilities in three districts (Mzimba North, Mzimba South and Dedza), the OHTA Initiative convened community leaders and facility staff to strengthen linkages between the facilities and communities they serve.

The aim was to formalize these linkages and jointly identify where gaps and challenges are occurring so that pregnant and breastfeeding women would be better supported by both the facility and their communities to stay in care. The process included four phases:

(1) Identifying existing Health Advisory Committees (HACs) and revitalizing those which were not active

(2) Conducting training sessions with HAC members

(3) Convening joint review sessions with HAC representatives, other community representatives, and health facility staff to review quarterly health facility data

(4) Follow up and support

Phase I: Identification of Health Advisory Committees

HACs are a formal structure in Malawi to support linkages between health facilities and communities. Established by the Ministry of Health in 1997 with the Malawi Decentralization Act,[9] HACs are intended to be a standard part of all health facilities in Malawi. Composed of 10 community members selected by communities themselves, HACs promote accountability and aim to improve the quality of facility health services. HAC responsibilities include dispute mediation between communities and health facility staff, overseeing the work of Health Surveillance Assistants (HSAs) (community health workers) and observing the shipments and use of all medical products at the facility. The Ministry of Health, through district health officers, is responsible for ensuring that HACs are functional. By using HACs, the OHTA Initiative built upon and enhanced support to existing structures that were already

"We invite all these people because we don't want to be disseminating different messages to the same communities. Men and chiefs in their villages all need to be speaking the same language." - Chief of Kakhome District

known and understood. In areas where HACs were dormant, the programme worked to re-establish or revitalize the groups.

Phase 2: HAC Training

Under the OHTA initiative, training programmes were held for 85 HACs in the three districts. The topics covered during the three-day trainings included reviewing the role of the HAC, conflict resolution, leadership concepts, community mobilisation, HIV/AIDS literacy and the importance of PMTCT. A key emphasis of the training was community participation in quarterly facility data review meetings so that the community understands the major challenges facing their facility in service delivery and so that the community can discuss obstacles to access and continuity of care from its perspective.

During the trainings, HACs identified priority activities for their facilities for the next three months and developed plans to improve services and facility infrastructure. For example, in some facilities this included communities moulding bricks to build additional staff houses and attract and retain staff. OHTA district task teams, composed of an EGPAF district technical officer, a social welfare officer, a community development officer and the district health office PMTCT coordinator, provided follow-up support to HACs to carry out prioritized activities.

Phase 3: Joint Data Review Meetings

Facilitated by a member of the district task team, the joint data review meetings take place at the local clinic and involve district health office representatives, facility-based health workers, HAC members, and other community representatives including traditional leaders, faith leaders and community based educators.

At the meeting, participants review simple dashboards which illustrate quarterly performance for a number of indicators through colour-coded graphs (see Annex 1). The dashboard includes thirteen key indicators, including antenatal care (ANC) attendance during the first trimester, male participation in ANC, delivery in health facilities, and retention in HIV care of women and children. Participants then discuss reasons why indicators are coloured red (poor performance), yellow (making some progress), or green (achieving targets). The dashboards are in English, while the discussions take place in local languages. The use of red, yellow and green to evaluate performance is easily understood by participants and helps to prioritize areas for action.

Tracking progress visually helps provides concrete justification for community actors to encourage community members to adjust behaviour or practices related to indicators showing poor progress. It also helps visualize improvements over time.

The meetings are vibrant and involve debate, discussion and argument. Together the community representatives and facility staff identify topics of concern where facility data indicate the need for change and improvement, and strategies to address the challenges are jointly discussed. Some proposed activities involve facility-level service delivery changes and others require community-level support or intervention. For example, a number of the 2015 monthly data review meetings

identified that indicators for early ANC, delivery in health facilities, and retention in care for pregnant and breastfeeding women with HIV were showing poor progress. In response, a number of activities were identified at the community and facility level to address these challenges, including:

Community level:

- Traditional and faith based community leaders committed to encourage men to play a role in maternal and child health and to communicate to couples the importance of starting ANC early in pregnancy and to deliver in health facilities.

- Community leaders committed to encourage families with young children to attend under-five clinics for integrated management of childhood illnesses, HIV screening, and to ensure linkages to HIV treatment for children who are HIV-positive.

- In some sites, mentor mothers were engaged to support efforts to improve retention of clients in care through provision of pre ART comprehensive adherence counselling and follow-up, including conducting home visits.

Facility level:

- Implementing partners committed to develop 'missed appointment registers' where they did not exist to more easily trace women who drop out of care and conduct training and mentorship for HSAs to encourage women to return to care.

- One clinic took action to shift the timing of HTC to take place before the physical ANC examination, in response to the observation by facility staff that some women were leaving the facility after receiving ANC exam but before receiving HIV testing.

> "The report is like an indicator which shows us our direction – where we are doing fine and where we are failing. Where we are not doing well, we try to find out what the cause is and how together, we can improve."
>
> Health care worker, Mtakataka Health Facility, Dedza District

Phase 4: Follow up and support:

At the end of each data review meeting, priority actions were recorded and OHTA district task teams provide ongoing support to community representatives and facility staff, to ensure agreed-upon actions were implemented. Support tools included registers for recording action plans, and teaching and learning materials sourced from the Health Education Unit (HEU) of the Ministry of Health. These materials included leaflets that were shared with men and posters for display in homes or public places with HIV prevention, care and treatment messages. The district task teams also conducted meetings with village chiefs to ensure the accuracy and appropriateness of messages on various topics, such as the importance of partners attending ANC together and importance of facility based deliveries.

Results

Since the quarterly facility-community review meetings were established, participating facilities in the three districts have seen a number of improvements in indicators related to male involvement, ANC attendance, skilled delivery, and early infant diagnosis of HIV. For example:

- Couples testing rates rose from 31 per cent in January 2015 to 34 per cent in June 2015, with Dedza district reaching a project high of 44 per cent
- Uptake of HIV exposed infant HIV testing at 12 months at Jenda heath centre increased from 13 per cent in May 2015 to 100 per cent in July 2015
- Uptake of HIV-exposed infant testing within two months of delivery increased from 0 per cent in March 2015 to 100 per cent in April - August 2015 at Katete Community Hospital
- Attendance at 4 ANC visits, 12-month retention of pregnant women on ART and 2 month infant HIV testing uptake increased in two districts (Mzimba and Dedza)

Lessons learned

- Joint community-facility reviews can result in better prioritisation of health activities/interventions to improve the impact of PMTCT programmes.
- Involving communities to identify areas to be strengthened can provide a better conduit to community-level adjustments of behaviour and practices.
- When involving communities in data review, it is critical to present the data in a simple manner that encourages joint problem solving and action.

Conclusion

While national-level data is important to monitor overall country progress, it can obscure specific issues facing individual health facilities and communities. By using facility-level data to diagnosis problem areas, health workers and community members are able to engage more meaningfully in conversation about how to improve health outcomes in their own communities.

The OHTA Initiative has catalysed a culture of joint data review, use of data for decision making and increased linkages between the community and facility. This case study illustrates the benefit of community-involvement in health planning and progress reviews and health action planning and increased citizen accountability. The implications of this approach are potentially far-reaching: The Chief of the Kakhome District spoke of his dream to see the meetings scaled up to other districts in Malawi so that ultimately *"Malawi may see an HIV free generation"*.

Annex 1

Sample Dashboard

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1		District:	Mkimbe South												
2		Health Facility:	Kanene Health Centre												
3	No	Indicator	Calculations	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	15-Sep	Oct-15	15-Nov	Dec-15
4		Antenatal													
5	1	% of pregnant women starting ANC in the first trimester during current pregnancy	ANC+Line 6/Total in the cohort	8%	8%	13%	10%	9%	10%	8%	8%	10%	18%	9%	3%
6	2	- % of pregnant women completing 4 ANC visits	ANC+Line (4+5)/Total in the cohort	24%	26%	19%	22%	21%	24%	19%	32%	25%	23%	24%	20%
7	3	Percentage of pregnant women with known HIV status in ANC	(ANC Report+ 18+19+20+21/Tot. women in cohort)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
8	4	Percentage of HIV+ pregnant women who received ARVs to reduce risk of MTCT of HIV in ANC	(ANC Report+ (26+27+28)/Tot. women HIV+ 19+21)	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	NA	100%
9		Maternity													
10	5	Percentage of previously untested women who were tested in Maternity	(Maternity Report+(3+4)/(3+4+5))	0%	0%	1%	100%	100%	100%	100%	100%	100%	100%	100%	50%
11	6	% of HIV infected women on ART in maternity		NA	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	NA
12	7	-Proportion of births attended by skilled health personnel	Maternity+(31+33)/Total babies	85%	85%	91%	95%	92%	100%	96%	97%	100%	100%	98%	98%
13		EIDT													
14	8	Percentage of infants born to HIV+ women who received HIV-PCR testing at 2 months of birth	(Exposed Report 2 months cohort+(4+5/3))	100%	100%	0%	0%	0%	0%	100%	0%	0%	NA	50%	NA
15	9	Percentage of exposed infants who had any HIV test (rapid HIV or HIV-PCR) by 12 months of age (includes transfer-ins)	(Exposed Report 12 months Cohort + 4+5/3)	67%	67%	100%	0%	0%	NA	100%	NA	100%	100%	50%	100%
16	10	% of exposed infants alive and confirmed not infected by age 24 months	Exposed infant 24 month follow up+ line 4/ line 3	100%	NA	0%	0%	50%	100%	100%	67%	NA	100%	NA	NA
17	11	% of children with confirmed HIV infection or PSHD who started ART at 24 months of birth		NA	NA	100%	NA	NA	NA	NA	NA	100%	NA	NA	NA
18		ART													
19	12	% of Option B+ known to be alive and on treatment 12 months after initiation of ART (Transfers assumed to be in care)	(Survival ART Report)	83%			100%			63%					
20	13	% of adults and children known to be alive and on treatment 12 months after initiation of ART (Transfers assumed to be in care)	(Survival ART Report)	71%			93%			75%					
21															

References

1. UNAIDS, World Health Organization, Guidelines for effective use of data from HIV surveillance systems. 2004

2. Doherty T, Chopra M, Nsibande D, Mngoma D. Improving the coverage of the PMTCT programme through a participatory quality improvement intervention in South Africa. *BMC Public Health* 2009; 9: 406: doi: 10.1186/471-2458-9-406.

3. Chaulagai C, Moyo C, Koot J, et al. Design and implementation of a health management information system in Malawi: issues, innovations and results. *Health Policy Plan* 2005; 20(6): 375-84.

4. Ndira S, Rosenberger K, Wetter T. Assessment of data quality of and staff satisfaction with an electronic health record system in a developing country (Uganda): a qualitative and quantitative comparative study. *Methods Inf Med* 2008; 47(6): 489-98.

5. Mphatswe W, KS. M, B. B, et al. Improving public health information: a data quality intervention in KwaZulu-Natal, South Africa. *Bull World Health Organ* 2012; 90: 176-82. doi: 10.2471/BLT.11.092759.

6. Nsingizwe M, Iyer H, Gashayija M, et al. Towards utilisation of data for program management and evaluation: quality assessment of five years of health management information system data in Rwanda. *Global Health Action* 2014; 7: 25829 - http://dx.doi.org/10.3402/GHA.V7.

7. Malawi Ministry of Health. Integrated HIV Program Report. Q4, 2014.

8. Gulaid, L. Community-Facility linkages to support the scale up of lifelong treatment for pregnant and breastfeeding women living with HIV: A conceptual framework, compendium of promising practices and key operational considerations. UNICEF. June 2016.

9. Ministry of Local Government and Rural Development, Malawi National Decentralization Policy. 1998. http://www.300in6.org/wp-content/uploads/2014/07/1.-National-Decentralisation-Policy-by-GoM-1998.pdf

Acknowledgements

UNICEF would like to acknowledge the following individuals who contributed to the development of this case study:

Malawi Ministry of Health: Michael Eliyah

EGPAF: Nicole Buono, Allan Ahimbisibwe, Peter Chalusa

UNICEF Malawi: Judith Sherman, Jacqueline Nkhoma, Emmanuel Saka, John Chipeta

South African Medical Research Council: Ameena Goga, Vundli Ramokolo, Nobuntu Noveve, Vuyolwethu Magasana, Tanya Doherty

UNICEF New York: Braeden Rogers, Catherine Richey

Sincere gratitude is expressed to the governments of Norway and Sweden for their financial support through the Optimizing HIV Treatment Access (OHTA) Initiative.

Photos: Karin Schermbrucker
Layout and Design: Era Porth

For additional information about the OHTA Initiative, visit:
http://childrenandaids.org/partnership/optimizing-hiv-treatment-access


2003
2013