IATT Webinar Summary and Discussion: Monitoring & Evaluation Option B+ Framework

This webinar marked the official launch of the IATT Monitoring & Evaluation Option B+ Framework, a joint effort by CDC, WHO and UNICEF, with the support of the IATT M&E Working Group. There has been rapid scale up of the implementation of Option B+ in countries with generalized epidemics and this framework is an important resource for countries to review, adapt and update current monitoring systems and continuously evaluate programmes in order to maximize the potential impact of lifelong treatment programmes to improve health outcomes and prevent HIV infections among women, their children and families.

There are four main recommendations proposed in the framework and outlined by James Houston of CDC:

- PMTCT programmes need to move beyond measuring coverage to look at ART retention and final outcomes using cohort outcomes analysis
- Combined review of data by ART and PMTCT programme managers
- Implement enhanced monitoring
- Conduct process and systems evaluation in the early phases of the roll-out of Option B+

The team from Kenya, with Brian Pavakavambwa, WHO presenting on behalf of Dr. Rose Wafula, NASCOP shared the results from a pilot cohort analysis of both mothers and HIV-exposed infants (HEI) enrolled in the PMTCT programme.

The maternal B+ cohort analysis pilot was able to demonstrate retention rates at 3, 6 and 12 months and observed higher retention in known positives and reducing defaulter rates as the cohort matures. Some challenges are outlined below:

- Low viral load (VL) suppression for clients: 58% @3/12 months; 41% @ 6/12 months; 85% @1 yr (small numbers due to missing data)
- Difficult to abstract data from source documents in the transition period to an MNCH-centered model of ART provision
- Incompleteness of some ART registers in MNCH
- There is no standard national approach to B+ cohort analysis

Results from the HEI cohort analysis (HCA) show that from 2012-2014, there was an increase in coverage among all pediatric HIV indicators and an increase in the number of HEI that are followed up through 18 months of age. Specifically, the proportion of HIV-positive infants linked to HIV care increased from 83% in 2012 to 93% in 2014.

The Uganda team, led by Dr. Linda Nabitaka, MOH and joined by Dr. Moses Walakira, EGPAF provided an example of an enhanced retention monitoring system, to monitor early retention and the district response, which consisted of three key components:

- Real time monitoring by SMS reporting
- Site level quality improvement
District oversight informed by dashboard review at weekly and monthly intervals

Key areas of focus for this enhanced monitoring system were early maternal retention and commodity stock outs.

- **Early maternal ART retention** indicators were feasible to collect and report
- **Three month retention increased** from 74% to 90%.
  - One month retention appears to still be a major challenge
- A 3-month learning and change period was needed before improvement was seen

Both countries shared challenges and provided concise lessons learned and recommendations going forward, which are detailed in the last slides of their presentations.

**Recommendations from Kenya:**

**Mother cohort analysis:**

- Need to address challenges in the documentation of PMTCT services to improve monitoring in context of option B+
- Pilot different approaches to cohort analysis tailored to facility B+ implementation approaches and provide standardized cohort analysis system and tools as part of PMTCT cascade
- Strengthen strategies for retention of MCH clients, such as tailored psychosocial support package for mothers enrolled in PMTCT
- Focus on loss to follow-up (LTFU) and defaulters identified during cohort analysis
- Accelerated initiative to increase VL testing among pregnant women - guidance for VL testing among pregnant women (i.e. baseline, preconception)

**HEI cohort analysis:**

- Routine, facility-based HEI cohort analysis is feasible and useful in evaluating and improving program performance
- Use of HCA has shown statistically significant improvement in uptake of HEI services and outcomes for infants in the last three years and is an important facility-level quality of care improvement for HEI
- Integration of HCA within national reporting tools and health information system
- Current tools under review to adopt a few key indicators that are critical for upward reporting with adoption of others as QI facility level indicators

**Recommendations from Uganda:**

- Maximize existing efforts to monitor both early and late retention for HIV positive pregnant women and mother-baby pairs
- Need for closer retention monitoring, especially immediately after initiating ART for both pregnant and lactating mothers and during ongoing risk period with continued breastfeeding due to the shortened period of adherence counselling
- Define interventions for specific target points along the cascade where greatest losses are occurring and support health workers to implement them
- Strengthening data use is critical for improved program implementation through quality improvement initiatives
- Working with the leadership at both district and MOH level is critical for ownership and sustainability
- Continued mentorship and supportive supervision is critical
- Effective engagement by implementing partners is critical for the successful implementation of new program initiatives
- Community structures including family support groups, peer mothers, VHTs are critical in supporting service access as well as retention

Q&A Session
Section A: Questions for Kenya

Question #1: Kenya was asked to clarify whether the known positives (KP) and newly positives (NP) in the ART cohort were women starting ART?

The known positives includes both women that were on ART those that were not. However, he did note that data shows that approximately 80% were on ART. And the newly positive women are those identified during ANC and initiating ART for the first time.

Question #2: Is viral load monitoring standard practice, and why was the viral load uptake low among pregnant women?

2014 we focused on building the capacity for VL testing in Kenya and by now I assume we are still scaling up, though most sites have access to a VL test. In 2014, we developed a strategic plan for VL testing and mapped out the labs that are currently capable of providing VL tests. We have two platforms mainly using the DBS sample for our sites and so we feel confident that this data was at a time that scale-up was still happening. Now, we have fairly good access to VL testing and we hope that actual patient access should be improving within the next year and have system to be able to routinely monitor VL testing.

A big plus for VL testing is the fact that we have a web-based system for recording all VL testing performed and sites are able to review VL tests online and see the results online. We have a robust system but when the data was reviewed VL testing was scaled-up. In the scale-up process, we have developed a plan that is currently being finalized to increase the capacity for testing even though it's already available.

Question #3: How are denominators used to calculate the retention of both women and HIV exposed infants tested with antibody (AB) tests?

For the HIV antibody testing indicator, we used all infants eligible for a nine month AB test, total number of HEI registered in the cohort less any infants previously identified HIV positive because we assumed there were transferred out of HEI follow up and put into care and treatment services or any infants that were transferred out or had a known death by the time they were able to receive an AB test. We used a similar formula for 18 month AB test.

For the mothers, we will have to consult for the exact answer, but I believe we used a system similar to standard ART cohort summary analysis and I think that many of you recognize the format that the pilot took. In those cases, I believe they have a net cohort that they use where they have the original cohort plus any transfer outs between the start of the cohort and point of assessment and plus any transfer-ins. We have to confirm, but I believe that is the denominator that they would have used.
Question #4: Kenya was asked to share the best practices that have contributed to the gradual improvement in the HIV exposed infant cascade over the years.

Documenting HEI outcomes was a key component for Kenya because previously sites didn’t have a mechanism to record outcomes. Being able to document and assign an outcome to an infant was critical. We also had targets for achieving each outcome. For example, including the loss to follow-up outcome and establishing a target for retention was helpful. Through the HEI cohort analysis, we have a format that sites can use to assess their performance and develop an action plan for improvement. On a monthly basis, sites come up with improvement plans to help the process. Kenya has also really integrated HIV care for infants into overall mother child health services to ensure that there is a one-stop shop and ensure all services are offered in MNCH and once an infant is identified as HIV positive, it is quite easy to link them to ART services.

Kenya has also been able to use mentor mothers and peer educators who help to offer support for tracking retention and providing support to other women. A combination of these factors has helped to monitor and improve outcomes for HEI.

Question #5: How did you treat women who were KP but already on ART when booked for ANC for the same period cohort analysis?

About 40%-50% of pregnant women we are seeing in HIV clinics are mothers who know their HIV status and are on 80-90% are on ART – it is a large percent. When these women are on ART and are part of the cohort analysis they are aggregated into one; as they have started ART at different time points. Since they all enter while on ART, they are included in one cohort and we are able to measure VL suppression. Those known positive and on ART were still enrolled and continued on ART and those who were not on ART were immediately started on ART.

Section B: Questions for Uganda

Question 1: Uganda was asked to briefly explain how the real time monitoring works?

Real time monitoring is done through free SMS sent from the host facility and it is seen centrally as it will flash on the dashboard. It comes through the m-track system and the SMS is free at the health facility. At the end of every week, there are nine indicators collected on testing, ART delivery, ARV and RTK stock outs, missed appointments. Each indicator is given a code and the health worker writes the code and number. These submitted to MOH and the report is collated for the facility each week and shows the performance of the facility. A similar process is followed on a monthly basis. The issue of costing is shared among partners. As UNICEF was providing financial support for m-track for surveillance, PMTCT quickly built on that existing system as we added a PMTCT dashboard. At the moment, we are not certain of the costs because each partners pays for a different section.

Question 2: What strategies are used for tracking retention in the smaller and bigger facilities given the difference in retention rates between them?

The strategies used for tracking retention are all the same at all the different facilities. The only difference is that they are closer monitoring at facilities with larger patient volumes. At
all facilities ideally there are peer support groups at bigger facilities, these groups meet more frequently because they have more participants. We also support the use of reminders via mobile phone with mothers who have phones and support home visits for some of these mothers. In some sites at larger facilities we have mentor mothers and these mentor mothers also support closer monitoring. Ideally, there are subsidies used across the facilities.

**Section C.** Questions in this section were for both Kenya and Uganda. However, due to technical difficulties we were unable to capture Uganda’s response.

*Question #1: How can this framework be implemented in the community outside of health facilities, and what mobilization strategies were used to increase enrollment in Option B+ and reduce lost to follow up?*

We tried as much as possible in Uganda to engage multiply stakeholders including political leaders at the community and district level. The MOH’s village health system structure where the village health team members directly engage with the community members. The MOH devolved a community resource person that is intended to guide the VHT activities, education communities about PMTCT and the new guidelines, but also help them to respond to the common questions and needs around EMTCT. We did orient that Village health teams to use this to be able to address the challenges. We also used the VHT teams to track women who have missed their appointments, without necessarily revealing the HIV status of these clients. A number of the health workers have stronger community-facility linkages and have monthly meeting with the VHTs, where they review performance of the VHTs and review the reports. We realized using that platform has been able to facilitate these linkages, but also minimize the costs for tracking clients in the communities we have explored the opportunity of using the VHTs to track clients who are lost to follow-up.

Kenya noted that most of the cohort tools are facility-based; however, we still have specific programmes that link back to the community. One key component is the full tracking and retention strategy where at facility level we have fairly robust tools for making sure we are able to track all appointments and mentor mothers/peer educators who have specific tools to track every mother to make sure they keep appointments and support home visits when needed for ART adherence, defaulter tracking or retention support. Additionally, in terms of support access to ART services for mothers who have not come to the health facility, we also have different strategies that have been implemented. Previously, we used community health workers and some mentor mothers who are able to support women who stay at home to access services within health facilities. Hopefully, this has improved ANC uptake. For Kenya ANC uptake is fairly good and we are trying to improve retention along the PMTCT cascade and attention right from attending the first ANC, delivery at a health facilities and retention through the 2-year period for the infant.

The government of Kenya is rolling out a reproductive health and maternal health scorecard, which keeps track of important indicators from childbirth until adulthood. We plan to ensure that some of the community health unit the community health unit monitoring tools are able to feed directly into the scorecard. This is something which we can share. We hope this can become a best practice for community health.
Question #2: How did the countries manage data collection and follow-up between ANC, labor and delivery, post-natal care and maternal child health services throughout the continuum of PMTCT care?

For Uganda, data collection is still a main challenge due to patient and reporting flow. Most of our mentoring is focused on improving the records. Mentor is in one section and ART in another section and the health facility has one ART register. The mother is initiated within MNCH and recorded within the ANC register. Then the mother's record is transferred to the ART register in the ART clinic. The patient card is kept with the mother in the ANC clinic. The cards are still left with MNCH when the mother delivers.

The biggest strength that Kenya has is the integration of all services within the maternal child health services; Tools are integrated. The only service that is provided separately is delivery; however, mothers are immediately brought back to the health services for continuous follow up. In addition, Kenya has standard tools for documentation at the antenatal, labor and delivery and post-natal clinic which has really helped. This also entails standard tools for the HEI, including a HEI card and register. For the actual cohort monitoring for the mothers, Kenya has adopted ART cohort that was been used since 2012 and that has been adopted for the Option B+ context. The HEI cohort has also been in use for three years. However, there is still more work that needs to be done in order to link maternal and infant cohort together, unless sites have electronic medical records. Each site is able to track the outcomes for their site respectively.

Question #2: How are the results used to inform further improvements at the site level?

The pilot project in Kenya hopes to build robust tools at a larger scale to support cohort monitoring for mothers and build systems to be able to use the results to improve performance at the site level. Nonetheless, for HEI cohort analysis results have been remarkable over the past three years. With national scale-up and integration into national tools, it will continue to be used to improve performance.

Question #3: What kind of support did you receive from the government sector, in particular financial support?

For cohort monitoring Kenya has used existing systems, which didn't require additional funding from the government. To scale-up the only additional funding needed would be to support training and printing of tools, which will not have significant financial implications. The additional resources for the HEI cards was for training and roll-out of tools which we were able to do with the national team. We are working closely with the MOH to look at national scale-up as an effort toward EMTCT of HIV. As mentioned earlier, Kenya is in a phase were we are supporting a national stock taking exercise to integrate HEI into MNCH. We are currently supporting a process to do the same at county level. It is part of the score card Kenya is developing to review to stakeholders, improve performance across the board for PMTCT, including outcomes for the both the mother and the baby, identify gaps and to support each site to reach a certain quality of PMTCT care which will help us reach EMTCT. After the recent stocktaking meeting, Kenya started the Bring Back the Mother Campaign, to identify and bring back 17,000 mothers that were not accounted for. The government is building the capacity of each county to review their data from all sources, including the cohort analysis to identify mothers and babies loss to follow-up, trace them and bring them back for treatment.
Next Steps:

- Meeting will be convened by IATT in October 2015 to bring together countries to discuss implementation of the M&E Option B+ Framework
- Documentation of best practices and case studies
- Developing a repository of tools and M&E registers (some are available via the IATT website)
- Enhanced data use for decision-making
- Use of programme data to evaluation outcomes and conduct impact assessments