BACKGROUND

In 2008, at the request of USAID/Cote d’Ivoire and the President’s Emergency Plan for AIDS Relief (PEPFAR), the USAID Health Care Improvement Project (HCI) was invited to assist the Ministry of Health and its National Program for HIV Care and Treatment (PNPEC) to conduct a national assessment of the quality of HIV/AIDS care. Together with PNPEC and its major implementing partners—International Center for AIDS Care and Treatment Programs (ICAP), the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Aconda Association, and CARE—HCI designed and carried out a baseline assessment of quality of HIV/AIDS care in July and August 2008.

The assessment, conducted in a nationally representative sample of 41 public and private clinics and hospitals selected from sites that provide antiretroviral therapy (ART) and/or prevention of mother-to-child transmission (PMTCT) services, documented several gaps in the quality of ART and PMTCT care. For both the pre-ART and the ART cohorts, adherence to standards of care during the initial patient visit was good at the assessed sites. It was better among ART patients compared to pre-ART patients, and generally better among children compared to adults. Basic HIV care standards of HIV typing, weighing, clinical staging, and CD4+ T cell count assessment were all performed for at least 65% of patients. However, the assessment found that adherence to standards of care was lower in the second semester of care for both cohorts. The assessment identified a number of clinical activities that were not conducted during clinical visits that represent low-effort opportunities for providing quality care, including clinical staging, weight-taking, and patient counseling.

For PMTCT services, the assessment found that only 67% of HIV-infected pregnant women received prophylaxis and only 43% of exposed infants received it as well. Information systems for tracking PMTCT patients were also poorly organized, making it difficult to track women and their babies to assure follow-up care.

The assessment also found that retention of patients in HIV care was poor. Six months after initiating care, two out of three pre-ART patients and 45% of ART patients were lost to follow-up, comparing unfavorably with retention figures from other studies in Africa. Wide variation among sites was observed with respect to the existence of medical records and medical record-keeping practices: 38% of ART patients who had no documentation in the medical record of any follow-up visits after the initial consultation actually received some kind of ART services according to pharmacy records.

Weak record-keeping and high patient attrition undermine program effectiveness and outcomes. To address these gaps in care quality, in December 2008, the PNPEC and HCI launched an improvement collaborative with 41 public and private hospitals and health centers providing ART and PMTCT services, located in 27 out of the country’s 83 districts (see map).

In March 2009, HCI was asked to provide technical support for quality improvement efforts in two new areas: care for orphans and vulnerable children (OVC) and HIV prevention. In the area of OVC services, HCI is providing technical assistance to the National Program for Orphans and Vulnerable Children (PN-OEV) of the Ministry of the Family, Women and Social Affairs (MFFAS). Activities to support
“After more than a decade of HIV care and ARV treatment, it appears very important and necessary for the PNPEC to focus on the quality of interventions. To meet this need, the PNPEC asked the technical support of URC to implement a Quality Improvement project with PEPFAR’s funds. The results of this national effort through the Health Care Improvement Project are already visible and satisfactory. We are in favor of an extension in order to involve more HIV care facilities, which will result in the improvement of patient care at a larger scale in the country.

—— Dr. Virginie TRAORE
Director, PNPEC

HIV prevention are being conducted with the Ministry of AIDS (MLS) and PEPFAR strategic information and prevention implementing partners.

IMPROVEMENT OF ART AND PMTCT SERVICES

Objectives

- Support PNPEC, implementing partners, and district management teams to apply collaborative improvement to rapidly improve the quality of HIV care and treatment services in 41 pilot sites located in 27 of the country’s 83 districts
- Based on identifying the key changes that lead to improvement, develop an intervention package and tools for improving ART and PMTCT services that can be spread to new sites
- Develop the capacity of PNPEC to train and support a network of regional quality improvement coaches

Improvement strategies

In late 2008, PNPEC and HCI organized a Technical Expert Group to guide the collaborative and to define the key interventions and improvement indicators which would be introduced by teams at the site level. Quality improvement (QI) teams were formed in each of the 41 sites, and orientation visits were made to each site to prepare for the first learning session. Of the 41 sites, 37 provide ART and 34 provide PMTCT services.

In January 2009, the collaborative held its first learning session with site teams. Also in January, HCI trained a core group of national coaches from the MOH, PNPEC, CARE, ACONDA, and other partners who would provide technical support to site-level QI teams.

The second learning session of the collaborative was held in March 2009. At the third learning session, held in August 2009, teams were divided into ART and PMTCT groups to allow for more in-depth discussion of the specific quality issues being addressed in each service area. Between learning sessions, QI coaches and HCI staff visited each site to provide encouragement and support for changes at the facility level to improve care and review data for monitoring indicators.

In February 2010, PNPEC and HCI selected eighteen QI team members who had distinguished themselves as being especially motivated and trained them to serve as regional coaches. The fourth and final learning session with the pilot sites was held in March 2010 for the PMTCT sites and in April 2010 for the ART sites. The sites that had improved their indicators the most were also recognized at the learning session with certificates recognizing their accomplishments.

Table 1. Effective changes developed by teams participating in the ART/PMTCT Improvement Collaborative

<table>
<thead>
<tr>
<th>Area of Changes</th>
<th>ART</th>
<th>PMTCT</th>
</tr>
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<tbody>
<tr>
<td>Improving patient tracking and follow-up</td>
<td>• Calling patients or contacts about missed appointments and encouraging them to return to the clinic&lt;br&gt;• Using NGOs to trace lost patients and bring them back to the clinic&lt;br&gt;• Designating a staff member to be responsible for reviewing records for completeness each day</td>
<td>• Tracking children for HIV testing during vaccinations&lt;br&gt;• Regular meeting set up between the general hospital where women deliver and the PMTCT site to share patient lists and information to track HIV-positive women and the children born to them.&lt;br&gt;• Improving counseling of pregnant HIV-positive women about the importance of returning for HIV testing of the infant</td>
</tr>
<tr>
<td>Increasing availability and competence of health workers</td>
<td>• Involving the obstetrician-gynecologist (OB-GYN) in ART provision to HIV-infected pregnant women</td>
<td>• Training and involving guards in patient orientation</td>
</tr>
<tr>
<td>Service organization and scheduling</td>
<td>• Recording appointments in two lists, one for the facility and one for the patient&lt;br&gt;• Making appointments to provide drugs to patient and CD4 control on the same day</td>
<td>• Regular meeting between OB-GYN and HIV service providers</td>
</tr>
<tr>
<td>Availability of supplies and equipment</td>
<td>• Created triage station&lt;br&gt;• Provided thermometer to ensure patients’ temperature taken at each visit</td>
<td>• New room designated for PMTCT activities</td>
</tr>
</tbody>
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Results
Most of the 41 teams have been active in testing changes to improve service integration and retention in care of ART patients and children born to HIV-positive mothers. Key changes tested by the teams are summarized in Table 1.

An important result of the collaborative thus far has been to increase providers’ attention to filling out all key items on patient medical records. Completion of key items improved from 5% of ART patient records at baseline to 82% by December 2009 (see Figure 1), and from 8% to 87% for PMTCT patient records in the same period. Patient retention also improved: Figure 2 shows that ART patient loss to follow-up fell from an average of 28% at baseline (July–December 2008) to 14% by December 2009.

Large gains were also achieved in the proportion of children born to HIV-positive women who were tested for HIV: infant testing rose from 15% in December 2008 to 55% by September 2009 (Figure 3).

Next Steps
Best practices and successful changes developed by the pilot sites are being consolidated now into a spread change package that will be introduced in another 79 facilities in new districts in 2010 (see map on pg. 1). A network of regional coaches is now being trained to support the new sites during the spread phase and build regional capacity in quality improvement.

HCI will also participate in laboratory accreditation activities sponsored by the WHO Africa Regional Office, to improve lab capacity to provide quality services to support HIV/AIDS care.

DEVELOPING AND IMPLEMENTING STANDARDS FOR OVC PROGRAMS
Based on activities championed through the PEPFAR-funded “Care that Counts” Initiative for OVC Programs, HCI was asked to assist the National Program for the Care of Orphans and Vulnerable Children (PN-OEV) of the Ministry of the Family, Women and Social Affairs to develop quality standards for OVC services.

Objectives
- Improve quality of programs targeting orphans and vulnerable children
- Develop outcome-based standards that define quality services for vulnerable children
- Assist sites in piloting the standards
- Gather evidence that these standards are feasible at the point of service delivery and are actually making a difference in children’s lives

Improvement strategies
At a consensus-building workshop in March 2009 for representatives from PN-OEV,
the U.S. Centers for Disease Control and Prevention (CDC), UNICEF, and other partners. HCI presented a conceptual framework for organizing for improvement at both the national level and the point of service delivery. Participants in the workshop then worked to develop an initial set of draft OVC standards for Côte d’Ivoire.

Following on that workshop, HCI circulated the draft standards and collected inputs from all partners and local OVC champions through a series of consultative workshops, including a workshop in July 2009 with youth representatives. These events were followed by a final workshop in July 2009 with PN-OEV and implementing partners where the standards were finalized. HCI also worked with PN-OEV, PEPFAR, and the MEASURE Evaluation Project to develop indicators to measure compliance with the new standards.

A final draft of outcome-based OVC standards was approved by PN-OEV in October 2009.

Next Steps
These draft standards will be piloted in four different regions of the country beginning in March 2010. The pilot testing is being implemented through the social service centers (plateformes) operated by the Ministry of Women and Social Affairs, which coordinate the efforts of all actors (community organizations, international NGOs, and government agencies) involved in the care and support for vulnerable children. The four plateformes that are engaged in testing the standards are Yopougn (Abidjan), Yamoussoukro, Bouaké, and San-Pedro.

DEVELOPING STANDARDS FOR HIV PREVENTION THROUGH PEER EDUCATION

In 2009, PEPFAR and USAID asked HCI to support the development of national standards for core competencies of peer HIV counsellors in collaboration with the Ministry of HIV/AIDS (MLS), CDC, PEPFAR, and other prevention partners. Peer educators are a key part of Côte d’Ivoire’s HIV prevention strategy, since they can be effective in reaching most-at-risk populations, including vulnerable youth, commercial sex workers, and men having sex with men.

Objectives
- Develop national standards for core competencies of peer counsellors
- Develop national indicators, data collection systems, and tools to measure the outcomes of peer education programs on targeted audiences.
- Develop indicators and tools that can be used to supervise and guide improvement of peer education programs.

Improvement strategies
Tools for quality assessment of peer education and outreach were drafted and field tested in June 2009. In August, HCI carried out an initial situational analysis of current prevention efforts in Côte d’Ivoire with the MLS and PEPFAR in order to assess the activities of seven prime PEPFAR partners (ANADER, CARE, JHU/CCP, Geneva-Global, EGPAP, PSI and FHI) and nine implementing partners in 14 of the 168 prevention sites in the country. A first draft of the situation analysis report was reviewed with the MLS, Ministry of Health, PEPFAR, and other partners in September 2009.

The assessment revealed both strengths and weaknesses in current peer education programs. A recurring theme among programs was the need to strengthen the behavior change communication (BCC) capacity of local organizations and enable them to apply BCC approaches to peer education programs. Another key finding was the need to link peer education programs to other existing prevention programs so that messages and behaviors can be reinforced through various media. The assessment also identified the need for greater awareness and knowledge of existing HIV/AIDS services so that peer educators can appropriately refer individuals. There was a general recognition at the prime and implementing partner level that all organizations could improve.

Next Steps
In 2010, HCI is working with the MLS and other partners to develop quality standards for peer education on prevention and tools to measure the processes and outcomes of peer education programs that can be applied on a nationwide basis. These indicators and tools will be used to supervise staff and guide improvement activities.

The USAID HCI Project Team in Côte d’Ivoire
Dr. Jean Hervé N’GUESSAN, Country Director
Mr. Daniel ZIRIGNON, Administrator
Dr. Alain ACKAH, Senior ART Advisor
Dr. Franck Olivier KABLÁN, PMTCT Advisor
Dr. Youssouf DOSSO, ART Advisor
Mr. Victor KOUASS Kan, M&E Advisor
Ms. Lucie DAGRI, OVC Advisor
Ms. Tana YAPI, HIV Prevention Advisor
Mr. Matthieu CLEGÉBA N’goy, Laboratory Advisor
Ms. Blaiho Gertrude AGOSSOU, Administrative Assistant
Mr. Gouanou Godefroy KOUE, Assistant Accountant
Mr. Paul BOGAU, Driver
Mr. Bertin KASSI, Driver

USAID Health Care Improvement Project in Côte d’Ivoire
2 Plateaux Aghien • Immeubles SICOGI Bat. L. porte 134 (Rez de Chaussée) entre le Les Palmas et la Mosquée d’Aghien (Sur le Blvd. Latrielle) • 225-22-52-99-87
University Research Co., LLC • 7200 Wisconsin Avenue • Bethesda, MD 20814-4811 • USA
TEL 301-654-8338 • FAX 301-941-8427 • www.hciproject.org