



## Executive Summary

# Evaluation of the Elizabeth Glaser Pediatric AIDS Foundation program to accelerate POC/PITC in Kenya, Eswatini and Zambia

Date: 30 November 2018

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# Executive Summary

## Introduction

Since 2013, the ELMA Foundation has invested in identifying infants, children, and adolescents living with HIV, and linking them to treatment. Among ELMA's suite of investments is a 36-month grant to Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) to expand access to HIV testing and treatment in Kenya, Eswatini, and Zambia for children aged 18 months to 19-years old.

The aim of this grant is to *'to rapidly scale up pediatric HIV testing for children aged 18 months and older, and initiate HIV-infected children on ART. EGPAF will work with and through the Ministry of Health (MoH) and its network of national partners in Kenya, Eswatini, and Zambia.'*

ELMA commissioned an independent evaluation of the project, which is being conducted by Itad, over two phases. The overall purpose of the evaluation is to assess programmatic outcomes in these three countries and to inform future decisions in relation to ELMA's investments to ensure that children living with HIV are linked with care and treatment. The report presents summative findings evaluation.

## Methodology

To ensure that our evaluation findings and recommendations are of greatest use, we have applied a **theory-based, utilization-focused evaluation approach**. Jointly with ELMA and EGPAF, we co-created a theory of change and evaluation questions (see Table 2). To interrogate the evaluation questions, we conducted over the two phases of the evaluation:

- Visits to 20% of ELMA supposed facilities.
- 171 KII with key stakeholders, including EGPAF staff, service providers, Ministries of Health (MoHs) and global HIV stakeholders.
- An online survey, soliciting 50 responses.
- 20 group discussions with project beneficiaries.
- Finally, we reviewed approximately 150 project documents and published and unpublished sources.

During the analysis process, we triangulated qualitative data with quantitative data from EGPAF's monitoring system and government and other documents. In March 2018, we presented draft findings to ELMA and EGPAF and co-created recommendations for project improvement, sustainability and the wider field of pediatric HIV services (HTS). Phase 2 of the evaluation serviced to verify and validate emerging findings from Phase 1. In October 2018, we discussed summative findings and recommendations with ELMA.

## Findings

Despite delays in commencing implementation, Provider-Initiated Testing and Counseling/Point of Care (PITC/POC) for children aged 18 months and older increased in the supported facilities in each of the three countries. Qualitative evidence suggests that this increase is largely attributable to the ELMA-supported activities. Equally, based on EGPAF monitoring data, this increase coincides with the commencement of activities. Table 1 presents a synthesis of key findings by strategic area.

**Table 1: Summary of key findings**

**Strategy**

**Key findings**



1. Implement intensified case finding for children older than 18 months in child-centered health services.

Across the three countries it was recognized that this project addressed a gap in the HIV response, with the 18 month to 19 year old age group highlighted as missing in testing efforts previously. ELMA-supported activities, which hinged on training in paediatric and adolescent HTS and on supporting additional frontline staff, are considered to have re-focused health care workers' attention on this age group in the facilities in which the project was based.



2. Scale up a family-centered model to test-and-treat children with HIV-infected parents and siblings.

The strengthening of index case contact testing emerged as a critical success of this project in all three countries. It appears that the MoH and other partners are adopting EGPAF/Zambia's contact tracing registers that enabled this activity across the national response, while EGPAF is scaling it up via other projects. Adaptations to this approach in Kenya, namely, adolescent partner and sibling testing and dead index family testing, were also deemed successful in reaching this age group, with a relatively high yield when compared with less targeted activities.



3. Support the rollout of universal HIV testing for children older than 18 months in selected communities.

Activities under this strategy are grounded in the community-based activities. For example, school debates in Eswatini were considered a triumph of the ELMA project. EGPAF Kenya implemented targeted hotspot testing on the shores of Lake Victoria (beach testing), which proved very effective, and EGPAF/Zambia collaborated with partners in high-yield community testing drives in two districts. Despite gains made in this area, there was concern that activities are implemented on a low scale and are not sustainable beyond donor funding.



4. Build capacity of national and decentralized health authorities and civil society partners to implement and sustain high-quality pediatric HIV testing and treatment services.

EGPAF worked closely with and through national and decentralized health authorities – building capacity through focused trainings, ongoing mentorship, and promotion of data use in sub-national review and planning meetings. EGPAF enhances the sustainability of this aspect of their work through ensuring new tools developed, such as training curricula, job aids, etc. are introduced via the appropriate technical working groups and approved by the MoH. There was limited focus on working with civil society partners in this project, which may speak to challenges around sustainability of community engagement activities.



5. Complement EGPAF's UNITAID-funded POC early infant diagnosis (EID) project, with the combined goal of expanding pediatric case finding from birth through to adolescence.

This aspect did not happen due to UNITAID's delayed launch; instead, the ELMA project complemented EGPAF's wider portfolio, this was most notable in Kenya and Eswatini. It was recognized that with ELMA funds, EGPAF could support activities such as community outreach activities, which are a priority of the MoH but not permitted under PEPFAR funding.

**Conclusions**

At the summative phase of the evaluation, it is clear that testing of children in the ELMA age range accelerated in the ELMA-supported health facilities, coinciding with the implementation of activities.

Qualitative evidence suggests that this increase is attributable to this project. Table 2 provides a summary of our conclusions by evaluation questions (EQs).

Table 2: Summary of conclusions against EQs

No	Evaluation questions	Conclusions
EQ1	To what extent has EGPAF implemented their strategies in each country? How have the seven types of interventions been implemented in sites? What adaptations have been made and why?	Working closely with the respective MoHs, EGPAF tailored the strategies to respond to the country contexts. Interventions were implemented to varying degrees of success – through adapting an innovation and adaptive management mind-set. To enhance yield and efficiency, EGPAF pivoted from implementing interventions or activities that were deemed unsuccessful or too costly. Work with CSOs appears to be one of the least implemented of EGPAF’s planned methods, and could speak to some of the tapering of community-based activities experienced after year 1 of the project.
EQ2	Is there evidence that a certain combination of activities produces better results? Were some strategies better than others in sites and why?	Evidence suggests that marrying community activities with intensified efforts in facilities is a key aspect of the success of this project. For example, index case testing is implemented at facility level but when paired with community-based aiders (CBAs) and door-to-door testing, it can increase the follow-up HIV testing and counseling (HTC) of contacts. Beach testing in Kenya had the highest yield, suggesting that targeted community-based HTC holds good potential to identify undiagnosed people.
EQ3	To what extent were the interventions necessary and sufficient to achieve the project’s intermediate outcomes?	The ELMA support augmented the ability of the supported facilities in each country to build and meet the demand for paediatric and adolescent HTC, particularly through increasing HCWs’ skills and awareness of the need and through support of additional frontline workers in facilities. While the inputs were sufficient to produce positive changes in the supported facilities, in all three countries those sites were a small fraction of national need.
EQ4	What changes have taken place with regard to the intermediate outcomes?	While the evaluation was not designed to assess this quantitatively, the qualitative interviews and observations provided evidence that EGPAF activities have had a positive impact on all intermediate outcomes. There is some limitation around the number of health workers and CBAs trained in order to ensure ongoing implementation of PITC according to national policy in all services and sites. Working closely with MoH and partners in this area, and collaboration with communities, are key to scaling up and sustaining the gains made.
EQ5	What additionalities have the ELMA grant allowed EGPAF to do at the country and site level?	A number of notable additionalities were highlighted. Respondents consistently stressed that the ELMA-supported activities allowed EGPAF to address a real gap in the HIV response, i.e. the 18 month to 19-year-old age group. ELMA’s flexible funding is unique in the response and enabled EGPAF to test activities on a small scale, to be scaled up through other projects and partners, for example, school debates, and strengthening index contact testing.
EQ6	What evidence is there that this combination of activities has contributed to the outcomes?	Evidence suggests that a concerted effort to marry different community-based approaches with intensified efforts at facility level has contributed to the increase in testing in facilities and associated outcomes. Combining demand generation activities in communities

with supporting the supply side in the health facilities was frequently highlighted as a key aspect of the ELMA project.

**EQ7** Has EGPAF been successful in increasing PITC in children aged 18 months to 19 years?

Yes, it appears that through the ELMA project, EGPAF have accelerated testing in this age group in the supported facilities in each of the three countries. Furthermore, it is submitted that the ELMA project has contributed to heightening the priority of pediatric HTC in both policy and practice in all three countries.

## Key recommendations

### Recommendations for current programming<sup>1</sup>

The evaluation team was asked to identify issues and opportunities for ELMA and EGPAF to strengthen paediatric HTC and linkage to care now in the three countries. ELMA can apply these recommendations in their programming decisions, and EGPAF can consider them in their broader portfolio.

- **Review and strategically assess the outreach strategies that were used in ELMA-supported sites.** Diverse outreach approaches were cited and observed in different sites in the three countries, with some demonstrating significant success. Learnings from these can be compiled, costed and used to formulate guidelines for more systematic action at site level. In addition, consider the limits of outreach that can be accomplished by health-care-facility-based services, and the benefits of systematic partnering with community-based organizations, especially for reaching vulnerable groups.
- **Systematically plan how to increase coverage of tailored HIV testing and counselling for underserved paediatric groups including the hard-to-reach.** Across all settings, some outreach strategies proved extremely effective. Adapting as needed, consideration should be given to scaling these up beyond the ELMA supported-sites. Work with local health authorities to identify and prioritize the underserved groups, including children of sex workers and other key populations, and “hotspots” where at risk children and adolescents can be found, as the opportunities and needs vary greatly from place to place.
- **Engage prospective beneficiaries in the design of activities and interventions.** These range from the children and adolescents themselves, to the service providers, parents and caregivers. While beneficiary participation may slow the progress of a project, it improves the acceptability and sustained impact of interventions, particularly around adolescent participation. Participatory approaches are especially important for identifying and reaching more vulnerable populations.
- **Require or promote use of tested and proven tools to institutionalize good practices.** In several areas of concern, tools are available to provide evidence-informed solutions. For example, scarce and possibly dwindling HIV resources militate against universal PITC, and a checklist or algorithm is available to help service providers decide when to test or not test. An adequate supply of printed copies of such tools should be available at facility level to support their routine use.
- **Invest in transferring the project’s training materials** on paediatric and adolescent HTC and HIV case management, linkage to and retention in care **to the MOH and the institutions responsible for pre-service training** of health care workers and psychosocial counsellors in all three countries.
- **Promote a shared understanding of sustainability goals, from the outset of a project:** Issues around sustainability and exit strategies are often pushed to the end of a project life cycle, when resources are scarce. Discussing sustainability goals during the design or proposal stage, and ensuring there are clear expectations and budget lines in place will enhance the likelihood that practices to plan for and

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<sup>1</sup> Project specific recommendations from Phase 1 can be found in Annex 9.

secure sustainability will be carried out. Consider the incorporation of sustainability indicators into results frameworks.

- **Engage in the global dialog on measures of success.** There are ongoing concerns about the availability of population-based and clinic-based data adequately disaggregated by age and sex to guide HIV programming for children and adolescents. Further, the debate regarding the true number of undiagnosed children living with HIV undermines target-setting. In settings where an organization is one of several partners collaborating toward common goals, guidelines are needed for reporting on the organization's contribution. Both ELMA and EGPAF are in a good position to engage with the WHO and UNAIDS platforms that set global standards and indicators for HIV monitoring and reporting, which are in turn implemented at country level. They can promote standards that work better for children and adolescents, and that realistically represent the donor's investment and the implementer's achievements.
- **Ensuring a smooth transition.** The ELMA project ceased service delivery in May 2018, leaving five months for project close-out. A number of concrete action steps, including a cascade of consultations, technical support, and public presentations could make the difference between ELMA results multiplying and lasting and those results fading away.

### Issues to explore in future programming

The evaluation identified several topics that merit research and/or programme effort that are important in advancing the health and wellbeing of children in the sub-Saharan Africa region, and that were beyond the scope of the ELMA project. These require flexible funding, to enable the relevant partners to define the issues, and to test potential solutions:

- **Improving the coverage and content of HIV testing, counselling, treatment and support for underserved paediatric age groups.** The testing results from sites in Zambia and Kenya (but not Eswatini<sup>2</sup>) showed that compared to the adolescents, the two-nine age group were underserved in terms of numbers tested. Increasing the testing rates in the under-fives, well-baby, immunisation and nutrition clinics will help to reach this population with testing services. This, combined with increased vigilance by community-based health workers for children who are not being brought to the clinic will help to ensure that few children in the community remain untested.
- **Intensify support for demand-promotion and prevention programmes.** Practical strategies are needed to enhance paediatric HIV testing and treatment literacy for parents, grandparents and other guardians of children and adolescents. HTC and prevention literacy should share the responsibility for seeking HTC for children and adolescents more equally between HTC service providers and caregivers or adolescents themselves through more demand-promotion activities. Today's focus on finding HIV-positive individuals also needs to be counter-balanced with prevention support for those who test HIV-negative.
- **Specify and address the stigma barriers that impede full coverage of paediatric HIV testing, counselling, linkage and retention in HIV treatment.** The evaluation found broad consensus about the importance of reducing stigma, yet little specificity or visible action to do so. Ministries and service providers need support to implement proven stigma reduction interventions<sup>3</sup> with service providers and communities.
- **Reduce the uncertainties around paediatric HTC indicators.** Both the Phase One and Phase Two findings identified a preoccupation with "yield" – finding undiagnosed HIV-positive cases to be linked

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<sup>2</sup> In Eswatini, the results were almost the same for 5 to 9 and 10 to 14. See Annex 3.

<sup>3</sup> Kidd, Ross and Clay, Sue, 2003. Understanding and challenging HIV stigma. Toolkit for action. Washington DC. International Center for Research on Women.

to care. This - that overshadowed other indicators of success in paediatric HTC, and left little space for investment in strengthening health promotion and HIV prevention messages for those who test negative. Clinics that test large numbers of clients, but with a relatively low yield, should not be considered as poorer performers than those that test fewer clients. Targeted testing as the project is doing is to be encouraged for efficiency, but those who test HIV-negative should not be considered to be wasted effort

- **Strengthening HIV prevention and treatment for mothers and babies during and at the end of breastfeeding.** Mothers who are HIV-positive at their child's birth (and were not tested either during their ANC visits or during labour) or who become HIV-infected during the breastfeeding period are likely to transmit their infection to their children. Infants should be HIV-tested during the weaning period.
- **Developing and disseminating a model "business case" for investing in HTC for children and adolescents, for tailoring to specific national and sub-national settings.** The project can demonstrate success in a number of interventions across two-three countries and a variety of urban and rural settings. The increased yield and case-finding, along with the community outreach, form a suite of interventions that could be demonstrated to be both effective and efficient. Attention needs to be paid to ensure that this is documented and disseminated this further, to influence policy and practice among other MOHs and partners.
- **Partnering organizations when the task requires multiple strengths.** When a combination of clinical and community-based strategies is required, consideration could be given to partnering clinic-focused organizations with organizations that are a leaders in community-based interventions. This would
- **Defining the roles of stakeholders outside the health sector in sustainable paediatric HTC.** A disconnect between the Ministry of Education and the MoH has been observed in the three countries, and beyond. This fragmentation stands in the way of sustainable increase in identifying and serving all children in need of HIV services.