

Leapfrog to Value-Based HIV Care in Sub-Saharan Africa

Putting people-centered metrics into practice

November 2021



Work is led through thought leadership and collaboration with USAID and implementing partners



USAID's Office of HIV/AIDS (OHA), a key PEPFAR implementer, provides HIV/AIDS technical and programmatic leadership to inform the potential integration of value-based care (VBC) approaches in programming.

**CENTER FOR
INNOVATION
AND IMPACT**



USAID's **Center for Innovation and Impact** (CII) in the Global Health Bureau partnered with the Global Development Incubator (GDI) to explore the use of VBC in developing country contexts and is currently exploring new pilots and partnerships around VBC, including with OHA for HIV/AIDS.

Data.FI
Data for Implementation

Data for Implementation (Data.FI) is a five-year cooperative agreement funded by PEPFAR through USAID. Data.FI provides expert input and contextual knowledge for how VBC approaches can be integrated in USAID's PEPFAR programming.

Activity management, thought leadership, and operational context

**Leapfrog
to Value**



Leapfrog to Value, an initiative of the **GDI**, hosts a global coalition on VBC in low- and middle-income countries (LMIC) that includes funders, innovators, investors, health system experts, and public servants. The GDI leverages its ability to execute effectively and matches leaders, concepts, and capital required to launch and scale transformational development ventures.

Technical lead and thought leadership

Scope is to advance value-based approach in HIV in sub-Saharan Africa

Value defined in terms of outcomes that matter most to people living with HIV (PLHIV) and longitudinal cost of achieving those outcomes. The work:

- Supports the case for value-based HIV care by defining the “numerator” of value, meaning **people-centered outcomes**, and by identifying outcome drivers along the client journey.
- Suggests a plan for how VBC can be **integrated in large-scale HIV programs**. Includes customized people-centered metrics and a practical set of considerations for operationalization of the metrics.

Notes: This project does not focus on the cost side of the value equation. Another USAID activity is focusing on longitudinal costing using the Activity-Based Costing and Management approach. The two activities can complement each other to offer a fuller picture of value.

Executive summary

Despite significant progress, the HIV community has not met the 95-95-95 targets and the COVID-19 pandemic has created additional challenges. Global efforts to address the HIV epidemic have reached a point where investing more in existing programs may not yield desired outcomes.

To address this, PLHIV spokespersons and HIV experts have advocated for a fourth goal beyond the three 95s.

The fourth goal focuses on elevating people-centered outcomes, specifically health-related quality of life.

Value-based HIV care starts with understanding what matters most to PLHIV, looking beyond clinical outcomes to include health-related quality of life and the client's care experience. It also assesses the longitudinal cost of delivering those outcomes.

The focus of our early work was on measurement of people-centered outcomes. It builds on existing measurement and quality improvement efforts by bringing quality of life and the care experience to the forefront as core indicators.

The approach includes the development of a conceptual value-based framework and synthesis of people-centered outcomes in HIV. We undertook an iterative process of consultation with global HIV experts and secondary research. We then developed a set of indicators to measure people-centered outcomes, accompanied by a practical set of implementation considerations.

The next step is to validate and refine the set of metrics in a program context, ensuring that they generate meaningful insights, can be collected efficiently, can be implemented in the operational constraints of HIV care, and are sensitive to clients' needs.

In the long-run, we can integrate people-centered outcome measurements and program delivery with payment incentive structures to unlock the full potential of VBC in HIV.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

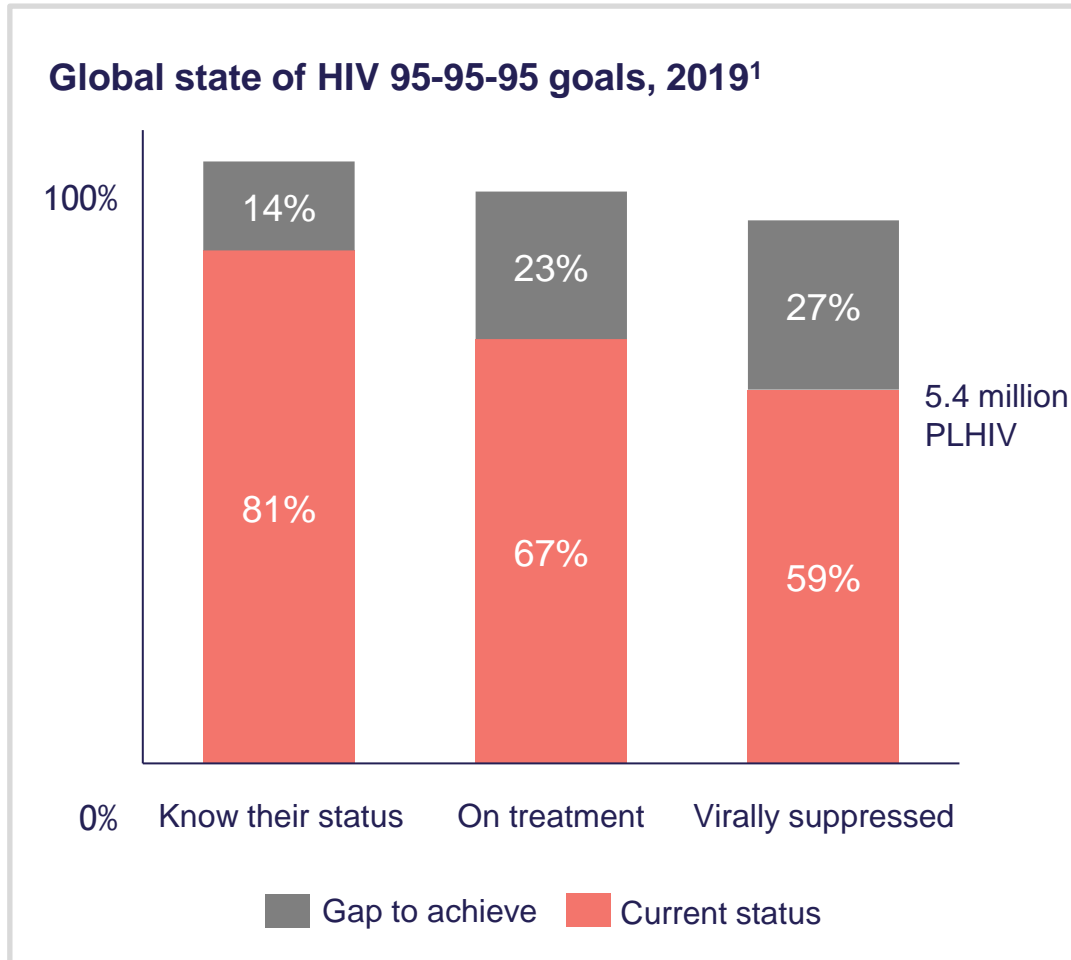
People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

Global state of HIV



The **global movement** to address the HIV epidemic has made significant strides:

- Developments in drugs and diagnostics.
- Mobilization of global financing from a variety of sources has led to improved access.
- Building data systems in HIV delivery platforms has created a framework for accountability.
- Growth in programs that address underlying social needs of PLHIV (e.g., for key populations).

However, we have reached a point where **investing more in existing approaches may not deliver the desired outcomes:**

- Despite improvements in access, quality varies.²
- Despite improvements in supply, demand continues to be a barrier to achieving the 95-95-95 goals.
- Despite strong advocacy for and emerging successes in providing client-centered care, key barriers remain (e.g., varying degrees of government ownership and advocacy, misalignment of human resource skills and motivations).

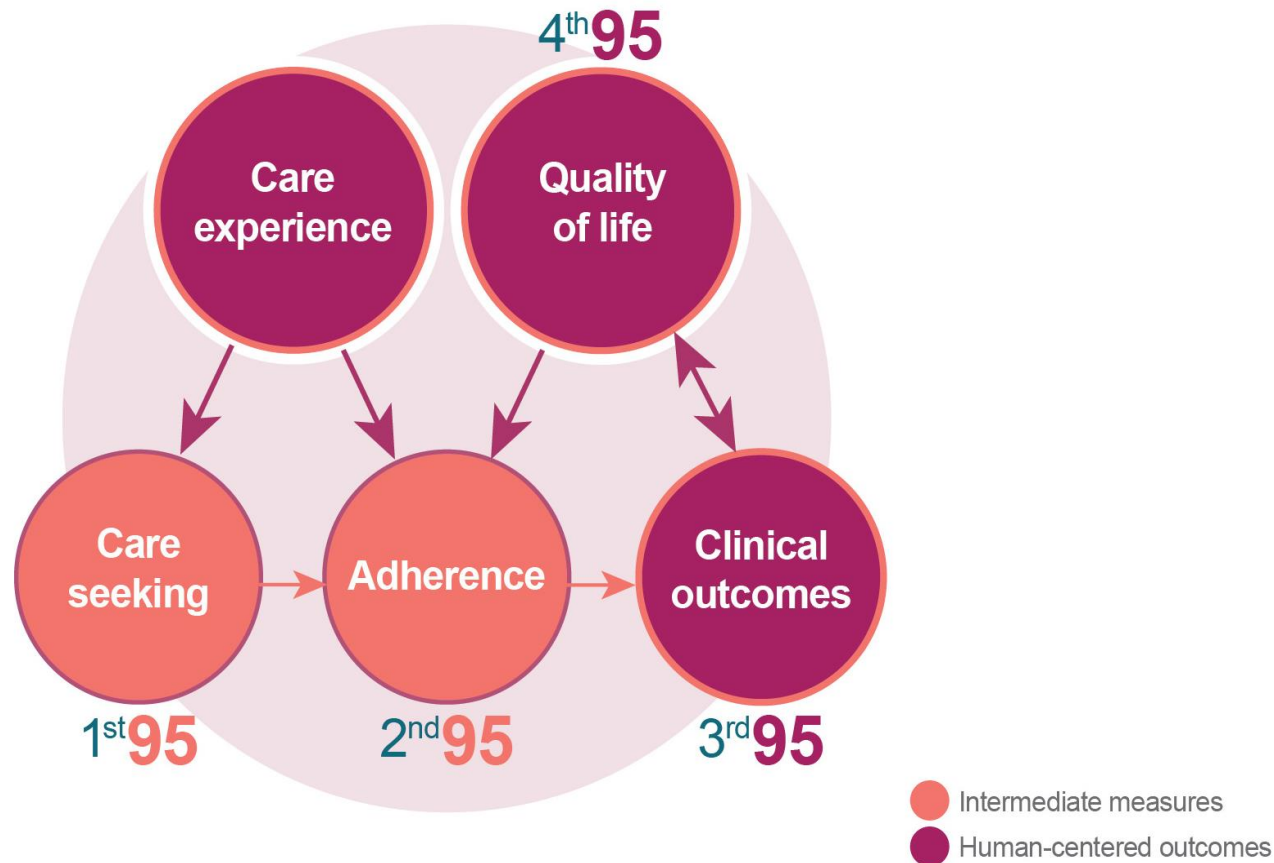
References:

1. Joint United Nations Programme on HIV/AIDS. (2020). COVID-19 and HIV. Retrieved from https://www.unaids.org/en/resources/documents/2020/20200909_lessons_hiv_covid.

2. Hirschhorn, L. R. (2007). Ensuring quality of care in the scale-up of HIV care and treatment in resource-limited settings: A challenge for all. *Therapy*, 4(6), 737-744. Retrieved from <https://www.openaccessjournals.com/articles/ensuring-quality-of-care-in-the-scaleup-of-hiv-care-and-treatment-in-resourcelimited-settings-a-challenge-for-all.pdf>.

Quality of life and the client's care experience are outcomes and enablers of the three 95s

Relationship between the 4th 95 and the three 95s



- Quality of life and the care experience—the 4th 95—are important outcomes in themselves. They are also important contributors to the first three 95s.
- Better care experience leads to better care-seeking behavior (1st 95) and better continuity of care (2nd 95) that, in turn, can lead to better clinical outcomes (3rd 95).
- Better quality of life leads to greater willingness to stay in care (2nd 95) that, in turn, can result in better clinical outcomes (3rd 95).
- Better clinical outcomes themselves can result in a higher quality of life.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

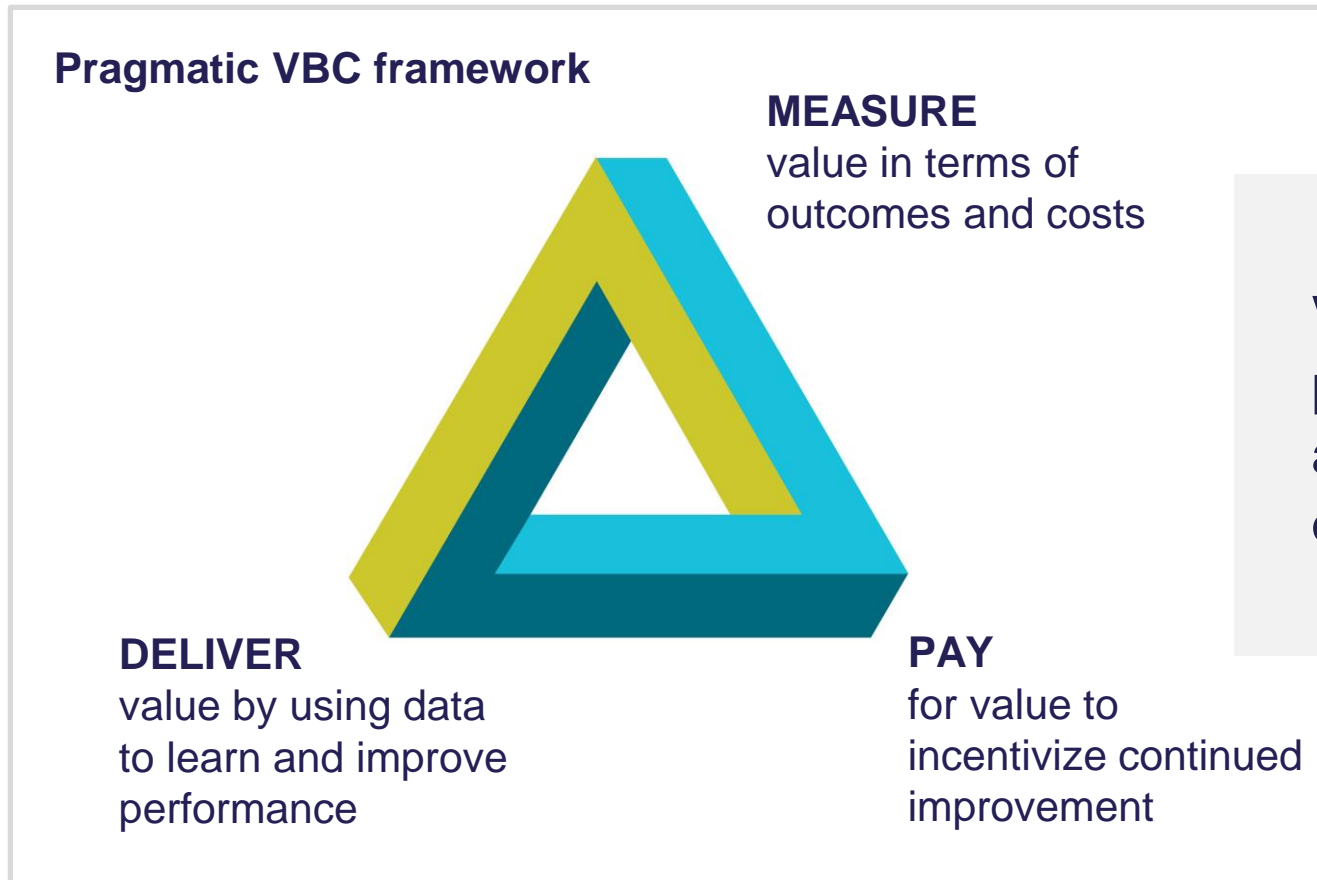
People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

VBC approach can orient the system to address drivers of people-centered outcomes



VBC aligns clients, payers, and providers around a common goal: achieving **people-centered outcomes at the optimal cost.**


Note: The [Leapfrog to Value report](#) elaborates on the application of VBC principles to LMIC contexts and presents a practical roadmap.

PEPFAR and the global HIV community can learn from existing programs that already apply elements of VBC

	What is the general practice today?	Opportunity to build on this positive momentum
Measure	PEPFAR has established a data-rich ecosystem where stakeholders at various levels routinely collect, analyze, and act on data for program design, planning, monitoring, and improvement.	<ul style="list-style-type: none"> ▪ Innovative approaches and tools can be used to interrogate the root causes of program challenges, better estimate costs of programs, and monitor service and non-service delivery functions at PEPFAR-supported sites. ▪ Digital health tools with a decision support and feedback loop can improve provider-client interactions.
Deliver	Differentiation of care for specific client segments has become standard practice and represents progress toward a more people-centered approach to HIV care.	<ul style="list-style-type: none"> ▪ HIV service delivery is increasingly supported by local implementing partners (IPs), which may allow room to empower local providers and experiment with more delivery models. ▪ They can be leveraged to bring people-centered design approaches to service delivery, increase the use of differentiated care and public-private integrated care models, and standardize tools to decrease stigma and discrimination.
Pay	Global HIV community has sought to align financing with results.	<ul style="list-style-type: none"> ▪ There is increasing adoption of global account budgeting and allocation, government to government funding, and cooperative agreements with IPs. ▪ They can be developed further to include results-based financing that incentivizes outcomes and efficiency, explores total market approaches that can increase access and quality of services, and increase strategic purchasing to promote quality and reduce costs.

Innovators in the global HIV community have successfully embraced a value-based approach

Innovators across high- and low-income countries



	Building blocks of value-based HIV care	Innovators
1	Create tools to measure what matters for PLHIV	ICHOM – Creates standard metric sets on people-centered outcomes. PROgress toolkit – Designs patient-reported outcome measures (PROMS) implementation toolkit.
2	Amplify PLHIV voices and create agency	Ritshizde – Conducts community clinic monitoring and advocacy.
3	Address social determinants	Seek-GSP – Organizes group therapy to address mental health of PLHIV.
4	Transform provider culture	Beyond Bias – Addresses provider bias to improve client trust. Wild4Life Health – Builds trust in the health system to improve care-seeking behavior.
5	Align payment models with outcomes	PPO Serve – Leverages the private sector to increase the reach of care to PLHIV.
6	Integrate all aspects of VBC—measurement, delivery, and payment	OLVG – Integrates VBC principles in HIV care across the client journey in a high-income settings.

See the Appendix for the detailed set of case-studies on [value-based innovations](#).

Wild4Life Health integrates the three aspects of VBC to improve client trust, which improves client traction and retention

Context

- In 2015, Wild4Life Health revamped its approach to **overcome the “silo approach”** that ministries and donor-funded programs often take around a single set of limited objectives.¹
- Its **systems approach includes comprehensive, integrated in-facility and community-based interventions.**²
- Wild4Life Health builds trust on **two levels:**
 - **Provider/HCW:** Build skills, confidence, and empathy via mentorship, training, continuous quality improvement (CQI) loops, and incentives.
 - **Client/community:** Fosters demand generation and buy-in via education, involving community leaders, and delivering on quality service promised.

Innovation

- In measurement
- At community level, Wild4Life Health:
 - Measures the pulse of the community via **dialogues and exit interviews.**
 - **Acknowledges** prevalent issues and shares relevant **information** in a non-judgmental manner.
- In delivery
- Uses mentorship and peer-to-peer support to increase the scope and quality of services:
 - Multidisciplinary peer-to-peer mentorship program trains staff to treat important primary care issues.
 - Gaps in community worker skills are addressed by nurse mentors.
 - Outreach program provides acute care services to attract client volume and offer treatment for a range of services, from HIV testing to enrollment.
 - CQI performance loops:
 - Indicators are tracked and when they fall below a threshold, a root cause analysis is done and corrective action is taken.
 - Successful approaches are documented and shared across clinics.
- In payment
- Non-financial reward: HCWs and clinics are recognized for their superior service with certificates of appreciation.
 - Clinics graded against a set of quantitative (e.g., access to HIV services) and qualitative (e.g., viral load) indicators and receive results-based financing against the metrics.

Impact

- Between 2015 and 2017 in Hwange District, Zimbabwe, across 17 centers:³
- Overall **HIV testing doubled** (and more than **tripled for children**).
 - Total number of **clients on ART increased by 38%.**
 - Number of **TB suspects identified increased by 93%.**
 - Number of pregnant women who made their **first antenatal visit before 16 weeks gestation rose from 31% to 48%.**
 - Differentiated service delivery models were set up and **30%** of the adolescent and adult clients on **ART access services** through **community ART refill groups.**



Wild4Life Health started in **2009** and works **closely with governments** to identify and plug gaps in local health systems.² It was developed with the belief that when **clinics** and supporting systems **work as they should** and **people trust** that the system works, they **flock to facilities.**³ It works in **17 clinics** reaching more than **70,000** people in **three districts** in **Zimbabwe.**²

Supply and demand needs must be understood and blended.

— **Latelang Ndlovu,**
Project Manager, Wild4Life Health

References:
 1. Levine, J.B. (2017, November 23). A Zimbabwe good-news story: Lessons on raising the quality of health care in rural Africa. Retrieved from <https://www.linkedin.com/pulse/zimbabwe-good-news-story-lessons-raising-quality-health-levine>.
 2. Wild4Life Health. (n.d.). Website. <http://www.wild4life.org/>.
 3. Wild4Life Health (n.d.). Our approach. <https://www.pzat.org/wild4life-health/#1556269575649-001cbf36-c2a6>.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

Synthesized people-centered outcomes that matter most to PLHIV to advance the VBC approach in HIV

What are people-centered outcomes?

What matters from the PLHIV point-of-view:

- Clinical outcomes, quality of life, and the care experience
- **Outcomes** rather than outputs, (e.g., **viral suppression**, rather than treatment adherence; and **social support felt** rather than access to social services).
- Can be client-reported and not necessarily measured by healthcare providers.

Our synthesis of people-centered outcomes:



Developed a set of indicators to measure people-centered HIV outcomes

There are many validated sets of indicators that provide great insight on people-centered outcomes. However, they have certain limitations and can be:

- Difficult to routinely measure and scale up.
- Lack HIV-specific insights.
- In-sufficient as a standalone; may need multiple tools.
- Provide a limited view on linking action to insight.

Our custom set of indicators:

- Focuses on quality of life (QOL) and the clients' experience of care.
- Facilitates routine measurement during the client's journey.
- Can be consolidated at the program level.
- Is feasible for insight and action.
- Not intended to replace more detailed qualitative tools.

- **Four QOL questions, one for each domain**
- **One care experience index question**

A collaborative process resulted in feasible, insightful, and actionable questions to measure outcomes

Using a combination of an index question and a follow-up question provide a rating score and deeper insights on what influences the score:

Client experience of care:

Example

Based on your experience so far, would you recommend this service to a friend or family member?

1 (not at all) 2 (somewhat) 3 (quite a lot) 4 (definitely)

What most impacted your score above?

- Cleanliness
- Timeliness
- Access to useful information
- Privacy and confidentiality
- Staff
- Services available in the clinic today
- Availability of accessing services outside the health facility (e.g., community ART pick-up points, community health workers, virtual or mobile communication with health facility staff)
- Other (Please specify)

See the [Appendix for the complete](#) indicator reference sheets.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

Indicator reference sheets provide a standard way of capturing people-centered metrics at the program level

Indicators	Definition
Client experience of care	<ul style="list-style-type: none"> Percentage of surveyed clients who would recommend an HIV health service as a proxy measure of their own care experience
Quality of life – Symptom control	<ul style="list-style-type: none"> Percentage of surveyed clients who report minimal HIV-related symptoms
Quality of life – mental well-being	<ul style="list-style-type: none"> Percentage of surveyed clients who report experiencing minimal mental or emotional problems over the past two weeks
Quality of life – Social support	<ul style="list-style-type: none"> Percentage of surveyed clients who report feeling socially supported by family and/or friends
Quality of life – Stigma and discrimination	<ul style="list-style-type: none"> Percentage of surveyed clients who report experiencing minimal discrimination as a result of their HIV status
Quality of life – Financial burden	<ul style="list-style-type: none"> Percentage of surveyed clients who report taking out a loan or selling belongings to pay for HIV-related care.

People-centered metrics have the potential to help programs allocate resources, develop capacity, and prioritize support services. Overall, the insights from the metrics can improve design delivery to better meet client needs, while complementing PEPFAR MER indicators that capture clinical outcomes.

Ultimately, improving the client's quality of life and care experience will influence the client's willingness to seek and stay in care and clinical outcomes. Similarly, improved clinical outcomes can impact the client's quality of life.

See the [Appendix](#) for details on how the data from indicators can be used. Visit "[Putting people-centered metrics into practice](#)" for the complete indicator reference sheets.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

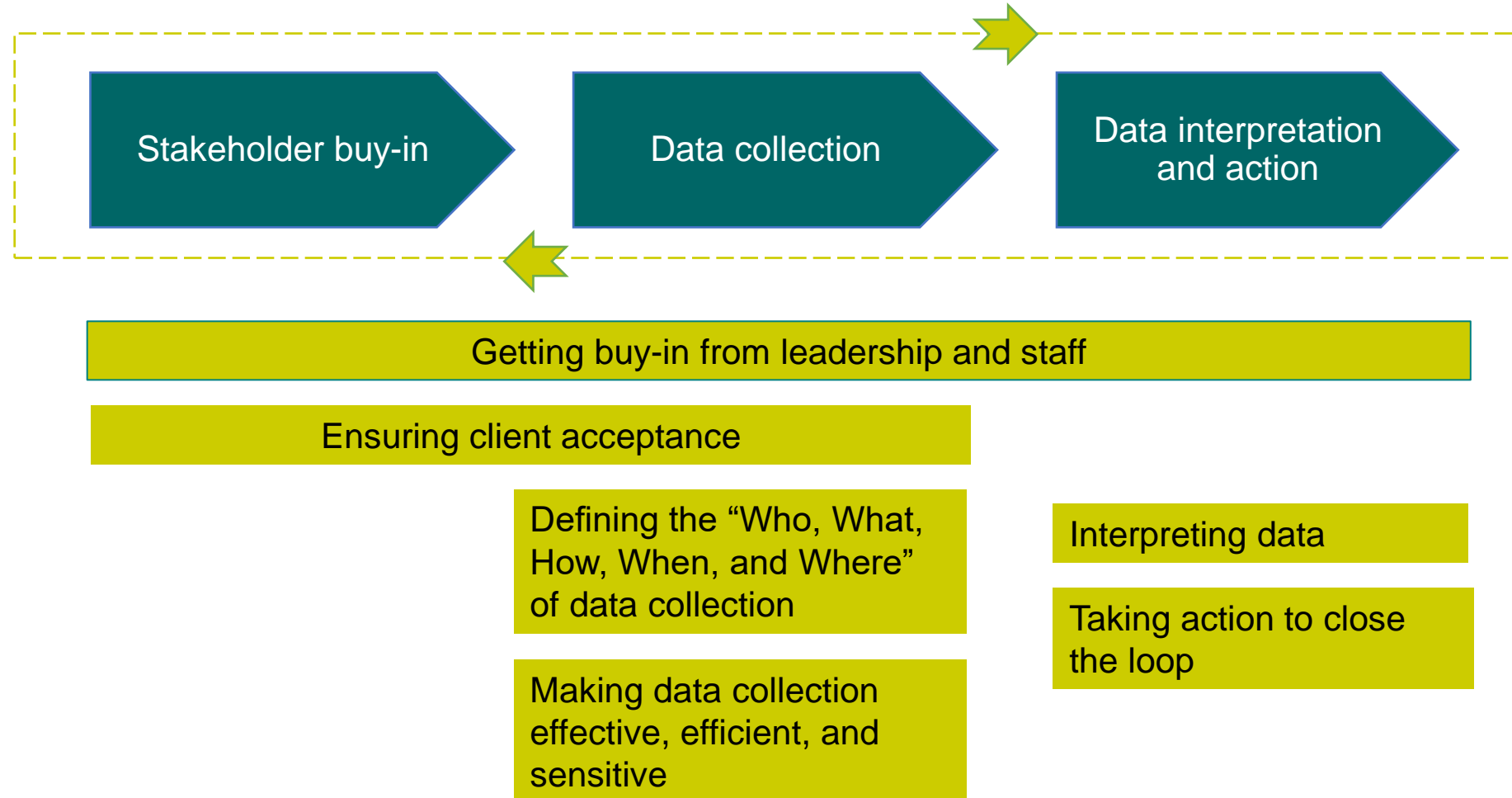
Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

The implementation process for people-centered metrics is iterative and will vary depending on the program context

Implementation process includes:



A set of practical considerations for implementation is provided for each stage

Stakeholder buy-in

To get leadership and staff buy-in:

- Assess their understanding of people-centered metrics.
- Understand their goals and priorities.
- Understand donors' requirements.
- Assess health system readiness.

To ensure greater client acceptance:

- Gauge ability of PLHIV to participate in discussions and design process.
- Understand clients' concerns.
- Assess current/past health system experiences of PLHIV.
- Assess various client personas relevant to the program.

Data collection

To design data collection to be effective and efficient:

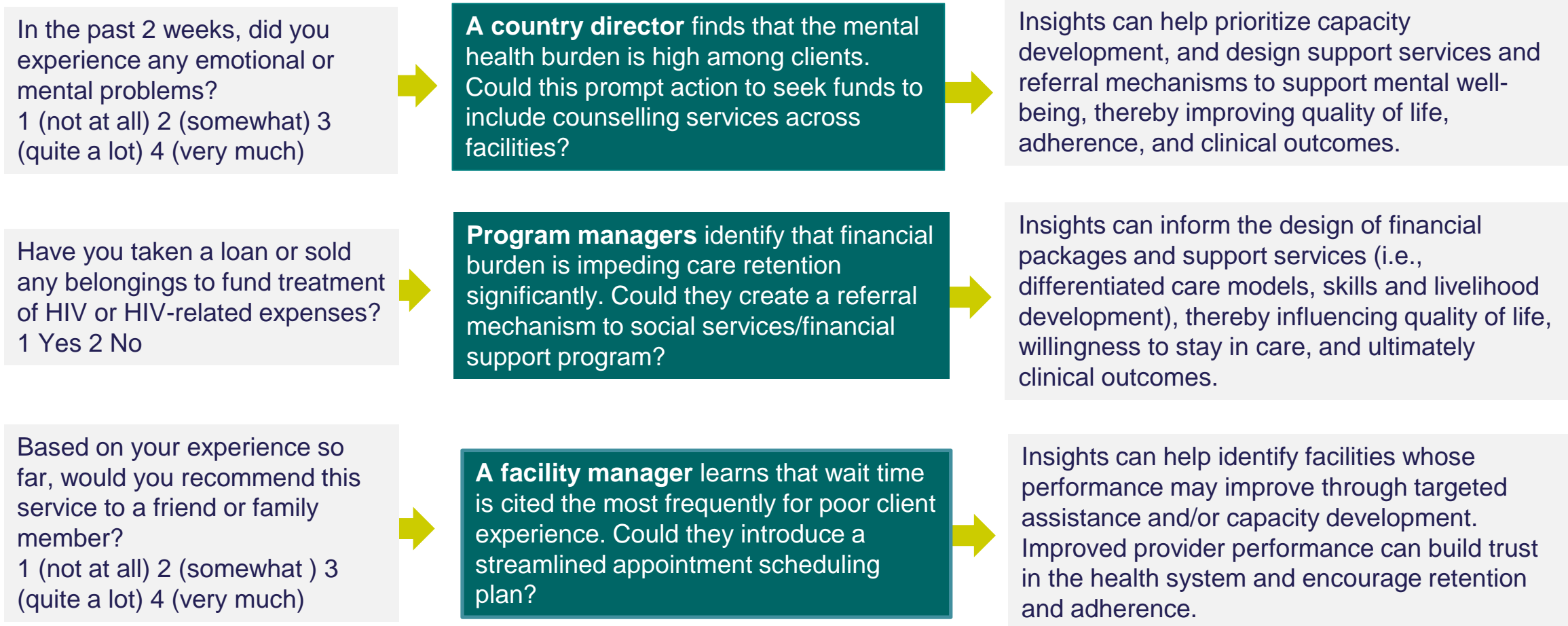
- Assess the overall resource constraints.
- Understand the level of health system maturity.
- Assess how best to balance for insight and confidentiality to ensure ethical collection.

Data interpretation and action

To facilitate action to close the loop:

- Understand how data can be provided at the right time and in the right format to each stakeholder to provoke action.
- Assess how interpretation of people-centered metrics and related actions can be integrated in performance management.
- Assess how data can be reused for population health services for country-level stakeholders.

Data insights from the people-centered metrics can inform actions across stakeholders and impact program success



Key funders learn of opportunities across programs. Can they cross-link services without a significant increase in budget allocation? Overall budget allocations, policy decisions, and design of service delivery can be continually optimized for better outcomes at better cost.

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix

People-centered metrics have the potential to shape the trajectory of HIV care

Learn

People-centered metrics can help HIV providers better understand what matters to clients to implement differentiated care strategies. They can also drive a research agenda on how meeting the needs can improve adherence and viral suppression.

Improve

People-centered metrics can be used to drive performance improvements of existing programs by integrating these metrics in existing efforts to collect, interpret, and take action on data insights.

Align incentives

Measurement of people-centered outcomes will provide insights to structure value-based purchasing models and non-financial incentives. They can lead to better outcomes at sustainable costs.

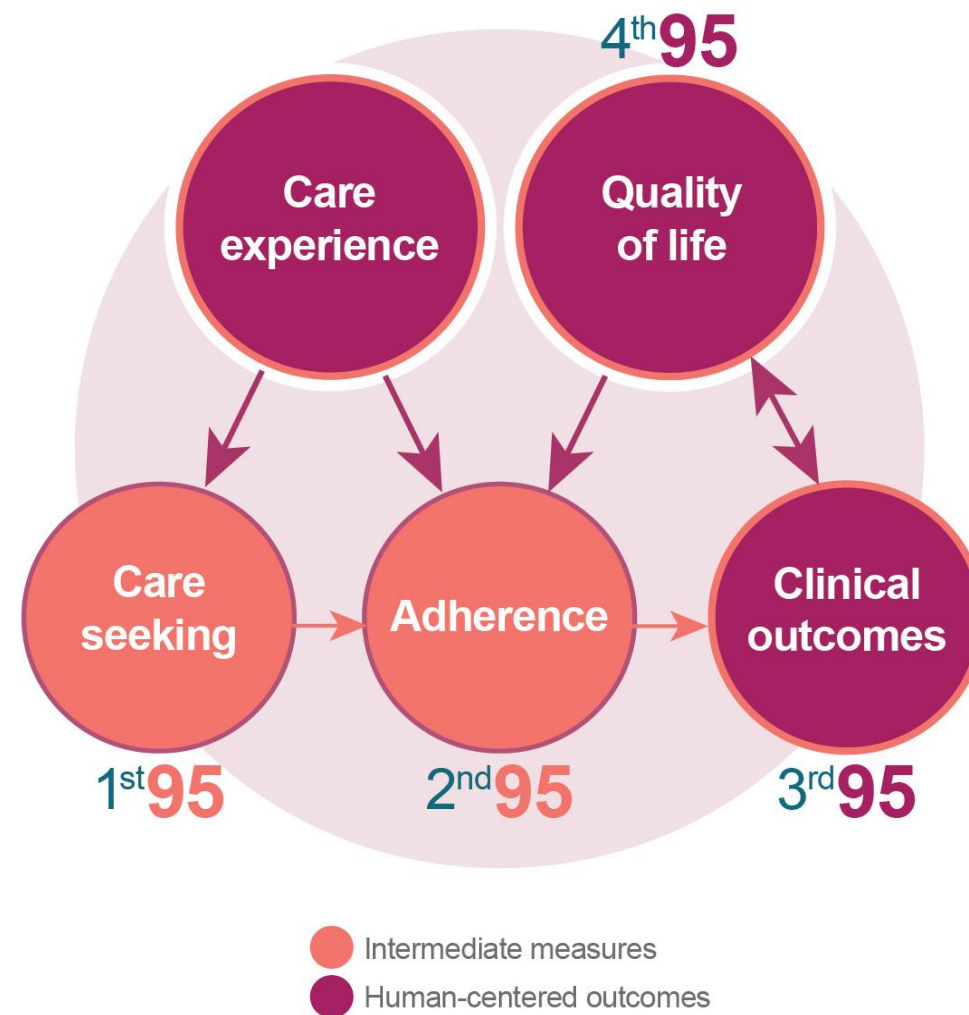
Innovate

Over time, “value measurement” can identify white spaces in delivery models to innovate in, build a case for such innovations, and prioritize investments.

Putting people-centered HIV metrics into practice can help programs improve care-seeking behavior, adherence, and ultimately, clinical outcomes to achieve the 95-95-95 goals

Data.FI can support country programs to put people-centered HIV metrics into action by:

- **Building the evidence base** through validation of the set of metrics to ensure that they provide actionable insight to improve the care experience and quality of life.
- **Integrating the indicators** and data collection processes in existing workflows for service delivery, data collection, and data use.
- **Triangulating results** with data from other reporting initiatives to identify opportunities to improve clinical outcomes.
- **Convening stakeholders** to link the outcomes metrics to payment and fundamentally shift the way PEPFAR programs incentivize performance.



Appendix

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix:

People-centered HIV survey questions and overview of data use from indicators

People-centered survey questions for PLHIV (1 / 3)

Client experience of care:

Based on your experience so far, would you recommend this service to a friend or family member?

1 (not at all) 2 (somewhat) 3 (quite a lot) 4 (definitely)

What most impacted your score above?

- Cleanliness
- Timeliness
- Access to useful information
- Privacy and confidentiality
- Staff
- Services available in the clinic today
- Availability of accessing services outside the health facility (e.g., community ART pick-up points, community health workers, virtual or mobile communication with health facility staff)
- Other (Please specify)

People-centered survey questions for PLHIV (2/3)

Quality of life – Symptom control

In the past 2 weeks, how often did you feel healthy/symptom free from HIV?

1 (never) 2 (sometimes) 3 (quite a lot) 4 (all the time)

Which symptoms impacted your score the most ?

- Pain and discomfort
- Gastrointestinal problems (vomiting, diarrhea)
- Body weight changes
- Feeling more tired than usual, unable to move easily
- Skin issues and sweating
- Sexuality-related issues
- Change in sleep pattern
- Change in mood
- Others - Please specify
- None of the above

Quality of life – Mental well-being

In the past two weeks, have you experienced any of the following? (mental or emotional problems)

- Feel nervous, anxious, constant worry
- Feel hopeless, depressed, little pleasure in doing things
- Difficulty concentrating
- Memory loss
- Self esteem and body image issues
- Feel unmotivated, lacking resiliency
- Other emotional or mental problems - Please specify
- None of the above

Follow-up question if client chooses one or more options (apart from none of the above)

If yes, how much have you experienced these problems in the past two weeks ?

1 (not at all) 2 (somewhat) 3 (quite a lot) 4 (all the time)

People-centered survey questions for PLHIV (2/3)

Quality of life – Stigma and discrimination

1. Have you faced any discrimination because of your HIV + status in the past month? (i.e., isolated, excluded, judged, denied, or threatened)

1 (none at all) 2 (somewhat) 3 (quite a lot) 4 (a significant amount)

**Clients rating 3 or 4 should be asked the following question:
Which of the following impacted your score the most?**

- Beliefs and behavior of your family toward you.
- Beliefs and behavior of the community toward you.
- Attitude and behavior of clinic staff toward you.
- Other - Please specify

Quality of life – Social support

How much support do you get from your family and friends/significant other?

1 (none at all) 2 (some) 3 (quite a lot) 4 (all that I need)

Quality of life – Financial burden

Have you taken a loan or sold any belongings to fund treatment of HIV or HIV-related expenses?

1 yes 2 no

Indicator reference sheets developed to provide a standard way of capturing people-centered metrics at the program level (1/3)

Indicators	Definition	Data from the indicator can be used to:
<p>Client experience of care</p>	<ul style="list-style-type: none"> Percentage of surveyed clients who would recommend an HIV health service as a proxy measure of their own care experience 	<ul style="list-style-type: none"> Design facility performance improvement initiatives. Illustrative improvements could include reducing wait times, task shifting, or providing training to prevent stigma and discrimination. Inform design making when developing training/mentorship models for HCWs, and financial and non-financial incentives to improve staff performance. Identify improvements in retention and adherence among PLHIV by linking with PEPFAR monitoring tools like Root Cause Analysis (RCA.) Provide a more holistic view of quality from the client's perspective for quality improvement efforts like Site Improvement Monitoring Systems (SIMS).
<p>Quality of life - Symptom control</p>	<ul style="list-style-type: none"> Percentage of surveyed clients who report minimal HIV-related symptoms 	<ul style="list-style-type: none"> Assist providers in better managing symptoms by adjusting treatment regimens, mitigating ART-related side effects, or mitigating other emerging opportunistic infections. Inform provider training and design of decision-support tools. Assist programs in prioritizing support services or referrals for comprehensive managed care.

Visit [“Putting people-centered metrics into practice”](#) for the complete indicator reference sheets and detailed information on data collection and use.

People-centered indicators can influence improvements at client, provider, and program levels (2/3)

Indicators	Definition	Data from the indicator can be used to:
<p>Quality of life - mental well-being</p>	<ul style="list-style-type: none"> Percentage of surveyed clients who report experiencing minimal mental or emotional problems over the past two weeks 	<ul style="list-style-type: none"> Guide provider-client consultation. At the provider level, this will allow earlier diagnosis of comorbid mental health challenges. Linking insights to recommended actions (protocol for symptom management, referral for counselling services, etc.) can assist providers in addressing the feedback effectively. Assist programs in prioritizing capacity development, designing support services, and creating referral mechanisms to support mental well-being. Inform more evidence-based, LMIC-specific mental health interventions for PLHIV.
<p>Quality of life - Social support</p>	<ul style="list-style-type: none"> Percentage of surveyed clients who report feeling socially supported by family and/or friends 	<ul style="list-style-type: none"> Assist programs in designing support services for PLHIV. At an individual client level, the information can be correlated with mental and financial health feedback to provide comprehensive support. Help programs prioritize social support services to more vulnerable client groups across facilities.

People-centered indicators can influence improvements at client, provider, and program levels (3/3)

Indicators	Definition	Data from the indicator can be used to:
Quality of life - Stigma and discrimination	<ul style="list-style-type: none"> Percentage of surveyed clients who report experiencing minimal discrimination as a result of their HIV status 	<ul style="list-style-type: none"> Design interventions to address stigma and discrimination in the community by training community health workers and sensitizing community leaders. Help make a case for more community-based interventions, such as peer-to-peer support groups or adherence clubs. Assist programs to prioritize interventions, such as staff training, performance reviews, and incentivization to reduce facility-based stigma and discrimination.
Quality of life - Financial burden	<ul style="list-style-type: none"> Percentage of surveyed clients who report taking out a loan or selling belongings to pay for HIV-related care. 	<ul style="list-style-type: none"> Provide a proxy for the extent of out-of-pocket costs and catastrophic expenses borne by PLHIV. Influence how programs design service delivery and support services to ease the financial burden. They can include more differentiated care models that make it more convenient to receive care, and skills and livelihood development or training for increased financial literacy.

Appendix

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix:

Process overview – development of indicators and implementation considerations

Process overview: development of indicator reference sheets and practical considerations for implementation

In Phase 1, we focused on developing a conceptual framework for VBC and people-centered outcomes, drivers of those outcomes, and a survey of innovations that support VBC in HIV. We:

- Consulted previous initiatives undertaken by PEPFAR and its partners.
- Interviewed 15 subject matter experts.
- Directly consulted PLHIV advocates through virtual workshops.
- Reviewed more than 50 articles on people-centered HIV care.
- Drew inspiration from 27 innovators selected from more than 300 health organizations.

In Phase 2, we focused on developing a set of questions to assess people-centered outcomes and implementation considerations. We:

- Reviewed HIV PROM implementation toolkits, validated custom tools from HIV and non-HIV therapy areas, and PEPFAR tools.
- Conducted a two-part workshop with experienced HIV service delivery providers from Ethiopia, South Africa, and Zimbabwe.
- Followed an iterative process and solicited ongoing feedback from workshop participants and OHA colleagues through the various stages of developing the indicator reference sheets and guidelines.

Process limitations:

- The indicators have not yet gone through a validation process.
- The guidelines are considerations for implementation and not a toolkit.
- The indicators and guidelines are not tailored to a specific country or program context.

Appendix

Introduction and context

VBC in HIV

People-centered outcomes in HIV

People-centered indicators

Implications of implementing people-centered metrics

Conclusion – Potential for impact and the way forward

Appendix:

Value-based innovations in HIV

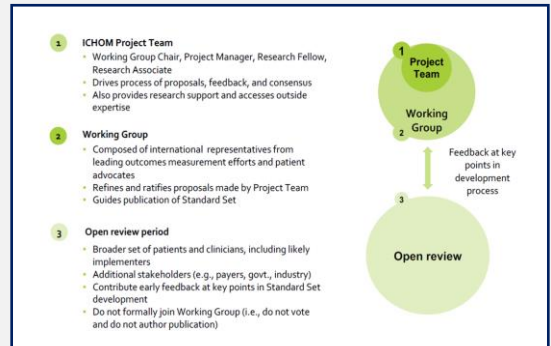
1. Create tools to measure what matters for PLHIV

ICHOM created a standard hypertension set for LMICs; an HIV-specific set would allow wider use (1/2)



Innovation

ICHOM follows a rigorous methodology to develop its standard sets¹



1. ICHOM project team drives the process

Specialty	Africa	America	Asia	Australia	Europe	Total
Infectious Disease specialist						
Psychiatrist						
Therapist						
Clinician						
Immunologist						
General Practitioner / Primary care physician						
Organisations						
Patient Rep.						
Patients						
Family, friends and carers						
Outcomes Research / Biostatistics						
Non-clinical expertise						
Psychometric evaluation of PROMs						
Public health, Payors (population health interventions)						
Registries						

2. It brings together a broad and cross-functional group



3. Working groups are led through a structured process over 12–15 months

ICHOM developed one for hypertension specifically for LMICs¹



It works with global experts to define a **standard sets of outcome measures** that matter most to clients and to **drive adoption and reporting** of these measures worldwide to create better value for all stakeholders.

Reference: 1. ICHOM. (n.d.). Website. <https://www.ichom.org>

1. Create tools to measure what matters for PLHIV

PROgress developed the HIV-PROMs implementation toolkit that can scale adoption across the health system (2/2)

Innovation

PROgress makes a strong case for PROMs in HIV via process recommendations and feasible tools¹

1. Assess and improve readiness to implement PROMs in HIV clinical care: Clinic leadership, client population, provider attitude, logistics, and costs.
2. Engage stakeholders: Identifying stakeholders, creating value, and co-development of design.
3. Build technical Infrastructure: Gather information from client, present to provider, store and reuse at the population level.
4. Create Patient Reported Outcome (PRO) assessment: Mode of delivery, domains to be included, scoring, interpretation, and intervals.
5. Outline workflow: When and where to collect PROs, staff roles and responsibilities, protocol for not collecting PROs, communication around PROs.
6. Train clinic personnel: Initial and ongoing training.
7. Monitor and evaluate: Define indicators of success, timing, and frequency for continuous quality improvements.

The detailed implementation toolkit includes the relevant PROM domains and instruments, including¹

- Needs assessment
- Adherence
- Symptom management
- Quality improvement

PROM use in actual consultation process²

Examples of types and uses of PROMs - Appendix



PROgress toolkit provides **practical advice to support** the introduction of clinical **PROM assessments** in routine HIV care.

It provides resources, tips, and effective practices to help **implement PROMs**, adapted, as needed, for individual clinics.

2. Amplify PLHIV voices and create agency

Ritshidze focuses on measuring the care experience across the client journey and advocates for changes in HIV service delivery

Context

- South Africa has the **highest burden** of HIV/AIDS in the world.
- This is worsened by **multiple issues** in the health system. Challenges faced by PLHIV when seeking care range from dilapidated facilities, long wait times, understocking of drugs, and poor provider attitudes to stigma and discrimination. These issues **deter good health-seeking behavior**.
- Ritshidze was developed in **response to this crisis**.
- Facilities chosen **cover nearly half of all PLHIV on treatment** in South Africa, with a focus on sites with large treatment cohorts and where data show poor linkage and retention rates.²

Innovation

Data are captured **across the care continuum from multiple stakeholders** to inform advocacy efforts.

- **Facility-based tools capture issues faced by providers and clients:**
 - An observation survey assesses the functionality of the clinic.
 - Client surveys assess the experience of care and service delivery.
 - Facility manager tools capture their perspectives on infrastructure and human resources.
 - Medicine surveys assess inventory requirements.
- **Community-based tools capture the needs for PHLIV-supporting communities:**
 - They include client surveys on adherence clubs, PLHIV and facilitator views, individual client testimonies, and focus group discussions.¹



Impact

- The community-led monitoring program covers **more than 400 clinics** and community healthcare centers across 27 districts in **8 provinces** in South Africa.²
- Ritshidze’s insights are captured in an exhaustive **annual report**. This report makes recommendations that inform both the government and PEPFAR’s budget allocations and program focus areas.



“Ritshidze”—meaning “**Saving Our Lives**” in TshiVenda—is a **community-led clinic-monitoring program**. It was developed by PLHIV and activists to hold the **South African government** and aid agencies accountable to improve overall HIV and TB service delivery.

References:
 1. Ritshidze. (n.d.). Website. <https://ritshidze.org.za/the-model/>
 2. <https://healthgap.org/press/a-new-initiative-the-ritshidze-project/>

3. Address social determinants

Seek-GSP employs a people-centered approach for optimal mental health delivery in a cost-effective way for PLHIV



Context

- **PLHIV with depression** experience multiple social and economic **vulnerabilities** and disadvantages.²
- The prevalence of depression and other mental health disorders among PLHIV in sub-Saharan Africa is estimated at **13%-78%** vs **5%-10%** in the general population.¹
- HIV treatment programs in the region do **not** generally **include mental health screening**.¹
- Seek-GSP is a **culturally tailored psychological intervention** aimed at addressing the mental health care and socioeconomic needs of PLHIV.²
- It is **incorporated in existing health systems** and deployed in the community itself.³



Innovation

A multidimensional approach:

- Group support psychotherapy incorporates principles of **cognitive behavior** theory, **social learning** theory, and the **sustainable livelihoods** framework.¹
- The approach includes addressing emotional symptoms but **also major risk factors for depression, including stigma and discrimination** and socioeconomic disadvantage through a structured 8-week program.⁴
- Participants are divided into **gender-specific groups** with a facilitator of the same gender to allow for open dialogue.

Empowering the community :

- **PLHIV were involved** in the development of the Seek-GSP training to best represent the cultural diversity and relevant areas.
- The unique advantage is that it does not require professional mental health experts and is **administered via training of primary healthcare and lay workers**.³
- Lay workers provide Seek-GSP training in the community, empowering them to **take control** of their own mental health needs.³



Impact

Assessment six months post-completion of the intervention showed:

- **<1% of participants in the Seek-GSP group** had major depression compared with **28%** of people in the **general HIV education group**.
- Average **overall functioning scores** for Seek-GSP participants was **9.85%**, whereas in the general HIV population it was **6.82%**.
- **Lower rates of PTSD symptoms** (< 1% vs 20%) and suicide risk (< 1% vs 12%, $p = 0.001$).
- Incremental cost-effectiveness ratio of **13 USD per disability-adjusted life-year** averted, which can be considered very cost-effective in Uganda.¹
- The **greatest impact was seen in male participants**, who traditionally do not participate in health interventions in low-resource settings.

SEEK-GSP

Is the first major **indigenous mental health program** providing evidence-based, culturally appropriate, first line psychological treatment embedded in an HIV care delivery platform to address mental health problems—in particular, depression among PLHIV.



Project started in 2016



Uganda



Funded by Grand Challenges Canada and MQ Transforming Mental Health Uganda

References:

1. Nakimuli-Mpungu, E., et al. (2020). Effectiveness and cost-effectiveness of group support psychotherapy delivered by trained lay health workers for depression treatment among people with HIV in Uganda: a cluster-randomised trial. *The Lancet Global Health*, 8(3), E387–E398. Retrieved from [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(19\)30548-0/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30548-0/fulltext).
2. Nakimuli-Mpungu, E., et al. (2019). Recruitment and baseline characteristics of participants in the social, emotional, and economic empowerment through knowledge of group support psychotherapy study (SEEK-GSP): Cluster randomized controlled trial. *JMIR Research Protocols*, 8(1), e11560. Retrieved from <https://www.researchprotocols.org/2019/1/e11560/>.
3. Results for Development. (n.d.). Global Innovation Exchange (GIE): Technology platform for development innovations and funding. Retrieved from <https://www.globalinnovationexchange.org/innovation/social-emotional-and-economic-empowerment-through-knowledge-of-group-support-psychotherapy-content-seek-gsp>.
4. Seek-GSP. (n.d.). Website. <http://seek-gsp.org/>.

4. Transform provider culture

Beyond Bias addresses provider bias to dispel mistrust in health systems and encourage better care-seeking behavior



Context

- There are approximately **38 million sexually active adolescents in LMICs**, of which roughly **23 million** have an **unmet need** for contraception.²
- Adolescents have demonstrated **low uptake of long-acting reversible contraception**, indicating that they are not systematically provided with a complete choice of contraceptive methods.²
- Several factors contribute to low use of contraception, including **stigma, lack of information, and misunderstandings** about side effects. This creates **mistrust** in the system.²
- One of the most pertinent obstacles to creating trust—which deters adolescents from accessing sexual and reproductive health services—is **judgment and bias from the healthcare provider**.²



Innovation

A multidisciplinary team of social and behavior change, communication, and people-centered design experts designed a three-part adaptive intervention.¹

- **Sensitization through story-driven format:**
 - Helps HCWs become aware of their own biases and trains them on unbiased care.
 - Co-decide on the most suitable interventions.
- **A peer-to-peer support group to action change:**
 - Fosters a professional community—connecting providers to one another.
 - Facilitates continued training via a multiweek program of texts, videos, and information over WhatsApp.
- **Recognize and reward positive behavior change:**
 - Facilities receive report cards with performance data and recommendations for improvement.
 - High-improvement facilities receive public recognition for their progress.



Impact

- In **September 2019**, Pathfinder International began implementation of the designed intervention in the **three focus countries** with **227 facilities**.²
- Although project implementation and data collection appear have been **impacted by COVID-19**, the **six intended outcomes** include:¹
 - Sensitive communication
 - Safe, welcoming space
 - Seek understanding and agreement
 - Security of information
 - Say yes to a safe method
 - Simple, comprehensive counseling



Beyond Bias is the first project of its kind to **rigorously characterize bias** across **multiple countries** and systematically test solution approaches to address provider bias. It aims to ensure that **young people have access to empathetic, nonjudgmental**, quality counseling and **provision** of a full range of **contraceptive methods** regardless of their marital status or parity.²



2016 to present



Burkina Faso, Pakistan, Tanzania



Funded by the Bill & Melinda Gates Foundation

References:

1. Beyond Bias. (2020). The Beyond Bias Project. <https://reports.prb.org/breakthrough-research/beyond-bias-pbc-sbc/>.

2. YLabs. (n.d.). Beyond Bias: Reducing healthcare provider bias that hinders the provision of contraceptive information and services to adolescents. <https://www.ylabsglobal.org/work/all/beyond-bias>.

5. Align payment models with outcomes

GP Care Cell is an innovative private model of HIV care that captures the “missing middle” to reach 95-95-95 goals



Context

- South Africa has a **well-resourced private sector** that serves ~ 32% of the population and an **overstretched public sector** serving the uninsured majority.
- The “**missing middle**”: 2.12 million PLHIV do not access the public health system due to long wait times, opportunity costs, etc. They access primary care at private general practice (GP) clinics.
- The **National Health Insurance** aims to expand access to HIV care services by **leveraging capacity of private general practitioners**.
- **GP Care Cell (GPCC)** is a structured **network of GP practices and community pharmacies** that are managed to deliver HIV testing and treatment services.



Innovation

- In delivery:**
- PPO Serve leveraged **private sector human resources and capacity** for HIV care:
 - GPCC included **task shifting** with mid- and lower-level health workers, such as nurses and community health workers (CHWs).
 - **By partnering with local organizations**, they reduced the need for full-time hires.
 - **Care coordinators** and an **Intelligent Care System** helped them manage workflow and client transitions.
 - **Feedback loops:** The early focus was on compliance. It has evolved to **capture the clients’ voices** via a call center that administers a “short PROMs” survey, the client’s experience, and provides adherence counselling.
- In payment:**
- **Capitated global fee for 1 year** (12 month dispensing period) versus fee-for-service.
 - **The 4 different installments at initiation**, 3rd, 6th and 12th month, **ensure payment against adherence**.
 - **Further incentivized at 6th and 12th month for viral suppression—a clinical outcome**.



Impact

- The pilot results showed:**
- High initiation rate: 91%
 - High client retention: 97%
- In terms of the GPCC’s client profile, high uptake by:**
- Men: 45%
 - Youth aged people <35 years: 42%
 - Asymptomatic PLHIV (median CD4 at baseline was 349 mm3 with an interquartile range of 170-552 mm3): <1% CrAG test positive



- PPO Serve is a healthcare management company that manages and oversees the Integrated Clinical Consortia, which are local/private business units owned by the participating clinicians.
- FPD is a higher education institute that focuses on learning, research, and community engagement.

Brian Ruff
 2016
 South Africa

A differentiated value framework is needed to gauge cost per patient in new and innovative versus mature systems.

— Visegan Subrayen, Project Consultant, PPO Serve



6. Integrate value-based measurement, delivery, and payment

OLVG integrated the three aspects of VBC, leading to better client agency, quality of life, and care satisfaction

Context

- The Netherlands had already achieved the 90-90-90 goal in 2016.
- OLVG looked beyond and toward the 4th 95*. It became the **first hospital in the world to determine which healthcare outcomes are important for HIV clients.**
- By applying VBC and measuring outcomes, OLVG was able to further bring down the **undetectable viral load from 91% to 97.6%.**

Innovation

- In measurement:
- A quality of life (**QOL**) **questionnaire** was administered during routine clinical practice four times in the first year of care and yearly thereafter.²
 - Themes in the questionnaire include: Anxiety and Depression, Physical Health, Stigma, Social Support, Sexuality Problems, Sleeping Difficulty, Self-Esteem, and Side Effects.¹
 - HIV care path was integrated in the electronic health record workflow and as part of the clinician decision-support system.³
 - Clients **can track their health records** and other health goals via Happi App.²
- In delivery:
- OLVG used learning loops (plan-do-check-act cycle) to suggest delivery improvements.
 - Nine outcome indicators* are defined. Each indicator has a dedicated working group that proposes suggestions for improvement.
- In payment:
- Developed a **new bundled payment contract** with a key national health insurer.
 - Contract is **outcome-driven** and **capitation-based.**

Impact

- When the PROMS were evaluated
- **Clients reported:**
 - A positive change in **client-doctor relationship**
 - Increased agency
 - **Improved** quality of life and quality of care¹
 - **Providers reported:**
 - Information obtained was **clinically relevant**
 - Improved **communication** and doctor-client relationship¹
 - **“No show”** protocol has led to a **decrease** from 20% no shows to less than 10% and a lost to follow-up rate of < 1%.²
 - Bundled payment has **increased quality of care while reducing costs.**³



The OLVG hospital is the Netherlands’s **largest HIV center with more than 3,000 HIV-infected** clients. OLVG uses value-based healthcare principles. It measures relevant health outcomes and costs to provide optimal HIV care to their clients.

- 1998
- Amsterdam
- Winner International Value-Based Healthcare Patient Outcomes Award (2019)**

References:
 1. Snijdersblok, M.R. (date). Three years of PROMs in HIV care: an evaluation. Amsterdam, The Netherlands: OLVG.
 2. van den Berk, G. (2019). Netherlands – Value based HIV care. Retrieved from https://hivoutcomes.eu/case_study/value-based-hiv-care/.
 3. van den Berk, G.E.L., et al. (2020). Value-based HIV care: A method to improve quality of HIV care. Research Square. Retrieved from <https://bit.ly/30uyhRe>

*Detailed outcome indicators in [Appendix](#)

This activity was informed by interviews and workshops with various stakeholders across four different objectives

Objective	Interviewee
Elevate clients' voices	<ul style="list-style-type: none"> • Right to Care • Clinton Health Access Initiative-Community Advisory Board (CHAI-CAB), AFROCAB, UNITAID, and CHAI • International Treatment Preparedness Coalition
Refine value drivers	<ul style="list-style-type: none"> • Data.FI • Boston Consulting Group • OHA • Percept • Aid for AIDS
Stretch our imagination	<p>Measure</p> <ul style="list-style-type: none"> • Laos, Thailand, Cambodia: University of California, San Francisco • Ritshidze • International Consortium for Health Outcomes Measurement (ICHOM) <p>Deliver</p> <ul style="list-style-type: none"> • Simprints • Wild4Life Health • Right ePharmacy • Project Last Mile <p>Pay</p> <ul style="list-style-type: none"> • PPO Serve and Foundation for Professional Development, South Africa • Netherlands: Onze Lieve Vrouwe Gasthuis (OLVG)
Ground it in reality	<ul style="list-style-type: none"> • Palladium • Population Services International • USAID/South Africa • Analysis of Variance (Anova) • John Snow, Inc. • Pioneering Solution Studio



FOR MORE INFORMATION

Emily Harris, Data.FI AOR, USAID Office of HIV/AIDS
emharris@usaid.gov

Jenifer Chapman, Data.FI Project Director
datafiproject@thepalladiumgroup.com

Data for Implementation (Data.FI) is a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Agency for International Development under Agreement No. 7200AA19CA0004, beginning April 15, 2019. It is implemented by Palladium, in partnership with JSI Research & Training Institute (JSI), Johns Hopkins University (JHU) Department of Epidemiology, Right to Care (RTC), Cooper/Smith, IMC Worldwide, Jembi Health Systems and Macro-Eyes, and supported by expert local resource partners.

This presentation was produced for review by the U.S. President's Emergency Plan for AIDS Relief through the United States Agency for International Development. It was prepared by Data for Implementation. The information provided in this presentation is not official U.S. government information and does not necessarily reflect the views or positions of the U.S. President's Emergency Plan for AIDS Relief, U.S. Agency for International Development or the United States Government.

(TL-22-02)