Endline Evaluation

Quality HIV and Reproductive Maternal and Neonatal Health (RMNH) services for women in Malawi through Good Clinical Governance and Community-Driven Accountability

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• Centre for Youth Development & Social Empowerment (CYDSE)
• Community of Women Living with HIV and AIDS (COWLHA)
• District Health Office, Lilongwe, Malawi
• Interchurch Organisation for Development Cooperation (ICCO)
• Meaningful Action on HIV and AIDS Support Network Association (MASUNA)
• Rights Institute for Social Empowerment (RISE)
1 Introduction

Quality reproductive, maternal and neonatal health (RMNH) services, including HIV care, are imperative to improving the quality of life and health outcomes for women and children throughout sub-Saharan Africa. Women living with HIV experience more rights violations in RMNH services than HIV-negative women. Rights violations within clinic settings may discourage women from seeking HIV and RMNH services contributing to vertical transmission of HIV and maternal mortality.

Clinical governance, defined broadly as systems that improve standards of clinical care is a key component to reducing rights violations in clinical settings. Within clinical governance, community-driven accountability has the potential to improve governance strategies; dialogues between communities and providers have led to better management of health facilities in multiple settings. For example, community-driven accountability has led to the improved performance of clinical governance committees and the improved use of health services, such as immunization coverage and use of skilled birth attendants. Aidsfonds (previously STOP AIDS NOW!), in collaboration with Interchurch Organisation for Development Cooperation (ICCO Cooperation) and local organizations in Lilongwe, Malawi, designed and implemented the ‘Quality HIV and Reproductive Maternal and Neonatal Health (RMNH) services for women in Malawi through Good Clinical Governance and Community-Driven Accountability’ Project (herein referred to as the Quality HIV and RMNH services Project). The Project aimed to improve the quality of RMNH and HIV services offered to women living with HIV in Malawi.

This report provides a summary of the Project and its impact as evaluated by a longitudinal study conducted by Invest in Knowledge (IKI). Pre-intervention data (conducted before the intervention) was collected between May-July, 2014. Process evaluation data (collected during the intervention) was collected between March – June, 2015. Post-intervention data (conducted after the intervention) was collected between January-February, 2016. The overall objectives of the study were to assess the Project’s impact on: (1a) knowledge and perceptions of RMNH and HIV services held by women living with HIV who participate in support groups; (1b) women’s perceived level of empowerment to influence the quality of RMNH and HIV services at their local health facilities; (2) quality of RMNH and HIV services offered at participating health facilities; (3) access to and use of RMNH and HIV services at participating health facilities; and (4) provider perceptions of quality assurance protocols, clinical governance, and community accountability mechanisms employed by the Quality HIV and RMNH services Project.

1.1 Setting

In Malawi, nearly 12.9% of women of reproductive age are living with HIV. Reproductive health services are available at health facilities, but use of services is still low. Only 44% of unmarried, sexually active and 59% of married, sexually active women use modern family planning methods. The majority of women access antenatal care (ANC coverage is 95%) and strategies to prevent mother to child transmission (PMTCT) are widely implemented however, retention in PMTCT programs is less than ideal. Seventeen percent of women who initiate ART during pregnancy are lost to follow-up (LTFU) within the first 6 months of treatment. Poor adherence to treatment increases risk of vertical transmission of HIV and puts both mother and child at risk of adverse health outcomes.

The Malawian health institution is organized in a pyramid structure: dispensaries are the smallest facility, then health centers, hospitals, and finally district hospitals. The majority of facilities in Malawi are health centers (70% of all facilities in 2013), followed by hospitals and dispensaries (13%, and 3%, respectively). Hospitals are primarily based in urban centers; therefore health centers are critical for reaching the majority of Malawians who live in rural areas. Government-run public health facilities comprise roughly 60% of all services provided in the country.
while the Christian Health Association of Malawi (CHAM) provides just under 40% of all services. Although private facilities are available, they represent a very small proportion of the country’s health services.\textsuperscript{17}

Malawi has historically struggled with staff shortages within the health sector. In 2011, 51% of all health care positions were reported vacant.\textsuperscript{18} Semi-urban, larger health centers face a unique challenge as the catchment areas are especially large, including a large population that have a variety of unique needs. Furthermore, larger health centers are expected to provide an array of health services, ranging from basic public health education and immunization services, to male and female inpatient wards and maternity wards. Unsurprisingly, staff are often not adequately prepared for the tasks they are expected to perform.\textsuperscript{19}

\subsection*{1.2 Intervention}

Aidsfonds and the Clinton Health Access Initiative, succeeded by ICCO in July 2014, partnered with local organisations in Lilongwe, Malawi to implement the ‘Quality HIV and Reproductive Maternal and Neonatal health services for women and young women in Africa through Good Governance and Community-Driven Accountability’ Project. The Quality HIV and RMNH Project aimed to increase women’s uptake of HIV and RMNH services through improved clinical governance and community-driven accountability, which should improve quality of services. Project objectives were to: (1) increase the capacity of health care stewards (decision makers, policy makers and overseers) and providers to improve HIV and RMNH service governance; and (2) increase the capacity of women living with HIV to participate in community-driven accountability activities for quality HIV and RMNH services.

Three large health facilities were chosen to participate in the Quality HIV and RMNH Project: Area 25, Mitundu Health Center, and Kawale Health Center. These facilities have large catchment areas and offer an array of HIV and RMNH services.

\subsubsection*{1.2.1 Intervention Activities}

The Quality HIV and RMNH Project trained over 340 women living with HIV who were members of HIV support groups in Lilongwe, Malawi in order to increase women’s knowledge of RMNH rights so they could participate in community-driven accountability activities. At the end of the training, core groups of participants worked with health service stakeholders, health stewards, and community leaders to improve existing protocols regarding quality of HIV and RMNH services. Previously, the Malawian Ministry of Health had developed protocols, guidelines, and service charters that were meant to regulate the provision of quality HIV and RMNH services, as well as protect the rights of clients accessing health care. However, these protocols were tailored toward providers and did not address clients who accessed health services, a barrier to successful community-driven accountability. The Project, therefore, built upon and expanded existing protocols to target clients in order to promote client and community involvement in ensuring quality care. The choice to include women living with HIV as developers of quality care protocols was important and was based on two factors: (1) women living with HIV are most affected by stigma and rights violations in HIV and RMNH services;\textsuperscript{20, 3} and (2) full and equal engagement of affected communities yields more effective HIV responses.\textsuperscript{20, 21}

A core group of women from the initial training program also formed 17 women’s rights protection committees (WRPCs) that advocated for quality services within their local communities and local health facilities, helping to develop community-advocacy models within each respective facility. Since local health facilities have large catchment areas, multiple committees were formed for each health facility to ensure that committees reached multiple geographic locations within the same catchment area.
2 Evaluation Strategy

We use a mixed-methods approach to assess the impact of the Quality HIV and RMNH services project. Pre- and post-data collection strategies were developed to allow comparisons before and after the intervention, as well as strategies to evaluate the implementation of the Project. We report on data across three phases of the Project to meet the aims of the evaluations (see Table 1 for the Aim, Methodology, and Analytical Strategy used for each corresponding Phase of the Project):

<table>
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<th>Phase</th>
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<td>Baseline Evaluation</td>
<td>Assess baseline levels of HIV-related knowledge, perceptions and use of care among HIV+ women</td>
<td>Exit survey with 244 women participating in HIV support groups facilitated by project partners</td>
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<td>Exit interviews with 24 HIV+ women who access HIV or RMNH services at one of the three participating health facilities</td>
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<tr>
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<td>Assess provider acceptability of the Project</td>
<td>In-depth interviews with 12 health providers at the three participating health facilities</td>
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<td></td>
<td>Assess barriers and facilitators to Project implementation</td>
<td>In-depth interviews with 8 personnel from implementing partners and 17 Women's Rights Committees (28 focus group discussions in total)</td>
<td>Constant comparison methods</td>
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The endline evaluation has five overarching objectives:

Objective 1. Assess changes in HIV-related knowledge, perceptions and use of care among women living with HIV and participating in HIV support groups after the implementation of the Quality HIV and RMNH services project

Objective 2. Assess changes in quality of HIV and RMNH services at intervention health facilities after the implementation of the Quality HIV and RMNH services project

Objective 3. Assess changes in access to and use of HIV and RMNH services after the implementation of the Quality HIV and RMNH services project
Objective 4. Assess provider acceptability of the Quality HIV and RMNH services project

Objective 5. Assess barriers and facilitators to the implementation of the Quality HIV and RMNH services project

Six types of data were collected to meet these objectives. All data was collected with the support and collaboration of local partners: COWLA, CYDSE, MASUNA, RISE, ICCO, participating health facilities, and support from the Ministry of Health. The six types of data were:

Surveys with Women Living with HIV and Participating in an HIV Support Group: To address Objectives 1 and 2, the IKI team conducted pre- and post-surveys with women living with HIV who were part of an HIV support group and participated in the Project’s empowerment trainings.

Exit Interviews with Facility Clients: To address Objective 2, the IKI team conducted pre- and post-exit interviews with health facility clients immediately following their consultation visit at one of the three participating facilities. The team recruited two types of clients: (1) women living with HIV who accessed ART services and (2) women living with HIV who accessed postpartum services. The quality of care across the continuum of RMNH services was assessed.

Registry Data: To address Objective 3, the IKI team collected registry data to assess if the Quality HIV and RMNH services project was associated with an increase in use of HIV and RMNH services. Registry data was collected from three participating and three control facilities.

In-Depth Interviews with Providers: To address Objective 4, the IKI team conducted pre- and post-in-depth interviews with healthcare providers who offered HIV and/or RMNH services at one of the three participating facilities.

In-Depth Interviews with Implementing Partners: To address Objective 5, the IKI team conducted post-in-depth interviews with implementing partners, along with the below FGDs.

Focus Group Discussions with Women’s Rights Protection Committees: To address Objective 5, the IKI team conducted surveys with the 17 Women’s Rights Protection Committees established through Quality HIV and RMNH services project.

Multiple forms of data were collected in order to compare and triangulate findings. Furthermore, multiple categories of respondents provided multiple perspectives on the quality of HIV and RMNH services offered to women living with HIV. Because methods are quite different for each type of data collected, below we discuss each method separately.

2.1 Surveys

Pre- and post-surveys were conducted with Women living with HIV who were members of an HIV support group and participated in empowerment trainings provided by the Project. At baseline, respondents were randomly selected from a stratified sampling frame so that each support group had proportionate numbers of survey respondents (n=244). At endline, the same respondents were traced and surveyed in order to compare responses across time (n=236). The number of respondents for post-intervention surveys is smaller than pre-intervention surveys due to death of respondents or stopping participation in the HIV support groups due to relocating or other reasons. No respondents who reported participating in a support group refused to participate. The tool was the same for pre- and post-surveys.

Surveys were conducted at or near local partner compounds. Written consent was attained for all participants. The survey tool was developed by IKI in collaboration with Aidsfonds and covered the following topics: knowledge
of HIV and RMNH services, perceptions of women’s right to health services and reproductive choices, male involvement in health services, women’s use of HIV and RMNH services, quality of services received, and perceived ability to influence the quality of care provided at local health facilities. The tool was translated into Chichewa and back translated to English. One focus group discussion was conducted to ensure internal validity. The final tool was piloted with 18 women from the target population. The tool is presented in Appendix A (available upon request). Surveys were conducted by trained female enumerators and lasted approximately 50 minutes.

2.2 Empowerment Scale
An additive empowerment scale was used to assess women’s perceived ability to influence the quality of care received. The scale combines four Likert-scale variables: (1) Some patients have good ideas about additions to existing healthcare services (q.505), (2) Healthcare providers should listen to the opinions of patients (q.506), (3) Do you think you can do anything to change what healthcare providers in your local clinic do so you can get better treatment (q.507), and (4) Do you think your support group can do anything to change what healthcare providers in your local clinic do so that you get better treatment (q.508). For the above statements, respondents were asked whether they strongly agreed (1), agreed (2), disagreed (3), strongly disagreed (4), or believed patients should not influence healthcare services (5). For analytic purposes, we collapsed the response categories into strongly agree/agree (coded as 1) and strongly disagree/disagree and beliefs that patients should not influence healthcare (coded as 0) and created an additive empowerment scale.

2.3 Taking action against Poor Quality Healthcare
In order to capture if respondents would take action against poor health services, we asked respondents “What do you currently do if a healthcare provider has treated you poorly?” Multiple responses were allowed and coded into 10 categories, one was open-ended for responses that did not fit previously determined categories. For analytic purposes, a new dichotomous variable was created to capture respondents who took action against poor health services (coded as 1) and those who did not (coded as 0). The new variable was coded as 1 if respondents talked to the health provider who provided poor service, talked to another health provider at the same facility, or talked to a health or advisory committee about the poor services provided. All other responses, such as switched facilities, talked to family members or friends, or talked to support groups, were considered as not taking action (coded as 0) because these activities are unlikely to result in direct action against the poor services provided.

2.4 Quality of Care
Quality of care was measured separately for antenatal, family planning, and antiretroviral therapy (ART) services. Two components of quality care were assessed for each service: (1) Comprehensive care, meaning all appropriate services were offered or provided, respondents were given time to ask questions, and questions were answered thoroughly; and (2) Freedom of choice, meaning respondents were allowed to make decisions about their own health and reproductive choices, and respondents did not feel coerced into making particular decisions about their healthcare.

2.5 Perceived Discrimination
Perceived discrimination due to HIV status was measured by one question: “In the past year, have you ever felt that a healthcare provider treated you poorly because you were HIV positive?” Respondents were asked whether they strongly agreed (1), agreed (2), disagreed (3), or strongly disagreed (4) with the above question. For analytic purposes, we collapsed the response categories into strongly agree/agree (coded as 1) and strongly disagree/disagree (coded as 0).
2.6 Analysis

Basic descriptive statistics were conducted to understand the prevalence of each outcome and the demographics of participants. A panel design was used to determine changes pre- and post-intervention. To test whether the comparisons of responses on the continuous variables were statistically significant, we used the Student t-test or the Mann–Whitney U test. Categorical variables were presented as frequencies and percentages and comparisons were made using the Chi-square or the Fisher’s Exact test.

We used ordered logistic regression models to identify predictors of the empowerment scale and logistic regression models to identify predictors of the following measures: (1) action against poor quality care; (2) quality of care; and (3) perceived discrimination. Demographic factors such as age, education, and household wealth were included in all models. Age and education were continuous variables and wealth was measured by an additive scale comprised of 11 items owned by the household. Specific facilities where respondents accessed health services were included in final models to assess if outcomes differed by individual facilities. Correlations with an alpha of 0.05 or lower were considered significant. Data were analyzed using Stata v. 12.0.

2.7 Exit Interviews

Exit interviews were conducted with 24 Women living with HIV who used ART and/or postpartum services pre- and post-intervention (48 interviews in total). Two client types were recruited for interviews immediately following HIV or RMNH consultations: (1) Women living with HIV who accessed ART services on the day of recruitment and (2) Women living with HIV who accessed postpartum services on the day of recruitment. The same interview guide was used for pre- and post-respondents.

Interview guides were developed by IKI in collaboration with SANI and covered the following topics: services received the day of the interview, quality of services received, unmet needs, and where they could report poor quality care. Postpartum clients were asked about each clinic visit they had during pregnancy— including antenatal care, delivery, and postpartum care. The tool is presented in Appendix B (available upon request).

A trained female research assistant recruited respondents immediately after clients received ART and/or postpartum services. Potential respondents were approached on varying days of the week and at different times of day in order to recruit a diverse group of clients. Recruiting potential participants on a variety of days and times increases the likelihood that the sample is more representative of facility clientele, although based on the small sample size representativeness cannot be assured. Exit interviews were conducted in private spaces on facility grounds and were tape-recorded, translated into English, and transcribed verbatim. Written consent was attained for all participants. Interviews lasted approximately 45 minutes.

Based on the nature of RMNH services, the same clients were not recruited for both pre- and post- interviews, however, since we are primarily interested in the quality of health care provided, data from pre- and post-interviews are still comparable.

2.7.1 Analysis

Interviews were analyzed in Atlas.ti v. 6.2 using constant comparison methods. A priori codes drawn from the current literature on quality health services for Women living with HIV were first applied to transcripts (deductive coding). Upon second and third readings, inductive codes were added to capture new, emergent themes that were not previously identified in the literature. We extracted relevant quotes from all interviews based on their representation of dominant themes and interpret these quotes throughout the report. Quotes are cited without the facility name in order to protect the identity of both the facility and the respondent. Codes from exit interviews and data from the respondent surveys are compared in order to assess if similar themes about quality of care are present in both groups.
2.8 Registry data

De-identified registry data on HIV and RMNH clients seen between February 1, 2014 - May 1, 2014 and February 1, 2016 – May 1, 2016 were collected from the three participating facilities and three control facilities to assess if the Quality HIV and RMNH services project was associated with increased use of HIV and RMNH services at participating facilities. Control facilities were included to adjust for changes in the use of services that could result from secular factors outside the Quality HIV and RMNH services project, such as changes in national policy, health service guidelines or protocols, or changes in international funding strategies that are likely to affect the distribution of health services in Malawi. Control and intervention facilities were matched based on (1) urban vs. semi-urban locations, (2) catchment size, and (3) type of services offered. De-identified photos of facility registers were taken for the specified dates at each participating facility (6 facilities in total).

2.8.1 Analysis

Photos were transcribed and analyzed using Stata v. 12.0. Descriptive statistics were used followed by regressions and Wilcoxon rank-sum tests to determine the association between the Project and changes in services utilization within intervention facilities. We analyzed 6 outcomes separately: (1) uptake of antenatal care (ANC) services; (2) the proportion of ANC clients who received 3+ ANC visits; (3) uptake of early infant diagnostic (EID) services; (4) the proportion of EID clients retained in care; (5) uptake of antiretroviral therapy (ART); (6) and the proportion of ART clients retained in care. While the program focused on improving quality of care for women living with HIV, improved clinical accountability and improved health services should also affect men’s use of care, not only women’s. Therefore, we include male clients in all analyses when possible (ART and EID outcomes). Male clients are particularly relevant for ART uptake and rates of default.

We used a difference in differences approach to assess the impact of the Project on use of services. Difference in differences uses observational data to mimic an experimental design – comparing if differences overtime are significantly different between control and intervention groups. For example, the number of ART clients may increase by 20% in intervention sites after the Project has been implemented (comparing 2014 data to 2016 data). At the same time, the number of ART clients may increase by only 10% in control sites after Project implementation (using the same data). We compare the percentage change for each outcome within intervention and control sites to determine if intervention sites experienced a significantly greater percentage change than control sites, regardless of the absolute number of new clients initiated. All differences between 2014 and 2016 data were reported as percentage change, therefore the Chi-square or the Fisher’s Exact test were used to determine if changes in intervention sites were significantly different from changes seen in control sites. Correlations with an alpha of 0.05 or lower were considered significant.

2.9 In-Depth Interviews with Providers

In-depth interviews were conducted with 12 healthcare providers pre- and post-intervention (24 interviews in total). One provider from each of the following departments at participating facilities was interviewed: ART, ANC, family planning, and the nurse or clinician in-charge of the entire facility. The nurse/clinician in-charge was interviewed in order to assess current clinical governance strategies. The same interview guide was used for pre- and post-respondents.

The interview guide was developed by IKI in collaboration with SAN! and covered the following topics: quality of services provided, rights to quality care for women living with HIV, existing clinical governance strategies, and acceptability of community-accountability strategies. The tool is presented in Appendix C (available upon request).

Providers were recruited and interviewed in the afternoons when patient load is low. Verbal consent was attained for all participants. Interviews were conducted in English in private spaces on facility grounds and were tape-
recorded and transcribed verbatim. Although interviews were conducted in English, a translator was available, if needed. Interviews lasted approximately 95 minutes.

2.9.1 Analysis
As with exit interviews with clients, in-depth interviews with providers were analysed in Atlas.ti v. 6.2 using constant comparison methods. Transcripts were read multiple times. Inductive coding was used to identify new themes. We extracted relevant quotes from all interviews based on their representation of dominant themes and interpreted these quotes throughout the report. To protect the identity of both the facility and the respondents, quotes are cited without the facility name.

2.10 In-Depth Interviews with Implementing Partners
In-depth interviews were conducted with 8 staff from implementing partners post-intervention (8 interviews in total) in order to examine barriers and facilitators to the Project’s implementation. The interview guide was developed by IKI in collaboration with SANI and covered the following topics: successes of the Project’s implementation, Project activities that were difficult to implement, and facilitators and barriers to each Project activity. The tool is presented in Appendix D (available upon request). Verbal consent was attained for all participants. Interviews were conducted in private spaces and were tape-recorded, translated into English, and transcribed verbatim. Interviews lasted approximately 55 minutes.

2.11 Focus Group Discussions with Women’s Rights Committees
Focus group discussions were conducted with 17 Women’s Rights Protection Committees (WRPCs). Each Committee participated in two focus groups in 2015 and 2016 to capture barriers and facilitators to program implementation immediately following the development of WRPCs and then again the barriers and facilitators to implementation after WRPCs had been established for several months.

Women’s Rights Protection Committees were recruited through implementing partners. Focus group discussions were conducted after routine WRPC meetings. Topics included facilitators and barriers to the implementation of WRPC activities, examples of successes and challenges within the last month, and perceived needs in order to successfully implement WRPC activities. The tool is presented in Appendix E (available upon request).

Findings from the first round of focus group discussions were presented in the preliminary report. Findings from the second round of focus group discussions represent persistent facilitators and barriers to implementation after WRPCs had been established and are presented in this report.

2.11.1 Analysis
In-depth interviews with implementing partners and focus group discussions with WRPCs were analyzed using Atlas.ti v. 6.2 using constant comparison methods. To protect the identity of participants and the implementing partners, quotes are cited without the name of the implementing partner represented.

2.11.2 Overarching Analysis
Multiple forms of data, and multiple categories of respondents, were used to triangulate data and provide different perspectives on the quality of HIV and RMNH services provided. In the findings, multiple forms of data
are combined to provide a holistic understanding of the quality of care provided and the context of local facilities.¹

2.12 Ethics
Ethical approval was received from the National Health Sciences Research Committee (NHSRC), the national ethics committee in Malawi. Measures were taken to ensure respondent confidentiality at all stages of data collection and data analysis. Results at the facility-level have been de-identified to ensure confidentiality of providers who participated in the study. Facilities are recognized by name only for exceptional performances that should not result in negative consequences for participating facilities nor individual providers employed at these facilities.

¹ Please contact Kathryn Dovel (kidovel@gmail.com) with IKI for more information regarding study design and analysis.
3 Results

“Before they [women living with HIV] were saying, “we people living with HIV, we are being discriminated by health care providers. They don’t regard us.” Especially when they [clients] want to go to take [collect] their ARVs, they wait for a long period of time. Some were complaining that even they give them ARV without Bactrum [antibiotic combination used to treat infections]. Some of the healthcare workers were shouting at them; taking them as they are not important people. So it was infringing the rights of women living with HIV. And some [women] were failing to comply with ARVs.

So we wanted that even the community itself, the women themselves, could build the capacity to demand quality services. And in the process, ah, we have seen that something has really started happening!

They [women living with HIV] manage to meet with the district health management team – those representing the DHO. The women came there and they expressed what issues they were encountering during the access of health services ... They were able to raise issues that mattered to their health when accessing HIV services ... And things changed ... And I can see now when they [women] are convening in their support groups, issues are coming out regarding issues of rights and they are being addressed. Yes, it’s like this project has added value and it is different for women who have experienced the project than if they had never experienced it.” Lead Personnel from Implementing Partner 2, male

The above quote represents the sentiments of female participants, health care providers, and implementing partners regarding the impact of the Quality HIV and RMNH services project. Respondents were largely happy with the Project and believed the Project has made important strides to improving women’s empowerment, improving relations between health facilities and the surrounding communities, and improving the quality of HIV and RMNH services provided. Continued needs after the Project’s implementation include (1) expanding the reach of empowerment trainings and community sensitization campaigns about Women’s Rights Protection Committees throughout the facility catchment areas, (2) the development of a monitoring and supervision system in order to ensure that facilities are using the Good Clinical Governance Package and are abiding by best practices that ensure quality of care for women living with HIV, and (3) building capacity within health facilities to ensure that providers have the physical and personnel recourses needed to provide quality care (e.g., more staff in high-volume facilities, working medical equipment that are needed on a regular basis, and improved physical structure of facilities).

The following results explore in detail the impact of the Quality HIV and RMNH services project and recommended next steps as reported by women living with HIV, healthcare providers, and implementing partners. Results are organized by the objectives of study.
Objective 1. Assess changes in HIV-related knowledge, perceptions and use of care among women living with HIV and participating in HIV support groups after the implementation of the Quality HIV and RMNH services project.

We answer Objective 1 using surveys completed with women who participated in HIV support groups in Lilongwe, Malawi before (n=244) and after (n=236) the intervention. Respondents were similar in pre- and post-surveys. At endline, respondents averaged 44 years of age, completed 4 years of education, had 4 children, knew they were HIV+ for approximately 8 years, and attended an HIV support group for 4 years. Approximately 50% were currently married (see Table 2).

Table 2. Survey respondent demographics pre- and post-intervention: 2014, 2016

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline (n=244)</th>
<th>Percentage or Mean</th>
<th>SD</th>
<th>Endline (n=236)</th>
<th>Percentage or Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, range: 18-71 (mean)</td>
<td>42</td>
<td>10</td>
<td></td>
<td>44</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Average years of education, range: 0-15 (mean)</td>
<td>4</td>
<td>3</td>
<td></td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Household goods index, range: 0-11 (mean)</td>
<td>2</td>
<td>1.8</td>
<td></td>
<td>2</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Worked for pay (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked for pay in past month</td>
<td>16</td>
<td></td>
<td></td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked for pay in the past 6 months</td>
<td>26</td>
<td></td>
<td></td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never worked for pay</td>
<td>32</td>
<td></td>
<td></td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of living children, range: 0-8 (mean)</td>
<td>4</td>
<td>1.8</td>
<td></td>
<td>4</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Ever pregnant (%)</td>
<td>100</td>
<td></td>
<td></td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently pregnant (%)</td>
<td>4.5</td>
<td></td>
<td></td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average years since last pregnancy, range: 0-3.33 (mean)</td>
<td>0.82</td>
<td>0.7</td>
<td></td>
<td>0.9</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Currently married</td>
<td>53</td>
<td></td>
<td></td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of years known HIV+ status, range: 1.7-21 (mean)</td>
<td>7</td>
<td>3.6</td>
<td></td>
<td>8</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>Number of years in the HIV support group: 0-15 (mean)</td>
<td>4</td>
<td>3.1</td>
<td></td>
<td>4</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Local Partner (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 1</td>
<td>31</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 2</td>
<td>18</td>
<td></td>
<td></td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 3</td>
<td>20</td>
<td></td>
<td></td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 4</td>
<td>31</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.1 Knowledge of HIV and RMNH services

Before the Program, most women in HIV support groups were well informed about the benefits of ART, child spacing, and knew best practices to prevent mother-to-child-transmission. We find that knowledge remains high at endline (see Table 3).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline (n=244)</th>
<th>Endline (n=236)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who are living with HIV are able to have an HIV negative baby</td>
<td>91.4</td>
<td>91.04</td>
<td>0.77</td>
</tr>
<tr>
<td>Child spacing can help women living with HIV stay healthy</td>
<td>97.6</td>
<td>99.3</td>
<td>0.58</td>
</tr>
<tr>
<td>Women who are living healthy with HIV may lower their immunity if they get pregnant</td>
<td>88.5</td>
<td>88.68</td>
<td>0.959</td>
</tr>
</tbody>
</table>

Despite high levels of knowledge, in both pre- and post-survey data respondents were afraid of vertical transmission. Women were asked, “If you found out you were pregnant tomorrow, would that news be: (1) very bad; (2) fairly bad; (3) neither good nor bad; (4) fairly good; or (5) very good.” In both baseline and endline surveys, over 75% of women believed this news would be very bad or fairly bad. Negative perceptions of pregnancy changed, however, under different scenarios.

When women were asked to imagine that there was no risk of vertical transmission of HIV during pregnancy, delivery, or during breastfeeding, negative attitudes toward pregnancy decreased by 46% and 51% in pre- and post-data, respectively (see Figure 1, Scenario 1). Women also feared provider responses to a future pregnancy, reporting that providers may shout at them for having a child while living with HIV. When women were asked to imagine that they could be confident that providers would be supportive during their next pregnancy, negative attitudes toward pregnancy decreased by 51% and 66% in pre- and post-data, respectively (see Figure 1, Scenario 2). These findings suggest that fear of vertical transmission and rude behavior by healthcare providers may negatively affect women’s fertility preferences. However, these findings should be interpreted with caution since the average age of respondents was over 40 years, older than the average age of childbearing in Malawi. Future interventions that engage women living with HIV should develop targeted strategies to involve younger women who may still be interested in childbearing in order to promote the safety and social acceptability of childbearing when living with HIV.
3.2 Perceived level of empowerment to influence the quality of RMNH and HIV services

Before the Project, the vast majority of respondents believed that clients have good ideas that could be used in health facilities (92%). However, when asked about their experiences in health facilities, it was evident that respondents felt largely helpless in their ability to influence health facilities or change poor quality services. Only 42% of respondents thought they could have any influence on health services, with only 21% believing they could make a big difference. Furthermore, 11% of respondents believed providers should not take their advice.

When asked how they respond to poor quality care, at baseline none of the respondents said they would talk to the provider who treated them poorly. Only 25% of respondents said they would talk to the health advisory committee. Importantly, perceptions of empowerment were significantly associated with taking action against poor quality care (for example, reporting poor care to health facility staff or a health advisory committee), showing that perceptions of empowerment are an important component to achieving community-driven accountability. Women who believed they could make a difference in their local health facility were more likely to take action against poor quality health services (adjusted OR: 1.61; p <0.01; not shown).

After the Project, women’s perceived level of empowerment improved significantly (see Table 4). Sixty percent of respondents believed they as individuals could influence providers (a 44% increase from baseline findings; p<0.001), with 35% believing they could have a large influence (a 66% increase from baseline findings; p=0.001). Less than 6% believed that providers should not take client advice (a 51% decrease from baseline findings;
Eighty-three percent of women believed that their support group could influence providers (a 11% increase from baseline findings; \( p=0.027 \)), with 67% believing their support group could have a large influence (a 34% increase from baseline findings; \( p<0.001 \)). Less than 3% of women at baseline and endline believed that providers should not take the advice of support groups – this finding did not change overtime (\( p=0.96 \)).

When asked how they respond to poor quality care, 20% of the respondents said they would talk to the provider who treated them poorly and nearly 75% said they would talk to a local committee (either the health advisory committee or the Women’s Rights Protection Committees; WRPCs).

Table 4. Differences in pre- and post-levels of perceived empowerment among women participating in HIV support groups as part of the Good Clinical Governance and Community-Driven Accountability Project: 2014, 2016

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage</th>
<th>( p ) value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual clients are able to influence providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals can do some things that can make a big difference</td>
<td>21.3</td>
<td>0.027</td>
</tr>
<tr>
<td>Providers should not take client's advice</td>
<td>11.48</td>
<td>0.001</td>
</tr>
<tr>
<td><strong>Support groups are able to influence providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support groups can do some things that can make a big difference</td>
<td>50</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Providers should not take advice from support groups</td>
<td>2.46</td>
<td>0.944</td>
</tr>
<tr>
<td>If you were treated poorly at a facility you would directly report poor health services</td>
<td>48</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Importantly, each measure of empowerment in Table 3 improved significantly after the Project’s implementation (see Figure 2).

Figure 2. Differences in pre- and post-levels of empowerment for women participating in HIV support groups as part of the Quality HIV and RMNH services project: 2014, 2016

\*<0.05; \**<0.01; \***<0.001
At endline perceptions of empowerment remained important to reaching clinical government. As with baseline, perceived empowerment at endline was significantly associated with actually taking action against poor health services – women who believed they could make a difference in the health facility were more likely to report poor health services (not shown).

### 3.3 Who feels empowered? Predictors of the empowerment scale

In order to understand if the Project influenced women’s perceived empowerment, we ran regression models that controlled for other factors that could be related with the developed empowerment scale. We assessed whether older or younger women, women with more education or more money, or women who had been members of support groups for longer periods of time were more likely to feel empowered to advocate for quality care. Table 5 shows a series of models used to show what had the most impact on women’s perceived level of empowerment. In every model, we see that the Quality HIV and RMNH services project had the greatest influence on women’s empowerment, with respondents being 2.3 times more likely to report positive levels of empowerment after the intervention than before the intervention (see Model 3). Indeed, the intervention was the greatest predictor of feeling empowered in every model. Importantly, the Project did not influence wealthy or poorer respondents differently – women who were poor benefitted from the Project just as much as women who were wealthier (see Model 4).

When controlling for the intervention, respondents who were members of an HIV support group for longer periods of time and those who had more household goods (a measure of wealth) were significantly more likely to feel empowered than respondents who had been members for less time or who were less wealthy. Education, age, and length of time with a known HIV positive status were not associated with perceptions of empowerment.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
<td>Model 4</td>
</tr>
<tr>
<td>Intervention (1)</td>
<td>2.13***</td>
<td>2.25***</td>
<td>2.32***</td>
<td>2.04**</td>
</tr>
<tr>
<td>Years of education</td>
<td>1.02</td>
<td>1.02</td>
<td>1.02</td>
<td>1.02</td>
</tr>
<tr>
<td>Age</td>
<td>1.01</td>
<td>1.01</td>
<td>1.01</td>
<td>1.01</td>
</tr>
<tr>
<td>Household goods</td>
<td>1.13*</td>
<td>1.16**</td>
<td>1.04</td>
<td></td>
</tr>
<tr>
<td>Years attending this HIV support group</td>
<td>1.18***</td>
<td>1.18***</td>
<td>1.18***</td>
<td>1.08</td>
</tr>
<tr>
<td>Health Facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Facility (ref)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Log Likelihood</td>
<td>-538.06</td>
<td>-521.53</td>
<td>-517.21</td>
<td>-516.95</td>
</tr>
</tbody>
</table>

* p<0.05, ** p<0.01, *** p<0.001

Importantly, after the Project was implemented, women who attended one of the three intervention health facilities were more likely to have higher levels of perceived empowerment than women who attended an HIV support group but did not attend one of the three intervention facilities (see Table 6). This finding was strongly significant for women who attended Facility 1, while the trend was weaker for both Facility 2 and Facility 3.

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2 The interaction between wealth and the Project is measured by the variable for household goods*intervention. It is clear that the impact of the intervention did not vary based on wealth since the variable for household goods combined with the intervention was not significantly associated with women’s perceived empowerment.
(p<0.1). Nonetheless, the difference between Facility 2 and Facility 3 and non-intervention facilities increased significantly after the Project was implemented (not shown), with greater improvements seen among intervention facilities. For example, by the end of the Project, women who attended one of the three intervention facilities saw greater improvements in their levels of empowerment than those attending non-intervention facilities. As a result, women who attended intervention facilities were more likely to feel empowered than women attending non-intervention facilities. Taken together, these findings suggest that the intervention is most effective when taking a multi-level approach: including both trainings for HIV support groups and changes within health facilities in which women are expected to access services.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline (n=244)</th>
</tr>
</thead>
</table>

Objective 2. Assess changes in quality of HIV/RMNH services at intervention health facilities after the implementation of the Quality HIV and RMNH services project

To address Objective 2 we use two forms of data to assess quality care: quantitative data from survey respondents and qualitative data from exist interviews with health facility clients.

We assessed quality care for three types of services: antenatal care, family planning, and ART.

3.4 Survey data

3.4.1 General health services

We examined respondents overall perceptions of discrimination based on their HIV status (see Table 7). Perceived discrimination was low during both pre- and post-intervention surveys: in the last year, 8% and 12% of pre- and post-intervention respondents, respectively, believed they were treated differently based on their HIV status. Thirty-two percent and 30% of pre- and post-intervention respondents, respectively, believed they were told they needed to use birth control based on their HIV status. Differences between pre- and post-data were not significant.
3.4.2 Antenatal care

The majority of both pre- and post-survey respondents reported being given time to ask questions about HIV testing before being tested (90% vs. 100%) and, if positive, given time to ask questions about ART (83% vs. 100%). In general, questions regarding HIV services were answered thoroughly (87% vs. 100%; see Table 8). The Project’s implementation was not significantly associated with improved communication between pregnant women living with HIV and antenatal care providers. However, the sample size for women who were pregnant within the last year is small and, therefore, these findings should be interpreted with caution.

Table 8. Quality of antenatal services as reported by HIV+ women participating in support groups before and after the Good Clinical Governance and Community-Driven Accountability Project: 2014, 2016

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Healthcare Services</strong></td>
<td>Baseline</td>
<td>Endline</td>
</tr>
<tr>
<td>In the past year, a provider told me that I should use family planning because I was HIV positive</td>
<td>38.11</td>
<td>32.55</td>
</tr>
<tr>
<td>In the past year, I felt that a healthcare provider treated me poorly because I was HIV positive</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td><strong>Antenatal Care (ANC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC quality of care: Provider gave me time to ask questions about HIV testing</td>
<td>90 (n=11)</td>
<td>100 (n=3)</td>
</tr>
<tr>
<td>Provider gave me time to ask questions about ARV</td>
<td>83 (n=24)</td>
<td>100 (n=16)</td>
</tr>
<tr>
<td>Provider took time to fully answer my questions (including both HIV testing and ARV)</td>
<td>87 (n=23)</td>
<td>100 (n=16)</td>
</tr>
<tr>
<td>Told I had to be tested for HIV</td>
<td>100 (n=12)</td>
<td>80 (n=5)</td>
</tr>
<tr>
<td>Told I had to use ARV in order to receive ANC</td>
<td>78</td>
<td>86</td>
</tr>
<tr>
<td>The provider told me how to protect my baby from HIV after birth</td>
<td>97</td>
<td>95</td>
</tr>
</tbody>
</table>

1 Only includes respondents who used ANC services in the past year
2 Only includes respondents who had questions during their last clinical visit
3 Only includes respondents who were HIV negative or did not know their status before their last pregnancy

Another important component of antenatal services is the use of HIV services, and the absence of coercion that insists pregnant women should use such services. While patient-provider communication improved after the Project’s implementation, perceived coercion regarding HIV services showed mixed results. The number of women who reported being told that they had to be tested for HIV decreased from 100% to 80% and the number of women who reported being forced to use ART once tested positive increased from 78% to 86%. However, based on the small sample size of women who were pregnant within the last year, the difference is not significant ($p=0.26$, $p=0.75$, respectively).

The decreased pressure for HIV testing may be based on the intervention, which encourages the human rights of pregnant women to make decisions about health care without coercion. The increased pressure to start ART when pregnant may be based on external policy factors related to Option B+, a relatively new policy implemented in 2011 that allowed all pregnant and breastfeeding women to start ART immediately and remain on treatment for life. After the implementation of Option B+, starting pregnant women on treatment became the major focus for preventing new infections. Based on the importance of treatment in order to prevent infections in children, other research has found that providers in Malawi believe pregnant women should not be allowed to refuse treatment since it puts another life at risk. The increased number of women who were told they must start ART...
suggests potentially coercive behavior by providers in order to achieve desired outcomes, namely pregnant women’s use of PMTCT strategies. This finding is supported by other work in Malawi. While use of services is desired, women should always have the right to opt out of services. Furthermore, the ability to delay treatment initiation may also have positive benefits for treatment adherence and retention. Others in Malawi have found that pregnant women who are allowed to start ART several days or weeks after their first antenatal visit have better treatment outcomes than women who initiate treatment the same day.

3.4.3 Family planning
Patient-provider communication for family planning services did not differ after the Project’s implementation (see Table 9).

Table 9. Quality of family planning services as reported by HIV+ women participating in support groups before and after the Good Clinical Governance and Community-Driven Accountability Project: 2014, 2016

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage Baseline (n=66)</th>
<th>Percentage Endline (n=57)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider gave time to ask questions</td>
<td>86</td>
<td>86</td>
<td>1</td>
</tr>
<tr>
<td>Provider took time to fully answer my questions</td>
<td>85</td>
<td>82</td>
<td>1</td>
</tr>
<tr>
<td>Provider listened to me and considered my opinions</td>
<td>84</td>
<td>89</td>
<td>1</td>
</tr>
</tbody>
</table>

1 Only includes respondents who received family planning in the last 6 months and had questions during their last clinical visit.

3.4.4 ART
The intervention had little impact on the type of services provided during ART consultations (see Table 10). However, after the intervention providers were significantly more likely to discuss safe childbearing practices (a 93% increase from baseline findings; p<0.001) and ask about symptoms related to other sexually transmitted infections (a 42% increase from baseline findings; p=0.002). Over 80% of both pre- and post-intervention respondents reported being able to ask questions during ART consultations, however, only 62% and 66% believed the provider actually took time to consider the client’s feedback, respectfully. Gaps in patient-provider interaction during ART services may be related to the fact that ART consultations are often considered a distribution site, not a medical consultation to identify and address health concerns (discussed in detail by many exit interview respondents).
3.5 Exit interviews with facility clients

Data from exit interviews provides more detail about the quality of care provided during consultations and how quality of care has changed after the implementation of the Quality HIV and RMNH services Project.

At both pre- and post-intervention, respondents reported general satisfaction with the services received. Discrimination from healthcare providers based on HIV status was rarely reported. Instead, some respondents reported how HIV positive clients were treated better than HIV negative clients or those with an unknown status. Although discrimination was not reported before the intervention, poor quality care was commonly described by respondents and was influenced by five overarching factors. Below we describe the changes in these five factors after the Project’s implementation. Themes were similar across health facilities.

- **Kindness of providers:** All respondents explained that their satisfaction was largely based on the warm greeting and kind behavior of providers. Being greeted by providers as they entered the consultation room was central to respondents’ satisfaction with the services received.

- **Post-Intervention:** After the intervention, more respondents reported positive interactions with healthcare providers, discussing how providers showed “love” by greeting them well and giving encouraging words about living positively with HIV. This theme was especially salient for antenatal and postnatal services. For example, when asked why, besides distance, a respondent went to an intervention facility, she answered:

  “*The way they take care for us here. At this place, we are welcomed well, and they give us the proper treatment. That is why we come to this place.*”

Some respondents reported mixed experiences with providers – with some feeling respected and “loved” and others reporting rude behavior by providers. Rude behavior usually involved not greeting clients when they entered the room, not asking clients if they had questions, and using harsh tones or words during the
consultation. However, almost all respondents who discussed rude behavior also discussed the overwhelming circumstances in which providers were expected to perform. For example, one respondent described the situation where there were large numbers of clients and too few providers, creating tension within patient-provider interactions since clients were tired of waiting and providers were exhausted from a long day's work. When the respondent was asked if providers respected her on the day of the interview, she said that providers told her:

“We are tired and too tired to respect each and every one of you, it is impossible, we are tired.’ So they just do what they could. You know, since morning up to the evening [they are working]. They are indeed tired ... We as patients, we just accepted whatever they say. We just obey.”

Later in the interview the same respondent was asked if she had ever been denied services. She replied:

“No only that they [providers] get tired because we are many. One is calling ‘come here’ ‘come here’. So how can one person assist us at the same time?”

Similar reports were given by providers themselves, acknowledging that an increased or overwhelming workload can lead providers to shout or be rude with clients because they are too tired.

“When there are a few doctors, the workload increase. Sometimes when the nurses become tired, they just shout at the patients. This is not good. They have to help on this issue.” (female provider)

- **Clinic start times:** All respondents discussed facility start times as either a barrier or enabler to their use of services, highlighting the importance of timely access to care. Most clients in both pre- and post-intervention interviews reported poor clinic hours and late start times as their primary complaint about facility services, stating that poor and inconsistent hours caused clients to miss work and contributed the potential disclosure of their HIV status to community members (delayed access to care may cause community members to notice respondents’ absence and wonder why they are frequently sick). Respondents contributed inconsistent start times to the lack of standardized rules enforced for providers.

- **Ability to have open-communication with providers:** Before the intervention, only four respondents said they could ask questions during their ART consultation. After the intervention, nearly half of all respondents said they could ask questions during the same consultation. Improvements in clients’ ability to have open conversations with providers were due to mechanisms: (1) Improved privacy during consultations where other clients were asked to stand away from the consultation door. One way this was accomplished was to give clients numbers instead of having each client stand in a physical line. Moving to numbers instead of a line increased privacy as waiting clients were no longer trying to stand near the consultation door. This strategy also decreased conflict among clients who, under other policies, would quarrel with one another about their relative position in the line. (2) Clients reported that providers began soliciting questions, which made clients feel able to discuss their concerns.

While improvements were evident, continued limitations to open communication were reported. The main factors limiting open communication were (1) the time-focused structure of consultations where clients are rushed through the consultation and, for some, (2) continued lack of solicitation by providers, making clients feel that it would be rude or disrespectful to ask a question if they did not have permission from the provider to do so.

- **Provision of comprehensive care:** Comprehensive care should result in the reduction of unmet needs among facility clients, increasing the number of services provided in one visit. The majority of ART exit interview respondents did not receive RMNH information or related services before or after the Project’s
implementation. ART consultations acted more as a pharmacy visit than a medical consultation, were medicine was dispersed and adherence assessed, but little additional care was offered. 3 Lack of integration between HIV and RMNH services should continue to be addressed.

Perceived options for clients to respond to poor quality care: Nearly all pre- and post-exit interview respondents did not know where they could report poor quality care. 4 The few clients who did know where to report were involved in HIV support groups. In both pre- and post-exit interviews, a very small number respondents said they could directly complain to providers, but providers were thought to often respond poorly to criticism. Thus, most clients preferred to tell their friends and relatives and instead, missing opportunities to report or discuss concerns within the health system. This finding represents a major barrier to community-based accountability programs: if clients are unaware where to report, they will not be able to benefit from the accountability structures that are in place.

Objective 3. Assess changes in the use of HIV and RMNH services after the implementation of the Quality HIV and RMNH services Project

3.6 Registry data

To address Objective 3, we use de-identified registry data from antenatal care (ANC), early infant diagnosis (EID), and antiretroviral therapy (ART) services at 3 intervention and 3 control facilities. We assessed the difference in difference for 6 unique outcomes at intervention and control sites between 2014 and 2016: (1) uptake of ANC services; (2) the proportion of ANC clients who received 3+ ANC visits; (3) uptake of EID services; (4) the proportion of EID clients retained in care; (5) uptake of ART; (6) and the proportion of ART clients retained in care. Men are included in ART outcomes since improved clinical accountability and improved health services should also affect men’s use of care, not only women’s.

Table 11 describes differences in outcomes between 2014 and 2016 and tests if these differences are significant between intervention and control sites. Overall, intervention sites experienced significantly greater increases in the uptake of services as compared to control sites. Baseline data showed that clients were likely to choose a facility based on the distance (71%) to the facility and the perceived quality of care provided at the facility (58%). Therefore, it is possible that the significantly greater increase in the use of services at intervention sites is due to improved quality of care. For example, improved quality care may increase the number of clients willing to continue seeking care at the intervention site and may increase the number of clients that actively seek out care at these sites.

Notably, retention in care did not significantly improve in intervention sites as compared to control sites. This could be due to the fact that the complete intervention was implemented late, limiting the time that the program could have an effect before the evaluation was conducted. Another possibility is that retention in care is influenced by factors outside the control of the intervention. Existing literature finds that primary factors associated with retention in ART services include: (1) distance to the health facility; (2) disclosure; and (3) food insecurity. These factors are largely outside the control of the health facility and the quality of care provided. Below is a detailed description of the use of services from 2014 to 2016 across intervention and control sites.

\[\text{Several respondents were asked if they used contraception and one was offered condoms on the day of the interview. None of the ART respondents were asked about pregnancy.}\]

\[\text{Notable exceptions were respondents from the facility with an active clinical governance system.}\]
3.6.1 ART Services

Intervention sites saw significant increases in the number of ART registrations as compared to control sites (intervention sites experienced a 53% increase in ART registrations between 2014 and 2016 versus a 15% increase for control sites in the same time period; \( p\text{-value}<0.001 \)). Intervention sites also experienced significantly greater changes in the number of pregnant women initiating ART in the same time period (56% increase for intervention sites between 2014 to 2016 versus 1% increase for control sites; \( p\text{-value}<0.001 \)). The percentage of ART clients retained in care decreased slightly among both intervention and control sites (9% versus 6%); however, differences between intervention and control sites were not significant (\( p\text{-value}=0.31 \)). Decreased retention was largely due to increased rates of default among ART initiates (not shown). Increased rates of default may reflect a higher default rate experienced by healthy clients who qualified for ART under new policies, or may reflect the historically poor tracking of clients who transfer to other facilities as more and more rural sites now offer ART.

3.6.2 ANC Services

The increase in the number of women receiving ANC consultations was significantly greater for intervention sites as compared to control sites (10% increase for intervention sites between 2014 and 2016 versus a 13% decrease for control sites in the same time period; \( p\text{-value}<0.03 \)). Intervention sites also experienced a significantly greater increase in the number of ANC visits had by pregnant women. Of women attending ANC, intervention sites saw a 72% increase in the number of women receiving 3+ ANC visits compared to a mere 4% increase in the number of women receiving 3+ ANC visits for control sites (\( p\text{-value}<0.001 \)).

3.6.3 EID Services

Following increases seen among ANC clients, intervention sites saw a significantly greater increase in the number of EID clients registered in 2016 as compared to 2014 (23% increase in EID registrations among intervention sites versus a 3% decrease among control sites (\( p\text{-value}<0.001 \)). The proportion of EID clients retained in care did not differ between intervention and control sites (9% increase for intervention sites versus a 5% increase for control sites; \( p\text{-value}=0.27 \)).

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Table 11. Use of HIV and RMNH Services before and after the Good Clinical Governance and Community Driven Accountability Project: Examining Changes in Services Used from 2014 - 2016 in Intervention (n=3) and Control (n=3) Sites

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control Sites 2014</th>
<th>Control Sites 2016</th>
<th>Intervention Sites 2014</th>
<th>Intervention Sites 2016</th>
<th>Percentage Change between 2014 and 2016</th>
<th>( p\text{-value} )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antiretroviral Therapy (ART) Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total registered for ART during 3 months in 2014 and 2016</td>
<td>153</td>
<td>177</td>
<td>179</td>
<td>273</td>
<td>15%</td>
<td>33%</td>
</tr>
<tr>
<td>Total pregnant women registered for ART</td>
<td>42</td>
<td>42</td>
<td>48</td>
<td>75</td>
<td>1%</td>
<td>56%</td>
</tr>
<tr>
<td>Percentage of initiates retained (%)</td>
<td>28%</td>
<td>71%</td>
<td>71%</td>
<td>69%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Antenatal Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total women attending ANC during 3 months in 2014 and 2016</td>
<td>673</td>
<td>581</td>
<td>1238</td>
<td>3343</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Percentage of ANC attendance with 3+ ANC visits</td>
<td>43%</td>
<td>45%</td>
<td>31%</td>
<td>35%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Early Infant Diagnostic (EID)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total infants registered for EID during 3 months in 2014 and 2016</td>
<td>134</td>
<td>130</td>
<td>184</td>
<td>330</td>
<td>3%</td>
<td>23%</td>
</tr>
<tr>
<td>Percentage of infants retained in EID (%)</td>
<td>80%</td>
<td>81%</td>
<td>74%</td>
<td>81%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
**Objective 4. Assess provider acceptability of the Quality HIV and RMNH services Project**

To address Objective 4, we use in-depth interviews with healthcare providers (n=24).

### 3.7 In depth interviews

#### 3.7.1 Provider perceptions of clients

Before the Project was implemented, most providers described an underlying tension between provider and clients, where providers were misunderstood and mistreated by clients who did not understand the challenges of working at a health facility. Providers believed that client perceptions of poor quality care were largely due to unrealistic client expectations about (1) the speed at which providers should treat clients, (2) the level of personalized care providers could offer clients, and (3) provider control over the health facility, including drug and shortages and provider absenteeism.

After the Project, more providers discussed an understanding between clients and providers. While clients still regularly complained about long wait-times and drug shortages, nearly half of all providers felt that clients were beginning to understand the large workload providers faced, and, for the most part, providers believed they were able to have positive interactions with clients.

#### 3.7.2 Provider perceptions of employment as a healthcare provider

Providers often discussed what it meant to be successful at their jobs. In pre-intervention interviews, providers’ largely measured success based on the number of people they treated, not necessarily the quality of care provided. One provider said, “We are in the work of quantity, not quality, business... we need to see many patients quickly. Otherwise no one will be happy.” (female provider)

In post-intervention interviews, nearly three-quarters of providers discussed the desire to provide quality, holistic care over quantity care. For example, one provider reflected on the benefit of facilitating private, in-depth conversations with her clients:

“It can help, because it will improve quality of services because as I have already said, if people come in a group [into the consultation room], one [client] will not be able to express her views or maybe the problem she has. As a [provider], we will be just saying, “I have worked the whole day, but I haven’t done a quality work.” But if I have examined those people thoroughly, and one by one, I have observed their rights, they will be able to speak their concerns openly, and I will be satisfied. Maybe seen ten people but with quality care, it’s enough [better] than treating one hundred people in a day with poor care.” (female provider)

Another provider who oversaw a facility also reflected on the importance of dialogue and actively engaging clients:

“A patient can come but he also has a right so we have to take our time and listen to what he is saying, and how we can help him. This improves the relationship between the personnel and the patients.” (male provider)

While providers discussed holistic, client-focused care in detail during post-intervention interviews, the topic was still discussed in light of high provider workloads, insufficient physical infrastructure within the health facility that limited truly private consultations, and drug shortages – all factors that limited providers ability to offer the type and quality of care they desired.
3.7.3 Provider acceptability of community-driven accountability programs

In both pre- and post-intervention interviews, providers believed that clients should be able to report poor quality care. During pre-intervention interviews, most providers believed that client offenses primarily centered around components outside providers’ control, such as drug shortages or late start times. During post-intervention interviews, however, there was a greater recognition of potential misunderstanding between clients and providers that could lead to offenses. The most common causes for misunderstandings were (1) education differences between providers and clients that led clients to not understand what was being said and thus take offense, (2) provider attitudes that may make clients feel unwelcomed, (3) the gap in socio-economic status between providers and some clients that can make clients feel intimidated and shy to ask for clarification, and (4) previous negative experiences with healthcare providers that may make some clients assume that providers will be rude and uncaring, leading to early offenses even if the provider offers quality care.

In both pre- and post-intervention interviews, providers believed clients should report complaints through “proper channels” as established by the health facility. These channels included anonymous phone numbers that could be called, talking directly with the in-charge at the facility, contacting the District Health Office, contacting the Health Advisory Committee for that particular facility, and after the intervention, a few providers said clients could contact the WRPC and HIV support groups. Importantly, at both endline and baseline almost none of the providers knew of a client in the last year that had reported a complaint through the more formal channels (excluding WRPC), suggesting that before and after the Project, standard community-accountability programs were either not known by clients, or were not seen as a viable option.

3.7.4 Provider knowledge and perceptions of the Quality HIV and RMNH services Project

Knowledge of the Project

In post-intervention interviews, all providers who oversaw the facility and providers who worked primarily with ART services knew of the Clinical Governance Package and the WRPCs. Providers in family planning and ANC services were unaware of the project. Very few providers had personally engaged with the WRPCs.

Perceptions of the Project’s impact

All providers who had a working knowledge of the WRPCs (n=5) had positive perceptions about the Project’s impact on the well-being of women living with HIV. The primary perceived benefits of WRPCs were:

Committees acted as bridges between communities and health services: In both pre- and post-intervention interviews, it was clear that clients were not comfortable directly approaching providers about poor quality care or even misunderstandings between providers and clients. After the intervention, providers recognized this gap and saw WRPCs as one way to help clients discuss their concerns freely. One provider reflected on the usefulness of WRPCs for women living with HIV and their experiences with health facilities:

“Of course it can be useful [for clients to talk about their concerns directly to providers], but here I have never experienced it where patients are flexible to talk to the provider. Many patients that come here they are coming from rural setting areas. So for such people it’s difficult for them to be open with a health worker. Even if you probe them [clients] a lot, just few of them will talk [about what they are unhappy with] ... We see many people who are non-educated. So through the WRPCs, it’s like women are free to discuss the challenges that they are meeting in their respectable homes. Whenever they have a problem and they need to come to the facility, they discuss first it with support groups, at the home-level, and then they come to us. So the committee is like a bridge.” (female provider)

Committees were seen to meet women where they were, within community and home-based settings where non-educated clients could be comfortable talking about their concerns and discussing, in tangible ways, the recommendations from the health facility. Furthermore, providers believed that committees were able to address
misunderstanding between providers and clients. Providers often discussed what were considered misunderstandings where, based on educational differences and clients’ previous experiences with healthcare providers, clients may misinterpret provider recommendations or take offense to the way providers interact with them. Several providers described the benefit of WRPCs as being able to address these misunderstandings within a community setting.

Committees helped women know their rights in the community, and to a lesser extent, in the facility: All providers who knew about the WRPC discussed the positive impact such groups have on women’s ability to navigate stigma, social pressure, and gender inequality faced within their communities. Providers discussed a range of women’s rights, from their right to access and take medication, to their right to work without discrimination, to their right to a violence-free relationship with their husband. One provider described the benefit he saw from the committees:

“These women (WRPCPs), they encourage their fellow women to know their rights. The woman comes to the hospital, tests positive, is HIV positive, and is advised to take the medication. She goes to the home, telling the husband “I am HIV positive. I have to start medication.” The husband would say, “No. Don’t start medication now.” This woman should have the right to know it’s my right to get the right treatment. And it is happening from those support groups [WRPCPs].” (male provider)

Notably, nearly all providers discussed the benefits for women’s rights within the community, but very few discussed how WRPCs increased women’s rights within the health facility, or how these committees increased women’s awareness of their rights to quality healthcare, although this was a common theme among providers in Facility 1.

Committees provided outreach services for health facilities: Providers believed WRPCs also helped increase women’s knowledge about health services. Outside of antenatal services and services for children under five, health facilities have relatively little resources to conduct community-based health education strategies or to recruit community members for services. Groups such as WRPCs provide an ideal opportunity to increase community’s awareness of health services without taking healthcare providers away from the facility. One provider reflected on the role of local WRPCs in his facility:

“[It is a] very important meeting. We as a facility we don’t have a capacity to actually go and see every client in the community. So when we use these groupings they are able to take information from the facility to the next community level. So it is very helpful ... I remember a situation where we were actually using the committees as well as supporting groupings to say “Every woman when on ARVs should periodically be screened for cervical cancer”. So they [WRPCs and other groups] shared the information.” (male provider)

3.7.5 Perceived barriers to the Project’s success

Providers listed several barriers to clinical governance and WRPCs. The primary barrier was related to resources within the health facility. Limited resources were seen to inhibit how providers could do their job. The constrained physical space of the health facility meant that providers felt they could not offer private, confidential care. Drug shortages (excluding ART) meant that clients would have to be referred out and likely leave the facility dissatisfied. And large numbers of clients without enough staff meant that even though many providers reported wanting to engage in client-centered care, they often needed to move through the line quickly in order to see everyone in need.

Limited resources also influenced the implementation of WRPCs. Some providers reported not having time to sufficiently meet with the committees, limiting the committees’ potential impact. Others reported that local partners or committee members needed a stronger presence at the health facility in order to truly act as a bridge
between communities and the facility (again, Facility 1 was an exception). It was suggested that members be at the health facility every other week or once a month, attending health talks and meeting with providers, in order to have a balanced perspective from the community and the facility.

Another barrier mentioned was the limited awareness of the WRPCs and other channels through which clients can report poor quality care. While there are several WRPCs for each intervention facility, the facilities’ catchment areas are large, and it is impossible for all communities to be connected with the few WRPCs that are active.

3.7.6 Perceived facilitators to the Project’s success
Providers also listed several factors that facilitate WRPCs’ success. The primary facilitator mentioned was teamwork with the partnering CBO. One provider who worked closely with the WRPCs reflected:

“I see advantages because these partners that we are dealing with, when we see a problem with the population we are dealing with, we call them, we explain to them and them they make support groups who will be going into groups to educate the community. If it is about men, they buy the bawo, and take somebody one to two people to be at the bawo with an intention to educate the fellow men to escort the patient. So they are helping us.” (female provider)

All providers who had worked with the partnering CBO spoke about the teamwork and efforts put forward by both the CBO and the facility.

Providers also mentioned prioritizing committee meetings and scheduling specific times to work with the WRPCs as crucial to the Project’s success. One provider noted:

“Most of the time there is just pressure of work [see clients]. But what is needed is good planning so we are able to at least interact [with the WPRCs].” (female provider)

Prioritizing community-driven accountability programs at the district and facility level would also help providers allocate time for these meetings.

Objective 5. Assess barriers and facilitators to the implementation of the Quality HIV and RMNH services Project

To address Objective 5, we use in-depth interviews with 8 staff from implementing partners and 17 focus group discussions conducted with WRPCs after groups were established. The following assessment is organized around the perceived successes, barriers, and facilitators experienced for the following Project components: (1) trainings for women in HIV support groups; (2) the Good Clinical Governance package; (3) Women’s Rights Protection Committees; and (4) overall project implementation.

3.7.7 Trainings

Successes
Implementing partners and WRPC members believed that empowerment trainings serviced an important role for the overall goal of the Quality HIV and RMNH services Project. Trainings were seen to sensitize women living with HIV to their rights as clients.

“After the training, people were able to voice out their rights if they were violated by the health providers. People were also able to point out some other mistakes. Before the project, it was very difficult for them to know that their rights were violated.” (Lead Personnel from Implementing Partner 1, male)

Women living with HIV who attended the training and went on to join WRPCs agreed.
“At first when they [clients] were mocked at the hospital, they thought it had to be so. So, with the coming of the rights trainings, it’s when people now have started realizing that it is their right to be well received and to get treatment quickly by the nurse, even ARVs. So this human rights thing is so powerful.” (female WRPC member)

Trainings were also seen as the initial step to bridging gaps between health facilities and the communities served. Several partners reported that health care providers from surrounding clinics attended the trainings to inform attendees about clinic protocols and discuss common misconceptions about healthcare providers. For example, trainings conducted by several different partners had engaged providers explain why services were not meeting client expectations. One partner explained:

“[During the trainings] doctors were taking responsibility on the issues of those who go to antenatal or go to receive drugs [ARVs] ... the doctor was explaining that things [like delayed care and waiting on the floor] are happening to women because [the facility] caters to a lot of people and that is why some people are found on the floor. But before the training, women were thinking that the doctors were cruel. Even the way the hospital opens, the doctor explained it. He said, ‘When opening the hospital at 7:30, we just don’t start treating people immediately, no. We ask each other how the night was. Has there been any deaths during the night? So we find ourselves starting work at 8:00.’ But at first the people [clients] did not know the program at the facility. And I realized that people now knew why they were not helped as they expected. Before they were saying that doctors are selfish and that they start working late. But after the explanation [at the trainings], they [women] felt helped because they understood. They now know that when doctors arrive it does not mean that they will immediately start injecting as they first have to know how things are and where to start from ... Because of this training, the doctors and the women work hand in hand but at the beginning, there was no such thing.”
(Lead Personnel from Implementing Partner 3, female)

Facilitators

Participants listed several factors that helped facilitate successful trainings. Nearly all participants from implementing partners said that it was helpful to identify training attendees from existing support groups. This strategy increased the feasibility of activities and ensured that training attendees remained in communication with the Project after the training was finished.

Participants also listed training topics as a primary motivation for women’s attendance. Women were believed to be very interested in the training because (1) trainings addressed concerns around maternal and reproductive health, a primary concern of women living with HIV, and (2) trainings stressed the value of women living with HIV and promised to address poor relationships between healthcare providers and women living with HIV. One partner reflected:

“Women were very excited ... the trainings had an advantage to the women because they were being helped and their relationship with the doctors should then improve for the better.” (female WRPC member)

Finally, participants believed that trainings were impactful because they situated client rights within already existing systems within the health institution:

“So they have to understand that in the healthy facility, even though they have their rights, they are not supposed to confront the health workers. They should not say ‘I have my rights. Why are you doing it like this!’ No. They should follow the right protocols. Just in brief this is what the trainings provided for empowering these women to understand their rights and also understand the rights of healthcare workers and understand the services they could access. The combination was successful.” (Lead Personnel from Implementing Partner 2, male)

Barriers
There were several barriers that limited the implementation and perceived impact of trainings. Over 75% of participants listed (1) stigma within communities and (2) lack of understanding among husbands as primary factors that limited women’s participation in trainings.

Stigma was cited as a major barrier to identifying potential women who could benefit from the trainings. The vast majority of participants believed that many women living with HIV had not joined a support group because they did not want to disclose their status. Since trainings solely targeted support group members, women who had not disclosed their status were missed. One implementing partner described the problem: “They need this education and empowerment, but we are not reaching them.” (Lead Personnel from Implementing Partner 2, male). Another implementing partner identified women of reproductive years as particularly vulnerable because of stigma and concerns of disclosure:

“Stigma is at a high level ... Even in households there is a lot of stigma. People still point fingers at people who are HIV positive. It is still a challenge ... Another challenge is that in most of the support groups you can only find elderly people and teen mothers. The reason is that the women in the middle are in-between. They are HIV positive and they also want to get married. If other people realize that they are living with HIV, it becomes a barrier [to marriage].” (Lead Personnel from Implementing Partner 1, male)

The anecdotal assertion made in the above quote is supported by survey data. Indeed middle-age women in their prime reproductive years were missing from HIV support groups. From surveys with women participating in the Project’s support groups, we see that the average age is 44 years. This is 13 years older than the average age of ART initiation for women in Malawi (median age of ART initiation for women is 31 years). Clearly there remains a gap in engaging women of reproductive years.

Another barrier identified was that husbands often did not understand the activities of support groups or the Project’s trainings. As a result, members of WRPCs reported that some husbands tried to keep their partners from attending. One member recalled:

“Others were stopped from coming by their husbands. They [husbands] would say, ‘you should not go there because you will learn to become a whore.’ But they [women] were still trying [to engage in the Project].” (female WRPC member)

Outside of attendance, several barriers were believed to influence the trainings’ impact on women’s empowerment and use of HIV and RMNH services. The primary barrier cited by nearly all participants was the high level of illiteracy among training attendees. High rates of illiteracy meant that some participants had difficulty understanding the information given. Teaching aids such as posters, flip charts, and other visuals were suggested in order to increase understanding among groups with low levels of education.

There was also concern that (1) trainings were one-time events and (2) that many attendees lived far from the health facility where they could apply the knowledge gained. To truly change knowledge and perceptions, ongoing and widespread trainings were suggested. One implementing partner reflected:

“Trainings should be conducted again and again, in short, they should be conducted often. I can do this so that they [women] should be able to remember what to do like ‘oh I have to do this and I have to do that’.” (Lead Personnel from Implementing Partner 6, female)
3.8 Good Clinical Governance Package

3.8.1 Successes
Implementing partners and WRPC members believed that the Good Clinical Governance Package was successfully developed. The majority of partners, and to a smaller extent WRPC members, also believed the package impacted the quality of care provided.

3.8.2 Facilitators
Participants did not discuss facilitators to developing the Good Clinical Governance Package, but instead, discussed in detail factors that facilitated the successful implementation of the package once it was developed. Over 75% of participants said that existing protocols and infrastructure for quality care helped providers readily accept the new package. Existing protocols for quality of care and gender policies meant that the introduction of the Good Clinical Governance Package was not new, it was more like a refresher course. One partner active in the package’s development and implementation reflected:

“Because these protocols were already in the system of the Ministry of Health. Health facility providers they were aware of some of these protocols because when they want even before the training ah they were trying to access them how they understand family planning to a woman or somebody who has come for a HIV test. Or somebody has come for labor and delivery. So they were able to tackle of what strategy do they follow to provide support. So in addition to whatever this project provided for good clinic governance, it really helped it add knowledge and skills for them how best to support these women living with HIV. This is factor because this protocol are not new they were ready in the system. There is not much more for them to understand.”
(Lead Personnel from Implementing Partner 2, male)

Another facilitator was the active engagement of community members, healthcare personnel from Project facilities, and the Ministry of Health personnel. One implementing partner reflected on the importance of providers in helping develop a tool that could be useful on the ground:

“The providers were telling the gathering [package development committee] about the challenges that are faced. They narrated different stories that they face on day to day basis and the challenges they saw clients facing. This really helped us write information for the manual.” (Lead Personnel from Implementing Partner 4, male)

3.8.3 Barriers
Participants discussed barriers to package development and barriers to the package’s impact on quality care.

Primary barriers to package development were (1) adapting and translating current policies from English to Chichewa so it was appropriate for clients and community members, (2) irregular attendance or changing personnel in development meetings that slowed down the process, and (3) that timelines for package development and implementation were too ambitious given the extensive approval protocols that needed to be followed.

The primary barrier to package implementation and the overall impact of the Good Clinical Governance Package was the limited resources available within resource-stripped facilities. All implementing partners and most WRPC members believed the infrastructure and resources available at intervention sites was insufficient to truly support quality care. This was especially true when comparing available resources against the large catchment areas and high client loads. One implementing partner reflected:
“Although we created awareness, and we even increased the uptake of HIV and RMNH services as can be shown from the annual report, but facilities were not able – or are not able – to accommodate the rising number ... You will find that in the labour ward there are only three beds and you may have six or seven women who are delivering at the same time so others are delivering on the floor and this has actually made some women to say that it is better to deliver at home because I will be on a comfortable place. When I go to the clinic I will be delivering on the floor ... Resources cannot match the increasing number of people taking up services.” (Lead Personnel from Implementing Partner 8, male)

Limited resources were understood to not only influence the infrastructure related to quality care, but the way providers interacted with clients. One female WRPC member reflected:

“When they [providers] have the workload of many people waiting for them maybe they cannot be able to manage [the recommendations] in the package.” (female WRPC member)

Multiple partners agreed. For example, one partner stated:

“A number of staff that are at the clinic go through shortcuts when assisting patients. They cannot go through each and every level. I would like to appeal to the government so that they must employ more staff so that maybe other things will be okay.” (Lead Personnel from Implementing Partner 1, male)

A minority of participants also believed that providers’ individual personalities limited the impact of the Good Clinical Governance Package. Some believed that some providers were accustomed to treating clients poorly, and would not change quickly. One partner reflected:

“People [providers] were trained, they received the manual. But still, people are born different. Some people are used to shouting at other people. We still receive complaints that a health care provider was shouting at patients so we need to advocate more.” (Lead Personnel from Implementing Partner 1, male)

To address issues of non-compliance multiple partners suggested that a rigorous monitoring and evaluation system was needed to ensure that the Good Clinical Governance Package was being used as intended, and to check the quality of care being provided at participating sites.

### 3.9 Women’s Rights Protection Committees

#### 3.9.1 Successes

Nearly all implementing partners and WRPC members enthusiastically supported the benefit of Women’s Rights Protection Committees. The committees resulted in three overarching benefits for women living with HIV: (1) empowering women living with HIV to have leadership roles in the community; (2) bridging the gap between facilities and the communities served; and (3) improving quality of health services.

Perceptions of empowerment came largely from the teamwork and unity developed through WRPCs. One WRPC member reflected:

“These committees look after their fellow women. It is like a team that solves any arising problem and takes up the issue with the doctors. It wasn’t the case before, but now we work hand in hand. We [women] support each other, which was not the case before.” (female WRPC member)

Implementing partners agreed. When asked if they thought the WRPCs influenced quality care, one partner responded:
“I can say yes, because they were trained, they are able to identify the problems, they are working, and they are so much closer with people living with HIV and AIDS. They do the work together. They are united. The Project is boosting morale for them.” (Lead Personnel from Implementing Partner 1, male)

Women’s Rights Protection Committees also created a bridge between facilities and communities, opening new lines of communication.

“They [women] first had no relationship with the health facilities because they felt like the health facilities is government property. But this time around [after the Project] they are now able to know that this clinic belongs to the people – to the surrounding communities near the clinic. Women are now free to talk to providers through WRPCs.” (Lead Personnel from Implementing Partner 1, male)

Finally, WRPCs provided an accountability structure for facilities and healthcare providers that improved the quality of care provided. One WRPC member reflected:

“At first they took us for granted being villagers. Now they know that we know our rights and positions as human beings too. Yeah. So they are able to help or treat us well because of this project of Stop AIDS [Aidsfonds].” (female WRPC member)

Another WRCP member from a different group describes a similar outcome. Her response was echoed by most WRCP members and implementing partners:

“So we all [providers and committee members] met together and we were trained. After the training we were asked to say about the relationship. So we were able to say some of the challenges that we face when we go to the hospitals to access medical care. When they heard these sayings the healthcare personnel realized that we know our rights. Before this, they were just mistreating us knowing that we will not go anywhere to complain and there was no one to speak for us. But now they know that we have committees in the villages and these committees speak on behalf of all women living with HIV and AIDS.” (female WRPC member)

3.9.2 Facilitators
Participants listed several factors that helped facilitate successful WRPCs. Nearly all participants listed the (1) extensive support from the District Health Office (DHO), (2) support and buy-in from village headman, (3) use of existing support groups, and (4) the provision of key items such as bicycles and t-shirts as critical facilitators of WRPC activities. To a lesser extent, participants also listed support from local leaders.

Participants believed it was critical that WRPCs worked within the existing structure of HIV support groups. Many committee members were drawn from existing HIV support groups and therefore were known and respected by other HIV+ women. Members also had high levels of motivation because of the emotional support provided by their longstanding HIV support group. One partner reflected:

“These are the women who are really motivated. You can just see it on your own when you visit them. So they have passion for whatever they are doing. They are volunteers if you look at the distances they cover in order address these meetings its unbelievable and credible they have passion to do it.” (Lead Personnel from Implementing Partner 8, male)

Some facilities were not automatically cooperative with the Women’s Rights Protection Committees. In these cases, the DHO was very helpful to act as a bridge, providing support to the committees and requesting facility engagement until the facility saw the benefit of the program. One partner reflected on the benefits of an engaged DHO for the Project’s success:
“In the first place we have been inviting the health facility people but they denied to attend the meeting. The women’s rights committee went to the DHO to say we need people from [the facility] to come to attend our meeting because we have more questions to ask them but they are not coming. Can you assist us? Then DHO office staff said, ‘Just give the date that you are supposed to have another meeting and I will direct them to attend.’ And the health facility people did attend and we now understand each other. They [DHO] assisted a lot, even at the community level.” (Lead Personnel from Implementing Partner 4, female.)

Local leaders were also critical to the success of WRPC activities. When WRPCs were initially implemented, some groups struggled to gain the buy-in of local community members. In response, partners worked hard to engage village headman and other local leaders, asking them to support and promote the WRPCs. Follow-up focus group discussions with WRPCs show that the additional support and buy-in from local leaders made all the difference in engaging the community and having the community’s support to address issues of rights within WRPC activities. One partner discussed the benefits of involving multiple key players, such as local leaders:

“The major factor [that facilitated WRPCs] was the involvement of group village headmen because they are the custodians of our culture. They are the ones who influence communities and they are the ones who makes bylaws at the community-level. So because these Women Rights Protection Committees are about taking on the violation of women’s rights, the group village headmen and other community leaders were critical to communities accepting the committees and having it [WRPC activities] happen in their respective communities. As well as good cooperation with health facilities through the Health Advisory Committee and the health advisory management team. It helped so much for the WRPCs to be effectively established and functioning.” (Lead Personnel from Implementing Partner 2, male)

Another partner echoes a similar sentiment:

“The local leaders within their communities are very supportive because we have also engaged them in the Project. They support the WRPCs very well. For example, when they [WRPCs] were organizing meetings with the communities most of the group village headmen were on forefront trying to support these women. So that’s tremendous. They really help.” (Lead Personnel from Implementing Partner 8, male)

Logistical support from the Project was critical to the WRPCs success. Bicycles, though limited, assisted in transport to the multiple community and facility visits made by WRPC members. Project t-shirts and handbags also facilitated community buy-in and helped to legitimize WRPCs.

“You could see how happy they [committee members] are here every meeting in the SAN uniform. They are proud to wear these t-shirts and they were also given hand bags written STOP AIDS NOW.” (Lead Personnel from Implementing Partner 8, male)

3.9.3 Barriers

There were several barriers that limited the implementation and perceived impact of WRPCs. The primary barriers limiting implementation of WRPCs were (1) stigma and fear of discrimination and (2) transport. Other barriers mentioned less frequently include (1), establishing community buy-in, (2) finding a common ground with health facilities, and (3) the inability to train new WRPC members if some members left the group.

As with other Project activities, stigma and fear of discrimination were a primary barrier to activity success. Fear of discrimination kept women from disclosing their status, limiting the number of women who would utilize WRPC groups. Stigma also inhibited some HIV negative community members from actively participating in the committee. One partner described barriers related to stigma for WRPC activities:
“30% of WRPC members are not living with HIV. For them to associate with a person who is HIV positive is very challenging and I can tell you right now that some members who are HIV negative, they refused to associate with these people [people living with HIV]. They left the committee and the Women`s Rights Protection Committee members” (Lead Personnel from Implementing Partner 4, female)

Transport was also a concern. While each committee was given a bike, all committee members shared that one bike. Therefore competing interests made it difficult to complete committee activities in a timely manner, particularly in large catchment areas.

To a lesser extent, WRPC members were still limited by poor buy-in by some community members. Members were no longer concerned about communities being unaware of the group due to the successful support of local leaders and Project paraphernalia that helped legitimize committees. However, they were still concerned that community members did not believe members had the credentials to be in leadership positions and this, at times, sidelined their work in communities. For example, one WRPC member describes some of her experiences with community members.

“Some [in the community] undermine us [WRPC] to say ‘Ah she is one of us coming from this same village, what else can she do to assist. Just sit down’. So they do mock. Some who wants to listen, they do listen and they do understand and take heed to what you have tell them. I consider this also a challenge.” (female WRPC member)

Finally, some WRPCs initially had difficulty finding common ground with healthcare providers, making WRPC activities a challenge.

“On health care provider level the problems are there, because at the beginning the health personnel took the Women`s Rights Protection Committee as police because these committees would go to the facility and finger point to say to the Doctor, ‘You are not doing good in such areas.’ So they doctors would say, ‘Ah no. I want you to stop where are you.’ And communication was broken. To be in a good conducive environment was a problem, but now the health facility providers are taking it to heart and they are able to communicate well with the committees.” (Lead Personnel from Implementing Partner 6, female)

While barriers between WRPCs and providers existed, multiple steps were taken to improve communication. By the end of the Project nearly all WRPCs felt they had a good, mutually beneficial relationship with health facilities and healthcare providers.

All implementing partners listed the resource-strained environment of health facilities as a barrier to achieving the desired results of WRPC activities. Issues of quality care moved beyond simply patient-provider interactions and related to facility constraints such as the limited number of beds and drug shortages that were outside the provider and facility’s control. One partner reflected:

“Some problems can easily be solved amicably, but other problems cannot be solved just amicably. For example, the issue of staff shortages. We need to go beyond the health facilities. One time we were meeting with the DHO whereby we presented our problems about shortage of staff ... Earlier on we can see that from the time they were designing the facility it meant to be a clinic. But this time around, it is serving people like a community hospital. So the demand is very high. In addition to that, there are issues concerning people escorting pregnant women to the maternity clinic. They don’t have place to stay at the facility. So you can see we cannot just stop at the health facility or providers. We need to consult maybe other people like the DHO or other partners ... It is like its ongoing process.” (Lead Personnel from Implementing Partner 1, male)
4 Recommendations for Programs

Implementing partners and WRPC members made recommendations to be considered for future Quality HIV and RMNH services Programs. Four overarching recommendations emerged throughout focus group discussions and in-depth interviews:

1. Implementing partners and WRPC members both recommended that religious leaders should have a greater involvement in the Project. This includes training providers and facilitating their explicit involvement in WRPC activities and community buy-in. Many of the concerns around use of HIV and RMNH services are religious beliefs that may interfere with provider recommendations. One implementing partner described concerns expressed by the majority of partners:

“The other thing that affected the implementation despite the success made is the failure to include the faith leaders and the traditional leaders. They brought challenges to the implementation of the program. If we invited the faith leaders, they would lead because they are the same people from the community. They would also take part in implementation of the program. Some of the faith leaders ask people to stop taking drugs because they have been healed by faith.” (Lead Personnel from Implementing Partner 5, male)

2. Many WRPC members and some implementing partners also suggested a greater focus on male partners. Male partners influenced women’s involvement in the Project and influenced women’s engagement in HIV and RMNH services. Furthermore, for the health of the family it is also important to engage men in health services. One WRPC member reflected:

“We also want to emphasize on male involvement, because we have some issues of misconduct even compliance with ART if men are not much involved for that woman to reach out to it comes of more challenge. Yeah we want also to emphasize much of male involvement and we also want to engage faith healers.” (Lead Personnel from Implementing Partner 2, male)

An implementing partner gave similar perceptions:

“On issues of women’s rights, I think involvement of men is also important since sharing fruitful information is mainly a challenge from a woman to a man. Not involving men in most of the activities is also a challenge because most of client rights are also violated for men. So greater involvement of men is greatly important.” (Lead Personnel from Implementing Partner 7, female)

3. All implementing partners believed the Project needed to involve additional health facilities because many women in partners’ catchment area did not attend one of the three intervention facilities.

“Some people live far. It is a long distance, some people cannot manage to move to that place. We would love to have two or three health centers to ease the distance problems. We would also like to have a good number of participants so that the program should be implemented at a good pace. A good number of people would be reached with this information. Only a few numbers of people are reached with the information because of the lack of enough health centers.” (Lead Personnel from Implementing Partner 5, male)

4. Nearly all implementing partners suggested that the structure of ART sites should be changed in order to increase women’s use of HIV services. In Malawi, ART services are not integrated with other services. Instead, large facilities often have separate ART buildings or separate ART hallways dedicated solely to HIV services. In this setting, those using ART are often seen by community members accessing ART services, therefore increasing their risk of unwanted status disclosure. Partners believed that even when
quality services are available, women are concerned about unwanted status disclosure based on how they access ART services. Partners recommend that ART services be placed in more private, confidential areas of the health facility. One partner reflected:

“What they [ART clients] fear is how the structures [of the health facility] are. They know that everybody that is going to that side is going to take ARV. It’s the ART Department. So the infrastructure itself has been a challenge ... My suggestion is for the Ministry of Healthy to improve infrastructure in facilities so that maybe when accessing ART no one can trace that an area of the facility is only for HIV.” (Lead Personnel from Implementing Partner 2, male)
5 Conclusions

Using a mixed methods evaluation, we find that the Quality HIV and RMNH services Project was successful at engaging multiple partners to improve the quality of care provided. The Project was positively associated with (1) perceptions of empowerment among women who participated in HIV support groups, (2) provider acceptance of community-based accountability strategies, (3) improved patient-provider interactions within standard HIV and RMNH consultations, and (4) increased uptake of HIV and RMNH services at participating health facilities. Importantly, combining trainings for women living with HIV with structural changes within health facilities provided the greatest change in (1) perceived empowerment among women living with HIV and (2) successful action taken by Women’s Rights Protection Committees, Continued multi-level interventions are needed to best promote community-based accountability. Figure 3 provides a Theory of Change Model that describes the activities completed by the Project and the impact of activities observed by the evaluation.

The primary outcome of interest was improved quality of HIV and RMNH services at intervention facilities. The Quality HIV and RMNH services Project was associated with improved quality care on multiple fronts. First, women living with HIV who accessed care at intervention facilities reported kinder interactions and higher levels of satisfaction with healthcare providers after Project implementation as compared to before the Project’s implementation. Second, both survey and exit interview respondents reported more open, friendly environments within the health facility after the intervention. Post-intervention consultations were more likely to include time for clients to ask questions and clients were more likely to have their questions answered. Finally, intervention facilities experienced a greater increase in the number of clients receiving HIV and RMNH services after the Project was implemented, potentially reflecting a decrease in unmet needs within facility catchment areas.

Remaining barriers to quality care included poor integration of RMNH services within ART services, potential coercion of pregnant women to use HIV testing and/or treatment services, and limited resources within the health facility to adequately handle high client loads. The primary complaint of clients before and after the Project was delayed start times and long wait times in the health facility, with clients waiting on average 3 hours for one consultation.
While the Quality HIV and RMNH services Project were associated with positive outcomes, two overarching barriers limited the impact of the Project: (1) clients outside of HIV support groups were largely unaware of where they could report poor quality care; and (2) health facilities were already strained and over capacity. First, In women living with HIV who attended intervention facilities but did not participate in HIV support groups were still unsure where they could report poor health services. Indeed, nearly all women who participated in exit interviews believed that they had to “respect whatever they [providers] say. [They] accept and just go.” This finding confirms the fact that both institutional- and community-based strategies are needed to engage clients in community-based accountability. Future activities could expand training and sensitization campaigns to communities as a whole, moving beyond HIV support groups.

Second, the large number of clients, combined with the limited number of staff and medical resources, led to environments where providers could not see clients quickly and did not have the energy to kindly solicit questions and provide holistic care. While the Project addressed capacity development through the Good Clinical Governance Package and multiple dialogue sessions, future community-based accountability projects could include additional funds to address financial and resource constraints within local health facilities that impede quality care.

Community-based accountability and quality of health services can be continued by actively inviting clients to ask questions and have open communication with providers, maintaining and widely publicizing systems within health facilities where clients can report poor quality care, and, perhaps more importantly, working with the Ministry of Health and international organizations to address the resource-strained environment of public health facilities.
6 Summary Bullets

Main outcomes:

Perceptions of Women living with HIV

• The Quality HIV and RMNH services Project was associated with significant improvements in the perceived empowerment of women living with HIV who participated in an HIV support group.
  • Trainings combined with changes at the health facility prove most effective at raising women’s empowerment, since women who attended intervention facilities and intervention support groups were more likely to report empowered perceptions and behavior than women who only attended an intervention support group (not intervention health facility).

• The Project had little influence on women’s knowledge and perceptions of HIV and RMNH. However, levels of knowledge were already high before the Project started, possibly due to the fact that participants already attended HIV support groups on a regular basis.

Community-based accountability

• Among women living with HIV who participated in an HIV support group, the Quality HIV and RMNH services Project was associated with significant improvements in reporting poor health services through legitimate avenues, such as the provider in charge, the health advisory committee, or a Women’s Rights Protection Committees.
  • Nearly 30% of participants said they would report poor services to the Women’s Rights Protection Committees.

• Improved empowerment and knowledge for reporting did not transfer to facility clients who were not part of the intervention’s HIV support groups.
  • Almost all respondents from exit interviews did not know where to report poor care and felt unable to influence the quality of care provided.

• The project was able to reach women beyond support groups through community dialogue sessions, sensitization of community leaders, and activities conducted by the Women’s Rights Protection Committees.

Quality of care

• Clients from the intervention facilities reported kinder behavior from healthcare providers after the Project’s implementation.
  • At each intervention facility, more clients reported feeling “loved” and cared for by providers after the Project than before the Project’s implementation.

• The Quality HIV and RMNH services Project was associated with significant increases in the number of clients who received HIV and RMNH services.
• Primary complaints remain late opening hours, long wait times, and at times, rude behavior by providers.
• The integration of services and comprehensive care has improved, but is still lacking.
7 Recommendations

Trainings for women living with HIV
• Future trainings for women living with HIV should target: (1) women who are not already in support groups who may have lower levels of knowledge and/or (2) younger women who are actively making decisions regarding childbearing, family planning, and HIV treatment.
  • One option could be to conduct a mass media campaign within health facilities and in communities, drawing attention to the value of reporting and one or two easy ways clients could report their concerns.

Community-based accountability
• Male involvement is a continued concern that can limit positive outcomes for women and children.
  • Facilities should create a specific location where men can lock their bikes and other property to prevent robbery.
  • Services where male involvement is suggested (such as antenatal) should provide male-specific activities so men feel engaged and will not become bored. Potential activities include health talks geared toward male partners, incorporating components of men’s health or couple’s health into the existing health talk, and services for men that could be easily incorporated such as screening for high blood pressure.

• One WRPC member or partner member should attend a health talk at the health facility once every other week so the WRPC can (1) re-emphasize the knowledge given during the health talk and (2) understand exactly what is being told at the health facility.
  • There is concern that clients are misunderstanding providers and are taking offense when the provider did nothing wrong.

• The reach of WRPCs could be expanded within the health facility. To date, only the in-charge and providers who oversaw ART were familiar with the WRPCs. It could be useful to incorporate WRPCs into other health services, especially family planning, so that committees can help address miscommunication and poor knowledge regarding these services as well.

• The reach of the Project could be expanded to other facilities near implementing partners. Distance to a facility is one of the primary barriers to care experienced by people living with HIV in sub-Saharan Africa. The catchment areas of intervention facilities are large, meaning that even if quality services are offered clients may not have access to services due to transport constraints. There are several smaller facilities, both private and public, near implementing partners that could be involved in the Project to help address these barriers to care.

• Posters or writing on the walls of the facility is one way to increase client and provider awareness of rights. One facility wrote a list of “client responsibilities” and “provider responsibilities” on the facility walls. This strategy hopes to increase understanding between providers and clients by addressing the role of both groups. Importantly, providers from this facility believed that clients were now more understanding about long wait times and the need for providers to care for themselves, for example, to take a lunch break or a 10 minute break. Such activities had been planned but were not yet completed at the time of the evaluation.

• Widely available channels to report poor quality care should be advertised in health facilities, along with protocols to ensure that poor quality care is addressed in a timely manner.

Quality of care
• To promote open provider-client communication, consultations should include: (1) privacy, (2) time for questions, and (3) a verbal invitation for clients to ask questions.
• Privacy: Intervention facilities have increased privacy by:
  - Providing numbers to clients as they wait in the queue. Client numbers are called for that one client to enter the room. All other clients must stand away from the door without crowding. By using numbers instead of physical lines, intervention facilities have been able to decrease client perceptions that others are “overhearing their questions” or ease dropping on health concerns they want to discuss with the provider (data taken from pre- and post-exit interviews with clients).
  - Facilitate a private consultation room, even when distributing ART. ART visits can often act more as simply a distribution site instead of a consultation. However, providers can take the extra time to create a private environment so clients may feel comfortable to discuss health concerns.

• A verbal invitation for clients to ask questions: Respondents from both the pre- and post-exit interviews and the pre- and post-surveys discussed needing to be given permission to ask questions. The most common ways respondents felt welcomed to ask questions were by (1) being greeted warmly with eye contact and a smile, (2) being asked a series of questions, such as, “How do you feel?” “Do you have any questions about your medicine?” “Do you have any other concerns or questions that you would like to talk about?”

• The primary complaint of clients continues to be long wait times. Providers and clients alike must be further sensitized to the importance of quality verses quantity care, and that quality care may result in longer wait times but better health outcomes.

• Clients, WRPC members, and implementing partners regularly reported that facilities were overwhelmed and under capacity to meet client needs in a timely manner. Future projects aimed to improve quality of care should consider including a capacity building component for facilities that are already strained.
8  References
