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Policy Brief

Evaluation of the Blantyre Prevention Strategy: Lessons for the HIV Response

Background

The Blantyre Prevention Strategy (BPS) is a package of interventions designed to improve the functioning of the Blantyre district health system to alleviate the high burden of new HIV infections. The strategy aims to co-create, through stakeholder mapping and involvement, a sustainable, responsive, and collaborative intervention informed by local data and resources. It is envisaged that tracking the interventions and learning along the way will help identify bottlenecks during implementation through regular assessments, communication, and course correction.

The BPS Initiative

The Blantyre Prevention Strategy, implemented since May 2020, is a collaboration between the Government of Malawi, Georgetown University's Center for Innovation in Global Health, and the Blantyre District Health Office. The BPS approach involved tapping into and using local and existing resources, capacity building, continuous quality improvement, with Pre-Exposure Prophylaxis (PrEP) as the entry point, health communication to generate demand, structural risk reduction, and data use to improve service provision.

This policy brief summarizes key findings and lessons from an external evaluation commissioned by the BPS funder (Gates Foundation) and undertaken by the African Population and Health Research Center in 2024.

The evaluation aimed to determine the extent to which BPS is on track to achieving its intended outcomes of addressing systemic vulnerabilities hindering an effective HIV prevention response in Blantyre, Malawi. The expected outcomes include but are not limited to leadership, coordination inter-vention uptake, investments, guidelines, policies, and sustainability. The evaluation employed a mixed methods approach, including a desk review of policies and BPS implementation documents, a secondary data analysis of HIV prevention indicators from the District Health Information System 2 (DHIS2), and qualitative interviews with key stakeholders at district, city, national, funders and international partners.

Key findings:

Co-creation: The design and development of the BPS program were informed by local epidemiological data and health systems structures and context. It took a collaborative approach involving the National AIDS Commission, Blantyre District Health Services, local implementing partners in the HIV response, and technical partners with overall coordination by Georgetown University. The collaboration and coordination were cascaded into the implementation phase and contributed to stakeholder commitment, reduction in effort duplication, and resource wastage.

Capacitation: The BPS contributed to capacity building at the community, health system, and leadership levels. Through the community labs initiative, the community got more engaged and demanded more services, while at the health systems level, there were activities geared towards strengthening leadership, communication, and quality of service through the quality improvement initiative and data management and use in programming. The Prevention Adaptive Learning and Management System (PALMS) improved real-time data access and contributed to data-driven decision-making. Stakeholders gained a better understanding of and use of program data in ongoing prevention efforts, for example, by identifying where new risks or hotspots were emerging. The greater impact of how the capacity built will contribute to a sustainable HIV response will best be appreciated after a longer period of follow-up.

Improved service uptake: While attributing impact to a given set of interventions is challenging, the evaluation used an innovative analysis approach to link the observed changes to the intervention-interrupted time series. Early outcome indicators of HIV Counselling and Testing showed significant and sustained uptake over the intervention period. On the other hand, PrEP, which started late, is showing great promise regarding eligibility screening and initiation.

Programmatic Challenges: The BPS faced challenges in design and implementation, including the complexity of the intervention and related terminology, perceived inadequate training, high health facility staff turnover, weak coordination, limited involvement of the private sector for in-kind or financial support and data access issues - delays in clearing data as fit for sharing by the National HIV program. Perceived limited involvement of district stakeholders in managing the PALMS may impact sustainability. External factors like COVID-19, Cyclone Freddy, and a cholera epidemic further compounded these difficulties.

Key Messages

- Improved district leadership contributed to better coordination and delivery of HIV prevention programming.
- Community-oriented platforms facilitated community health communication. Campaigns like "Konda Moyo, Konda Blantyre" made HIV prevention services more accessible.
- Launching the PrEP Quality Improvement Collaborative (QIC) created a platform to strengthen quality improvement at the district and facility levels.
- The onset of BPS coincided with a shift in the HIV Testing and Counselling trend, changing from a downward decline to a steady rise, with an average of around 533 individuals tested for HIV each month.
- The involvement of Blantyre City councillors as agents for structural HIV risk reduction efforts seems a good entry point for political ownership. Unfortunately, the cyclic changes of elected leaders means that this has to be revisited after every election cycle.
- PALMS improved data access and use by consolidating information from multiple sources into a single data pipeline, simplifying visualization and decision-making. It has great potential, but there are sustainability concerns.

Implications for Scale-up and Sustainability

Co-creation of the program created a sense of ownership and pride among stakeholders, which has contributed to better acceptability by stakeholders and the community.

Working within existing structures and improving on them through mentorship and training negated the need for new and expensive tools. The deliberate effort to institutionalize and scale-up in areas such as quality improvement for PrEP has great promise.

However, the long-term sustainability of BPS could be at risk due to the need for continued external funding and technical capacity, particularly for the PALMS, commodities, and retention of human resources built over the period.

Conclusions and Policy Recommendations

1. **Co-creation and design of program:** It is plausible that co-creation and design of the program, use of local and context-specific data, engaging multiple stakeholders, leveraging existing systems, and utilizing technology all contributed to a thriving intervention per our assessment of ongoing implementation and early outcome measures. Going forward, for the program to be sustained (with relevant adjustments according to prevailing conditions, such as available financing), a closer look at the cost implications needs to be undertaken. The current evaluation did not assess program costs due to the complexity involved in tracking costs across different workstreams at the time.
2. **Greater Involvement of Stakeholders:** While the BPS initiative involved multiple stakeholders from the beginning, numerous voices, such as the private sector and other implementers, pointed to the feeling of not being involved enough. Increasing engagement with additional parties could attract more investment and have a better long-term impact.
3. **Extra Resources:** While BPS leveraged existing resources, it also introduced some new innovations, such as PALMS. For the PALMS platform to be sustained locally with minimum or no external human resources and technology investments, capacity must be built within national and district teams for effective data management. If PALMS' potential to inform near-real-time epidemic tracking is to be realized, timely availability of data from original sources such as DHIS 2 should be prioritized.
4. **Sustained Learning and Action:** There is a need to build local capacity to continually conduct in-depth analyses to offer insights into the program's performance.
5. **Sustaining district-level coordination of activities:** The coordination of partners for the HIV response needs to be firmly institutionalised by mainstreaming coordination activities leveraging routine coordination meetings at the district level.
6. **Sustaining capacities built for HIV response:** The district capacities built by the BPS for coordinating the HIV response, such as quality improvement in service delivery, data use in programming, and client-centered health communication, need to be sustained by established training guidelines or standard operating procedures for future training of new staff, refresher training for existing staff, and having clear transitional plans.

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