Evaluation of the Partnership for HIV-Free Survival Country Assessment: Tanzania

Findings

This brief on findings from the evaluation of activities related to the Partnership for HIV-Free Survival (PHFS) in Tanzania focuses on six components:

- Partnership
- Mother-baby pairs
- Integration of services
- Quality improvement
- Knowledge exchange
- Community engagement

The findings are drawn largely from a rapid assessment conducted in Tanzania in June 2017 by MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

Findings from assessments of PHFS in other participating countries are available on MEASURE Evaluation's website, here: https://www.measureevaluation.org/our-work/hiv-aids/evaluations-of-the-who-pepfar-partnership-for-hiv-free-survival-1.

Core Components of PHFS in Tanzania

Partnership

Tanzania's implementation of PHFS could serve as a global model for partnership. Through strong collaboration among stakeholders and a common vision, Tanzania achieved cohesive implementation of PHFS among a large network of actors in three distinct regions of the country.

The national PHFS steering committee was the partnership's driver. Led by its secretariat—the Reproductive and Child Health Section/Prevention of Mother-to-Child Transmission of HIV (PMTCT) Unit of the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), the committee chair, and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)—the steering committee coordinated the shared responsibilities of the national, regional, district, and community partners.

Members of the steering committee were the following:

Implementing partners

- EGPAF
- Deloitte (through the USAID- and PEPFAR-funded Tunajali program)
- Baylor University

Technical assistance partners

- University Research Company, LLC (URC), through USAID's Applying Science to Strengthen and Improve Systems (ASSIST) project
- The USAID-funded Food and Nutrition Technical Assistance (FANTA) project
- Tanzania Food and Nutrition Centre
- Jhpiego
- USAID mission in Tanzania

Before PHFS began in Tanzania, in 2013, the steering committee developed a protocol and a joint monitoring and evaluation plan to guide implementation. The protocol outlined the PHFS structure and activities and assigned roles to partner organizations. Although each partner managed its own funding and activities, clear distribution of responsibilities from the start established shared expectations and opportunities for teamwork. The joint monitoring and evaluation plan established common goals and ensured the transparency of the partners' work. Quarterly reporting on indicators helped the steering committee track the progress of the members' combined efforts across regions.

The vision for PHFS was shared from the national level to the three PHFS regions to the implementation sites. Implementing partners introduced PHFS to facilities as a MOHCDGEC initiative and provided consistent messaging to all stakeholders. Regional health management teams (RHMTs), council health management teams (CHMTs), implementing partners, facility staff, and community health workers (CHWs) shared a common understanding of PHFS and were able to collaborate effectively to achieve PHFS goals.

Mother-Baby Pairs

The value of linking HIV-positive mothers and their HIV-exposed infants as pairs was an early and important lesson from PHFS. Seeing the mother and child together, at a single clinical visit, and tracking their patient records jointly are two key components of this approach. These components are essential to reaching the global 90-90-90 goals of the Joint United Nations Programme on HIV/AIDS, which state that by 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of those diagnosed with HIV will receive sustained antiretroviral therapy (ART); and 90 percent of those in treatment will have viral suppression.

In Tanzania, mother and baby cards are stapled and filed together. Mothers visit the clinic once a month for combined appointments with their infants. Patients benefit from the mother-baby pairing, by spending less time in the clinic each month. Another benefit is that clinics manage fewer total appointments, allowing them to track patients more easily and efficiently.

Integration of Services

Integration of services for HIV-positive mothers and HIV-exposed infants is a fundamental component of PHFS/PMTCT programs in health facilities. The integrated services included antenatal care; postnatal care; Option B+ (lifelong ART); and nutrition assessment, counseling, and support (NACS). In Tanzania, integrated services were introduced with PHFS.

Across all PHFS facilities, mother-baby pairs can receive these services during one monthly appointment. At each facility, mothers first receive general antenatal or postnatal care, and then HIV-positive mothers continue their appointment with the Option B+ nurse to receive their HIV medication and support. Integrating services reduced time constraints for service providers, improved patient experiences, and increased retention rates of mother-baby pairs.

Quality Improvement

Many PHFS partners in Tanzania referred to PHFS as a quality improvement (QI) project, because QI teams were new to health facilities with the launch of PHFS. Facility staff were proud to present their QI work along with associated increases in retention of mother-baby pairs and reduction of new HIV cases among infants. At each facility, the QI team met once a month to track 11 predetermined PMTCT indicators in their QI journals and plan "change ideas" to address identified challenges. (A change idea in the PHFS QI model is a proposed action that when implemented, is anticipated to improve an indicator outcome over a defined period.)

Although several facilities added their own indicators to the initial 11, the majority reported on the same indicators throughout PHFS's implementation, even when they were consistently performing well. Change ideas grew out of national and regional sharing meetings (see "Knowledge Exchange," below), and thus were similar across facilities, which resulted in less facility-led innovation to address distinct challenges in each community.

Coaching

Facility-level activities were supported by QI coaches from the CHMTs, who made regular visits to the hospitals and clinics participating in PHFS. The coaches worked closely with the members of each facility's QI team to reinforce the knowledge and skills required to identify areas for improvement, and develop and implement solutions. Facility staff members described strong relationships with their coaches that allowed for open sharing of challenges and concerns. As the capacity of QI teams within facilities grew and matured, the ability of the coaches to serve as mentors and external monitors remained important. When PHFS was scaled up to new facilities, health workers from demonstration facilities became coaches for health workers at the scale-up facilities. This coaching model is designed for sustainability, but staff shortages at facilities made it challenging to allocate time to coaching activities.

Knowledge Exchange

In Tanzania, PHFS stakeholders valued the opportunity for knowledge exchange and collaboration through "regional learning sessions" and "national learning platforms" (NLPs).

At regional learning sessions in each of the three regions, facility staff, CHWs, QI coaches, and implementing partners gathered to share their experiences and feedback on the change ideas they had implemented. Facility staff then returned to sites and tried the ideas, resulting in similar changes across facilities. Additionally, there were three annual NLPs, with participation by government partners and local PHFS implementers from all three PHFS regions. Stakeholders from each region shared their work and learned from the other regions. The first NLP was held in Dar es Salaam, the second in Mbeya Region and

the third in Nzega Region, allowing for site visits to PHFS health facilities and activity demonstrations. Health facility staff and CHWs said they were motivated by the opportunity to be recognized for their efforts and acquire new ideas from other regions at NLPs. Tanzania also participated in several international knowledge exchange sessions to share experiences with other countries.

Community Engagement

Community engagement was integral to the success of PHFS in Tanzania. CHWs and peer mothers provided substantial community outreach and adherence support for Option B+ clients. This work was essential to retaining mother-baby pairs in care.

Each of the three PHFS regions had a slightly different model for community engagement. In all three regions, CHWs provided community outreach, with the primary role of linking patients with health facilities. After being notified by the health facility, CHWs tracked patients who missed appointments and encouraged them to return for care. In addition, Mbeya trained peer mothers, who worked directly at facilities to support clients and assist with appointment scheduling; Nzega had psychosocial support groups for PMTCT clients; and Mufindi introduced income-generating activities for people living with HIV.

Although CHWs played a fundamental role in PHFS, most were volunteers and received little or no financial support for their work. CHWs were dedicated to their work, but were challenged at times by inability to pay for transportation or air time to communicate with patients.

Conclusion

In Tanzania, PHFS was built on strong partnership among stakeholders; integration of health services; QI work guided by shared PMTCT indicators; coaching; knowledge exchange; and engagement of CHWs, peer mothers, and psychosocial support groups.

Stakeholders saw PHFS as an opportunity for partnership to improve PMTCT services through QI at health facilities and to support mothers to remain engaged in care. Partners worked hard to convey a clear and consistent message at national, regional, district, and community levels, which helped introduce PHFS and sustain its success. With increased support, supervision, and documentation provided by the PHFS structure, health facilities were activated to improve their services, ultimately leading to increased retention rates of mother-baby pairs and reduction in the number of infants diagnosed with HIV.

The demonstration and scale-up sites in Tanzania have continued PHFS activities, including QI work, beyond the official close of the program. Partners would like to see the PHFS approach scaled up to additional sites and regions in Tanzania. Financial support for CHWs and increased staffing at health facilities to allow time for experienced staff to serve as QI coaches for new facilities will be needed for future scale-up and sustainability.

Background

The Partnership for HIV-Free Survival was implemented in six countries in eastern and southern Africa between 2013 and 2016. PHFS was a collaboration among PEPFAR, UNICEF, and the World Health Organization (WHO) to accelerate the uptake of the WHO 2010 guidelines on HIV and infant feeding in participating countries: Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda. Although specific aims differed slightly by country, the initiative was designed to reduce mother-to-child transmission of HIV and increase child survival, through improvements in breastfeeding practices, ART uptake and coverage among HIV-positive pregnant women and mothers, and overall mother-baby care.

Rapid assessments that MEASURE Evaluation conducted in participating PHFS countries used a qualitative lens to examine key PHFS activities and accomplishments. The primary purposes of these assessments were (1) to review the outcomes, and potentially the impact, of PHFS on PMTCT programs and related maternal, newborn, child health, and nutrition activities, and (2) to capture good practices from PHFS implementation that can be scaled-up across the region, particularly pertaining to the QI approach and its contributions to epidemic control.

Fundamental PHFS approaches to QI were facility-level or department-level assessments of PMTCT services and outcomes, QI training for staff, on-site technical assistance, routine data collection and reporting, information sharing, and follow-up support. At the start of PHFS, each participating country created a practical and locally relevant set of metrics to track changes implemented to improve program performance.

In Tanzania, PHFS was implemented in a total of 90 sites located in three districts in each of three regions (Mbeya, Mufindi, and Nzega). Each district had 10 demonstration sites; 20 scale-up sites were added after one year. Partners at the national level were USAID, the Reproductive and Child Health Section/PMTCT Unit of Tanzania's MOHCDGEC, URC-ASSIST, FANTA, Tanzania Food and Nutrition Centre, and Jhpiego. At the district level, URC-ASSIST provided technical assistance for QI activities and FANTA provided technical assistance for NACS activities. The three implementing partners (Baylor University, Deloitte/Tunajali, and EGPAF) were each assigned to one of the three districts. Each implementing partner worked with the regional and district government to supervise and support PHFS facilities in implementing relevant activities.

PHFS facilities were dispensaries, health centers, and hospitals. PHFS activities in Tanzania began at the same time as the Option B+ approach to PMTCT. Option B+ was implemented in all regions of the country. In PHFS districts, PHFS activities complement Option B+, and Option B+ provided the PMTCT services and strategies that made PHFS possible.

Methods

For the country visits, MEASURE Evaluation developed an interview guide with topics ranging from partnership structure, activity design, and perceptions of QI to implementation, tracking specific outcomes in identified program improvement areas, successes, and challenges. The evaluation teams gathered qualitative data on PHFS design, implementation, and scale-up/spread, through interviews and discussions with key stakeholders and partners and site visits to a selection of PHFS demonstration and scale-up health facilities.

Key stakeholders and partners were MOHCDGEC representatives, subnational-level health representatives, the local USAID mission, PEPFAR implementing partners, and on-site health facility staff. When possible, the team photographed QI journals that facility teams maintained to track PMTCT indicators and outcomes. After a country visit, the evaluation team synthesized results in the following common thematic areas across interviews: community engagement (community/patient links), efficiency, the health system/HIV structure within which PHFS was functioning, innovation, integration of services, knowledge exchange, nutrition, partnership, QI activities, reach, the role of USAID, and site selection.

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