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## **EVALUATION**

# **PERFORMANCE EVALUATION OF THE STRENGTHENING PEDIATRIC HIV AND AIDS SERVICES IN TANZANIA PROGRAM**

March 2015

This publication was produced at the request of the United States Agency for International Development. It was prepared by a team of independent consultants (Ms. Judith Harkins, Ms. Mpundu Mwanza and Dr. Sylvester Nandi) led by Dr. Robert Bernstein and contracted by the Global Health Program Cycle Improvement (GH Pro) Project.

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March 2015

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## **DISCLAIMER**

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



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# ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
BIPAI	Baylor International Pediatric AIDS Initiative
CDC	U.S. Centers for Disease Control and Prevention
CoE	Center of Excellence
CTC	Care and treatment clinic
FGD	Focus group discussion
GH Pro	Global Health Program Cycle Improvement Project
HAART	Highly active antiretroviral therapy
HCW	Health care worker
HIV	Human Immunodeficiency Virus
KII	Key informant interview
KYCS	Know Your Child's Status campaign
LZ	Lake Zone
M&E	Monitoring and evaluation
MCH	Maternal and child health
MoHSW	Ministry of Health and Social Welfare
NGO	Nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
PMP	Performance monitoring plan
PROMIS	PEPFAR Recording Management Information System
RCH	Reproductive and child health
SHZ	Southern Highlands Zone
TDHS	Tanzania Demographic Health Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
UN	United Nations
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
WHO	World Health Organization



# EXECUTIVE SUMMARY

## PURPOSE

The purpose of this performance evaluation was to learn to what extent the goals and objectives of the Baylor International Pediatric AIDS Initiative (BIPAI) have been achieved and to provide guidance on any modifications needed to improve the future effectiveness and sustainability of this type of program. In addition, the evaluation aimed to document lessons learned to inform USAID's design of follow-on programming for strengthening pediatric HIV/AIDS services in Tanzania.

## BACKGROUND

Global, regional and country-specific reports from UNAIDS, WHO and UNICEF indicate that between 2005 and 2013, substantial progress was made in reducing the incidence of HIV infections, identifying HIV-infected adults (including pregnant women), initiating antiretroviral therapy (ART) and providing care.<sup>1</sup> These reports, together with the 2014 UNAIDS *Gap Report*<sup>2</sup> and data slides from UNICEF and UNAIDS,<sup>3</sup> indicate that such progress has varied widely and has been substantially less for infants, children and adolescents. This is due to a combination of inadequate capacity among human resources and institutions and a lack of equity in the availability and accessibility of quality services and products for prevention, diagnosis, treatment and care of infants and children who are exposed to or infected with HIV. When early diagnosis is not made and proper treatment with highly active antiretroviral therapy (HAART) is not initiated in a timely manner and adhered to in accordance with the correct protocol, it is estimated that half of HIV-infected children die before the age of two years, and one-third of those who live to age two years die before they reach five years of age.<sup>4</sup> The data in these reports indicate that such disparities continue to have a profound adverse impact on morbidity and mortality of children living with HIV.

## THE HIV/AIDS SITUATION AND TRENDS IN TANZANIA

The 2014 UNICEF-WHO-UNAIDS progress report on the global AIDS response indicates that during the period from 2005 to 2013 in Tanzania, the total number of new HIV infections decreased by 46 percent and the total number of AIDS-related deaths decreased by 44 percent. However, estimates prepared by UNAIDS and the Ministry of Health and Social Welfare (MoHSW) indicate that the sub-national prevalence of HIV-infected adults and the number of

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<sup>1</sup> UNAIDS, WHO, UNICEF. *Global AIDS Response Progress Reporting, 2014*. Available at [http://www.unaids.org/sites/default/files/media\\_asset/GARPR\\_2014\\_guidelines\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/GARPR_2014_guidelines_en_0.pdf) (accessed 20 March 2015).

<sup>2</sup> UNAIDS. *The Gap Report*. Available at [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf) (accessed 20 March 2015).

<sup>3</sup> UNICEF. *2014 Statistical Update: Children, Adolescents and AIDS*. Available at [http://www.childrenandaids.org/files/Stats\\_Update\\_Presentation.pptx](http://www.childrenandaids.org/files/Stats_Update_Presentation.pptx) (accessed 20 March 2015). UNAIDS. *Epi Slides*. Available at: [http://www.unaids.org/sites/default/files/media\\_asset/01\\_Epi\\_slides\\_2014July.pdf](http://www.unaids.org/sites/default/files/media_asset/01_Epi_slides_2014July.pdf) (accessed 20 March 2015).

<sup>4</sup> UNICEF. *Towards an AIDS-free Generation: Children and AIDS Sixth Stocktaking Report, 2013*. Available at [http://www.unaids.org/sites/default/files/media\\_asset/20131129\\_stocktaking\\_report\\_children\\_aids\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/20131129_stocktaking_report_children_aids_en_0.pdf) (accessed 20 March 2015).

adults living with HIV/AIDS vary widely across the regions and districts of Tanzania<sup>5</sup>. The 2014 UNAIDS *Gap Report* indicates that in Tanzania there has been a 48 percent reduction in the rate of new HIV infections among children between 2009 and 2013, but the 2010 MoHSW baseline survey<sup>6</sup> and the 2014 MoHSW-UNICEF pediatric treatment rapid assessment<sup>7</sup> indicate that there continue to be widespread weaknesses and disparities in the availability, performance and quality of such services. Among the root causes of their persistence is the fact that the density (number per 10,000 population) of physicians and nurses in Tanzania is about one-fifth of that in other countries in Africa<sup>8</sup>, and there are very few pediatric specialists in the country (more than 40 percent of regions do not have a pediatrician).<sup>9</sup>

Public sector pediatric ART services began during the roll-out of Tanzania's first National Care and Treatment Plan in 2004. However, over the next five years, the proportion of ART-eligible children receiving HAART remained relatively constant at about 25 percent<sup>10</sup>. Despite a 2012 revision of the national HIV/AIDS guidelines<sup>11</sup> and scale-up of pediatric ART services to lower-level health facilities, the overall ART coverage for infants and children has not increased substantially and remains at about 27 percent<sup>12</sup>.

## **THE BAYLOR INTERNATIONAL PEDIATRIC AIDS INITIATIVE (BIPAI)**

In order to address the challenges identified above, in August 2008 USAID/Tanzania awarded a 7-year grant to Baylor University to strengthen services for prevention, early detection, treatment and care of pediatric HIV/AIDS in the Southern Highlands and the Lake zones. Using a combination of private and public funding, the BIPAI program established two Centers of Excellence (CoE) on the campuses of the Bugando Consultant Hospital in Mwanza and the Mbeya Regional Hospital in Mbeya, and it initiated a comprehensive set of activities to reduce HIV/AIDS-related morbidity and mortality of infants and children by achieving the following five specific aims:

- I. To provide comprehensive, family-centered pediatric HIV/AIDS prevention, care and treatment services

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<sup>5</sup> United Republic of Tanzania Ministry of Health and Social Welfare and UNAIDS. *Developing Sub-national Estimates of HIV Prevalence and the Number of People Living with HIV*. September 2014.

<sup>6</sup> United Republic of Tanzania Ministry of Health and Social Welfare. *Baseline Survey on Quality of Paediatric Care in Tanzania*. November 2010. Available at [http://www.who.int/childmedicines/countries/QUALITY\\_TANZANIA.pdf](http://www.who.int/childmedicines/countries/QUALITY_TANZANIA.pdf) (accessed 8 March 2015).

<sup>7</sup> United Republic of Tanzania Ministry of Health and Social Welfare and UNICEF. *Final Report of a Rapid Assessment of Pediatric HIV Treatment Service Delivery in Tanzania, January - May 2014*.

<sup>8</sup> World Health Organization. *United Republic of Tanzania Health Statistics Profile 2010*. Available at [http://www.who.int/profiles\\_information/images/a/aa/Tanzania-Statistical\\_Overview.pdf?ua=1&ua=1](http://www.who.int/profiles_information/images/a/aa/Tanzania-Statistical_Overview.pdf?ua=1&ua=1) (accessed 10 March 2015).

<sup>9</sup> Personal communication based on the experience of Dr. Sylvester Nandi, the team's evaluation specialist.

<sup>10</sup> MoHSW. *Baseline Survey on Quality of Paediatric Care in Tanzania*. November 2010.

<sup>11</sup> United Republic of Tanzania Ministry of Health and Social Welfare, National AIDS Control Programme (NACP). *National Guidelines for the Management of HIV and AIDS, Fourth Edition*. April 2012.

<sup>12</sup> United Republic of Tanzania Ministry of Health and Social Welfare and UNICEF. *Final Report of a Rapid Assessment of Pediatric HIV Treatment Service Delivery in Tanzania, January - May 2014*.

2. To expand case finding for children who are HIV-positive through strengthened pediatric HIV/AIDS counseling and testing using a family-centered testing model
3. To strengthen the local human resources and health system capacity to provide comprehensive and family-centered pediatric HIV/AIDS prevention, care and treatment services
4. To sensitize and mobilize people living with HIV/AIDS and the general population to support the provision of comprehensive and family-centered pediatric HIV/AIDS prevention, care and treatment services
5. (specific to the Southern Highlands Zone as part of the Partnership for HIV-Free Survival program) To contribute to elimination of HIV infections in children and reducing deaths among HIV-infected mothers and children through strengthening of post-partum care in Mbeya City

## EVALUATION DESIGN

With the end of the 7-year grant approaching in August 2015, USAID/Tanzania commissioned an evaluation of the performance and results of the BIPAI program that has been supported with funds from the President's Emergency Plan for AIDS Relief (PEPFAR). At the request of USAID, the Global Health Program Cycle Improvement Project (GH Pro) fielded a team to conduct this performance evaluation from January to March 2015.

The evaluation team was composed of a medical epidemiologist and health systems specialist as team leader, a medical epidemiologist and evaluation specialist, a clinical HIV nurse practitioner, a health communications and outreach specialist and three research assistants. The team was tasked with obtaining data to answer the following five evaluation questions:

1. How effective is the program in identifying, testing and treating HIV-exposed and HIV-infected children in the Lake Zone and Southern Highlands Zone?
2. How effective is the health care workers (HCW) training program (including clinical attachment and mentoring) at the CoEs and outreach sites?
3. How satisfied are the various stakeholders with the program?
4. What best practices can be learned from the program?
5. How could the program's implementation be improved?

The evaluation team used a mixed-method performance evaluation approach to respond as comprehensively as possible to all five evaluation questions. The mixed-method approach systematically integrates two or more evaluation methods at every stage of the evaluation process, drawing on both quantitative and qualitative data. This type of design has a high potential to provide strong results and is organized in accordance with recommendations published in the *USAID Evaluation Policy* (2011),<sup>13</sup> the *PEPFAR Evaluation Standards of Practice*

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<sup>13</sup> USAID. *USAID Evaluation Policy*. January 2011. Available at <http://www.usaid.gov/sites/default/files/documents/1868/USAIDEvaluationPolicy.pdf>; USAID. *Evaluation at USAID: November 2013*

(2014)<sup>14</sup> and the 20 critical components of the 76-factor *Checklist for Assessing USAID Evaluation Reports*.<sup>15</sup> Purposive sampling was used to select facilities and communities in which to review data, interview key informants, observe the performance of clinical services and hold focus group discussions (FGD). In both Mwanza and Mbeya, data were collected from the CoE, one district hospital, a health center or dispensary, and the communities near these facilities.

Limitations included limited time and other resources, delays in access to records and lack of documents. These have the potential of threatening the internal validity of the evaluation. Because this was a performance evaluation, the team was not required to establish plausible counterfactuals against which to measure the effectiveness of the various approaches used by BIPAI. However, by evaluating all five of the specific program aims in a convenience sample of settings, the team was able to examine the range of BIPAI's approaches and thereby to address the evaluation questions. Using a purposively selected convenience sample limited the generalizability of findings and did not provide the same level of the rigor that random sampling would provide, resulting in potentially biased or skewed results. Because limited resources prevented the collection of representative and generalizable primary data, the team relied on secondary quantitative data provided by the BIPAI and PEPFAR Recording Organization Management Information Systems (PROMIS) and primary data collected in qualitative KIIs, FGDs and clinical observations that were carried out among a small number of purposively selected individuals, facilities and communities.

## **EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

Based on the findings of this performance evaluation, the team concluded that the performance and quality of the BIPAI's work have met or exceeded the expectations of USAID/Tanzania in regard to the five evaluation questions.

Key findings included quantitative and qualitative evidence that the program has been (1) increasing the early identification, testing and treating of HIV-exposed and HIV-infected children in the Lake and Southern Highlands zones; (2) improving the early identification, treatment and care of HIV-infected children through outreach activities and the improvement of HCW competencies by combining case-based classroom training with a clinical attachment followed by on-the-job mentoring at the CoEs and outreach sites; and (3) satisfying most stakeholders with the performance and quality of its training, outreach and clinical services.

Key lessons learned from best practices included:

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*Update*. Available at <http://www.oecd.org/derec/unitedstates/Evaluation-at-USAID-November-2013-Update-FINAL.pdf>; USAID. *The USAID Evaluation Policy at 18 Months: Challenges and Successes from the Field*. July 2012. Available at [http://usaidlearninglab.org/sites/default/files/resource/files/Evaluation%20Policy%20at%2018%20Months\\_Introduction.pdf](http://usaidlearninglab.org/sites/default/files/resource/files/Evaluation%20Policy%20at%2018%20Months_Introduction.pdf) (accessed 9 March 2015).

<sup>14</sup> U.S. President's Emergency Plan for AIDS Relief. *PEPFAR Evaluation Standards of Practice*. January 2014. Available at <http://www.pepfar.gov/documents/organization/221324.pdf> (accessed 9 March 2015).

<sup>15</sup> USAID. *Checklist for Assessing USAID Evaluation Reports*. Available at [http://usaidlearninglab.org/sites/default/files/resource/files/mod11\\_checklist\\_for\\_assessing\\_evaluation\\_reports.pdf](http://usaidlearninglab.org/sites/default/files/resource/files/mod11_checklist_for_assessing_evaluation_reports.pdf) (accessed 9 March 2015).

1. Provider-initiated testing and counseling for all children at all entry points contributed to increasing identification of HIV-exposed and HIV-infected children.
2. Know Your Child's Status (KYCS) activities and other creative outreach services (Teen Clubs and Expert/Peer Mothers) resulted in increasing early identification of HIV-infected children who could be started on ART and care.
3. Case-based classroom education plus clinical attachment followed by on-the-job mentoring and follow-up are an excellent adult learning model for pediatric HIV post-graduate training.
4. The family-centered continuum-of-care model, including advanced TB diagnostic and treatment services, extends beyond the usual episodic care of the child and leads to more comprehensive testing, treatment, care and case-finding of adults and children.
5. The BIPAI online curricula (ART adherence and HIV care and treatment), toolkit and standard operating procedure charts are useful job aids that increase the performance and quality of services.

The evaluation team made a number of recommendations to improve the reach, coverage and effectiveness of BIPAI's capacity-building efforts through a cascading training-of-trainers approach and improvements in its outreach activities and monitoring and evaluation (M&E) methods. Additional recommendations include strengthening the undergraduate and post-graduate training programs in the fields of medicine, nursing, pharmaceutical practice and laboratory science. The team's overarching recommendation is for the continuation, expansion and/or transition of the BIPAI program in support of the MoHSW's efforts in pediatric HIV/AIDS.



# I. INTRODUCTION

## BACKGROUND

The HIV/AIDS pandemic has had a devastating impact on children and families worldwide, especially in sub-Saharan Africa, where a large proportion of deaths of children under 5 are caused by HIV/AIDS. Current coverage of pediatric HIV care and treatment in Tanzania, relative to the need, is inadequate. Many challenges have precluded expanding pediatric care and treatment, primarily the difficulty of identifying children who have been exposed. Another major challenge is the shortage of HCWs trained and confident in the complex aspects of treating HIV-infected children.

The U.S. Agency for International Development (USAID) 2006 pediatric assessment in three regions of Tanzania<sup>16</sup> revealed a number of challenges and opportunities. Few children are enrolled in HIV care and treatment or ART, particularly in Mbeya and Mwanza; these numbers do not meet Tanzania's stated care and treatment goal for children of 20 percent of adult numbers. Identification of HIV-infected children is poor, including provider-initiated routine counseling and testing services. Pediatric outpatient care infrastructure is inadequate, and there are training gaps, particularly relating to pediatric HIV/AIDS care and treatment. There is a distinct lack of specialized human resources, especially in pediatric health. Prevention of mother-to-child transmission of HIV (PMTCT) coverage is not optimal and linkages of HIV-positive mothers into adult HIV care and treatment are weak, as are follow-up efforts with infants and links to early infant diagnosis. Maternal and child health (MCH) services can be important entry points to pediatric HIV/AIDS prevention, care and treatment services but are underutilized.

A 2010 WHO-MoHSW national baseline survey of the quality of pediatric care in Tanzania<sup>17</sup> confirmed the results of the 2006 assessment, and the 2012 WHO Report on Statistics reported that Tanzania's public sector physician density is among the lowest of any country in the world.<sup>18</sup> A 2013 study of HCW practices in prescribing essential medicines for children found that in Tanzania, nurses, general practitioners (including non-physicians) and assistant medical officers are the cadres with the lowest levels of formal education and without any specialized pediatric training. These primary health care cadres provide the majority of care to

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<sup>16</sup> USAID. *Report of a Pediatric HIV/AIDS Care and Treatment Assessment in the Kilimanjaro, Iringa, and Mbeya Regions of Tanzania*. December 2006. Available at: [http://pdf.usaid.gov/pdf\\_docs/Pnadr385.pdf](http://pdf.usaid.gov/pdf_docs/Pnadr385.pdf) (accessed 8 March 2015).

<sup>17</sup> United Republic of Tanzania Ministry of Health and Social Welfare. *Baseline Survey on Quality of Paediatric Care in Tanzania*. November 2010. Available at: [http://www.who.int/childmedicines/countries/QUALITY\\_TANZANIA.pdf](http://www.who.int/childmedicines/countries/QUALITY_TANZANIA.pdf) (accessed 8 March 2015).

<sup>18</sup> World Health Organization. *United Republic of Tanzania Health Statistics Profile 2010*. Available at [http://www.who.int/profiles\\_information/images/a/aa/Tanzania-Statistical\\_Overview.pdf?ua=1&ua=1](http://www.who.int/profiles_information/images/a/aa/Tanzania-Statistical_Overview.pdf?ua=1&ua=1) (accessed 10 March 2015); and World Health Organization. *World health statistics 2012 (page 128)*. Geneva: World Health Organization. Available: [http://www.who.int/gho/publications/world\\_health\\_statistics/2012/en/](http://www.who.int/gho/publications/world_health_statistics/2012/en/) (accessed 8 March 2015).

children and therefore share with obstetrical HCWs the responsibility for early identification and referral for testing and counseling of HIV-exposed and HIV-infected children.<sup>19</sup>

In 2008, USAID/Tanzania entered into an agreement with Baylor International Pediatric AIDS Initiative (BIPAI) to collaborate with the government of Tanzania to accomplish the following:

- strengthen pediatric services, building on existing programs and specifically contributing to the reduction of HIV/AIDS-related morbidity and mortality among infants, children and adolescents in Tanzania;
- expand case-finding for children who are HIV-positive through strengthened pediatric HIV/AIDS counseling and testing using a family-centered approach at all levels of service delivery;
- increase the number of skilled HCWs with the capacity to provide comprehensive pediatric care and treatment services, through formal short- and long-term training as well as clinical mentoring and quality improvement programs;
- address national policy issues related to the provision of pediatric care and support for HIV-positive children on a platform of general pediatric care, in order to have a sustainable impact on maternal and child health, HIV/AIDS, tuberculosis and malaria through the combined efforts of many partners; and
- strengthen national systems, abiding by Government of Tanzania requirements and identifying methods to transition programs to local entities over the long term to ensure sustainability.

With resources provided by USAID/Tanzania, the two BIPAI/Tanzania Centers of Excellence have produced a large number of clinical interventions, training curricula and other activities and products in order to accomplish the overall goal and each of the specific aims of the program. The details of these publications and activities are available in peer-reviewed publications, in regularly updated web-based documents and in the CoE “drop boxes” that are accessible to USAID (see References).

## **EVALUATION PURPOSE**

This evaluation aimed to learn to what extent the project’s goals and objectives have been achieved and to provide guidance on what modifications would help to improve effectiveness and sustainability if further USAID support is contemplated.

## **EVALUATION QUESTIONS AND TASKS**

This performance evaluation is commissioned to provide specific answers to the following evaluation questions:

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<sup>19</sup> Adams LV, Craig SR, Mmbaga EJ, et al. *Children’s Medicines in Tanzania: A National Survey of Administration Practices and Preferences*. Available at: <http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0058303&representation=PDF> (accessed 8 March 2015).

1. How effective is the program in identifying, testing and treating HIV-infected children in the Lake and Southern Highlands zones?
2. How effective are the HCW training program (case-based classroom plus clinical attachment and mentoring) and outreach activities at the CoEs and outreach sites?
3. How satisfied are stakeholders with the program?
4. What are the best practices that can be learned from the program?
5. How can the program implementation be improved?

## **EVALUATION AUDIENCE**

The primary audience for this performance evaluation will be USAID/Tanzania, the Tanzania PEPFAR interagency technical team, BIPAI, other stakeholders in pediatric HIV/AIDS and the Government of Tanzania, specifically the MoHSW. Results will provide evidence for making resource allocation decisions, exploring unintended consequences, shedding light on implementation successes and shortcomings, highlighting areas of accomplishment and potential, identifying emerging problems and building consensus on the causes of problems as well as potential responses to aid future programming in strengthening of pediatric HIV/AIDS services in Tanzania. Also, the results of this evaluation will be used by USAID/Tanzania and PEPFAR/Tanzania's interagency technical team to inform future decisions regarding pediatric programs. The results will also be used by the Government of Tanzania and implementing partners for the purpose of learning best practices in pediatric programming in the country.



## 2. BACKGROUND

### PROGRAM RATIONALE

In August 2008, BIPAI was awarded by USAID/Tanzania a 5-year cooperative agreement to address shortcomings in the implementation of pediatric HIV/AIDS services in Tanzania. The agreement was extended to a total of seven years of project implementation (August 28, 2008 to August 27, 2015). Total funding for the agreement was \$45,000,000. This performance evaluation was conducted from January to March 2015, approximately five months before the official closing date of the agreement.

The project was designed to address challenges originally identified in the 2006 USAID assessment of pediatric HIV services in Tanzania. The key findings from this assessment revealed a number of bottlenecks to effective implementation of comprehensive pediatric HIV/AIDS services in the country. Extremely few staff were trained in pediatric HIV, and most HCWs lacked confidence in pediatric care in general and especially in pediatric HIV. While several services catered to children, no one service had clear responsibility for HIV-exposed children. Many services, such as PMTCT, MCH and care and treatment clinics (CTC) were functioning vertically, with weak linkages between them. Child-centered services were lacking. Multiple steps were involved in seeking diagnosis, care and treatment for infants and children. There was no routine offer of HIV testing for infants and children, even in the presence of multiple symptoms suggestive of HIV infection (for example failure to thrive or recurrent pneumonia) and diagnostic HIV testing is not often ordered for children at MCH, reproductive and child health (RCH), and outpatient and inpatient department settings. This is true for all children and is more of a problem in infants under 18 months. Rapid HIV tests are not being used in infants and children even though the National Guidelines for the Clinical Management of HIV and AIDS indicate that rapid tests can be used for children.

The 2006 assessment team strongly recommended that USAID consider designing a project that would accomplish the following goals:

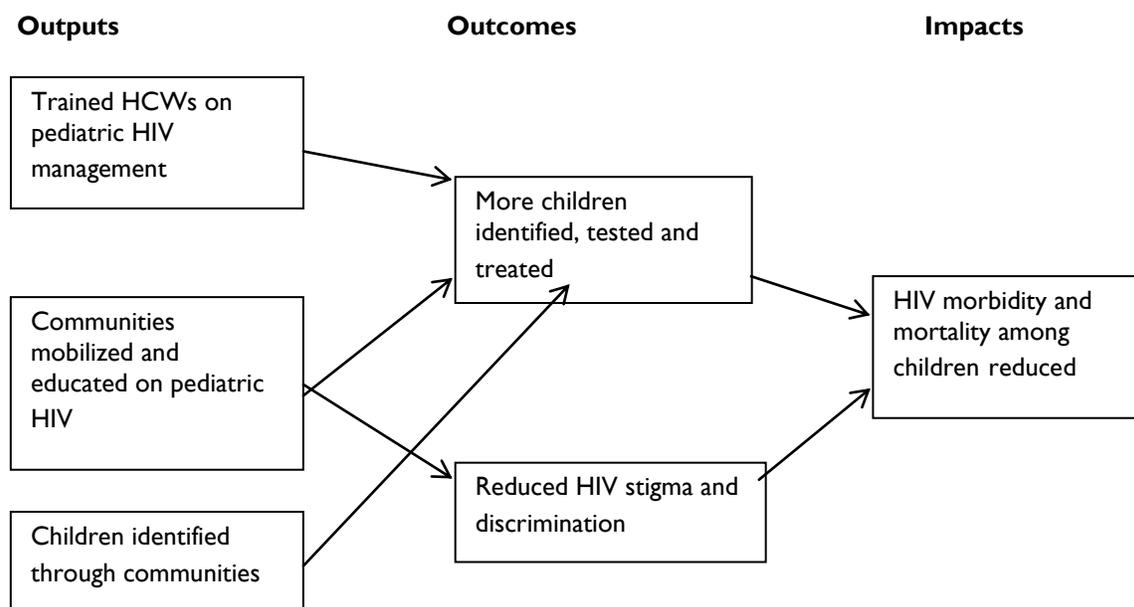
1. Maximize opportunities to identify exposed and infected infants and children at multiple entry points, (for example MCH, RCH, PMTCT, CTC, home-based care programs and orphans and vulnerable children programs) in order to provide or refer for necessary care and treatment and to improve linkages and systematize referrals between all services that see mothers and children.
2. Expand testing for infants and children by harmonizing all guidelines regarding HIV testing in children, ensuring that all infants born to HIV-infected mothers are tested and expanding the cadre of HCWs trained to counsel and test outside of the voluntary counseling and testing unit, for example on pediatric inpatient wards or MCH clinics.
3. Train more HCWs at all levels in pediatric HIV/AIDS care and treatment. Some HCWs need sensitization and others need training to be prescribers, but all must be sensitized to ensure that HIV-exposed and infected children are identified and ensured access to services. Provide mentorship and mobile teams if necessary to improve the ability of providers at lower levels of care to diagnose and manage pediatric HIV patients and to rapidly scale up the number of infants and children identified and reached with services.

4. Consider options for streamlining current ART services so that CTC have the capacity to take on treatment for children. One possibility would be to devolve routine follow-up of stable ART patients to lower-level facilities so that CTC can take on new patients. Consider expanding the CTC team to include providers and prescribers in the RCH, antenatal care and MCH clinic settings.
5. Educate and mobilize communities about pediatric HIV and link community and facility services for referrals, follow up and adherence support to families.

As a part of implementing the recommendations from the assessment, USAID designed a program titled Strengthening Pediatric HIV and AIDS Services in Tanzania. During the design, USAID hypothesized, “HIV morbidity and mortality among children will be reduced with more children identified, tested and treated for HIV, and by reducing HIV stigma and discrimination. These intermediate outcomes will be achieved by a) training health care workers on pediatric HIV management; b) mobilizing and educating communities on pediatric HIV; and c) working with communities to identify children at risk of HIV & AIDS.”

The schematic diagram of the USAID logic model below shows the assumed links from the output level to outcomes and impacts.

**Figure 1. BIPAI Program Logic Model**



## **GOAL AND OBJECTIVES OF THE BIPAI PROGRAM**

The overall programmatic goal of the BIPAI program is to contribute to the reduction of HIV/AIDS-related morbidity and mortality among infants, children and adolescents in Tanzania. To achieve that goal, BIPAI outlined five primary objectives meant to strengthen the performance, quality and results of pediatric HIV/AIDS services. These include:

1. To provide comprehensive, family-centered pediatric HIV/AIDS prevention, care and treatment services
2. To expand case finding for HIV-positive children through strengthened pediatric HIV/AIDS counseling and testing using a family-centered testing model
3. To strengthen the local human resource and health system capacity to provide comprehensive, family-centered pediatric HIV/AIDS prevention, care and treatment services
4. To sensitize and mobilize people living with HIV/AIDS and the general population to support the provision of pediatric and family-centered pediatric HIV/AIDS prevention, care and treatment services
5. (Southern Highland Zone only) To contribute to elimination of HIV infections in children and reduce deaths among HIV-infected mothers and children through strengthening of post-partum care in Mbeya City through the Partnership for HIV-Free Survival (PHFS).



# 3. EVALUATION METHODS AND LIMITATIONS

## EVALUATION DESIGN AND ANALYSIS MATRIX

This performance evaluation used a mixed-method design to comprehensively respond to all evaluation questions outlined above. A mixed-method evaluation design systematically integrates two or more evaluation methods at every stage of the evaluation process, drawing on both quantitative and qualitative data. This design has the highest potential to provide strong results and is endorsed by the USAID Evaluation Policy, which states, “Given the nature of development activities, both qualitative and quantitative methods yield valuable findings, and a combination of both often is optimal.”

Quantitative data about the performance, quality and results of BIPAI’s activities, and from relevant work of other implementing partners, were prioritized when available, because these data were usually derived from database records of activities and achievements for relatively larger and often more complete samples of BIPAI’s target populations in each of the two zones and the regions within them. Qualitative data collected by the evaluation team during key informant interviews (KIIs), FGDs and observations were used to supplement, complement and help to verify quantitative data.

When possible in the same geographic areas, the data about the performance, quality and results of the clinical, training and outreach work of BIPAI were compared with or supplemented by quantitative and the KII data from record reviews and meetings with other implementing partners in an attempt to verify, validate and improve the team’s confidence about BIPAI’s efforts. This effort at triangulation<sup>20</sup> was limited to the use of qualitative data from KIIs and FGDs, because by mutual agreement among the pediatric AIDS implementing partners, each partner’s clinical interventions were carried out in different settings and outcome data were separate as well. BIPAI’s training of various HCW cadres on pediatric AIDS was a possible basis for triangulation, but the evaluation team was not able to obtain triangulated data from larger and more representative samples for KIIs and FGDs that would have enabled an assessment of the effectiveness of training.

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<sup>20</sup> See: “Triangulation” as defined in the Robert Wood Johnson Qualitative Research Guidelines Project. Cohen D, Crabtree, B. “Qualitative Research Guidelines Project.” July 2006. Available at: <http://www.qualres.org/HomeTria-3692.html> (accessed 30 April 2015).

**Table I. Data Analysis Matrix**

<b>Evaluation questions</b>	<b>Illustrative indicators or other assessment criteria</b>	<b>Data source/ collection methods</b>	<b>Sampling/ selection criteria</b>	<b>Data analysis method</b>
I. How effective is the program in identification, testing and treating HIV infected children in the Lake and Southern Highlands zones?	Children tested for HIV through community outreach, early infant diagnosis, clinical services or other mechanism	Documents: annual reports, quarterly reports, semiannual and annual program results, performance monitoring plan (PMP) indicators		Review of existing reports, narrative and indicator results regarding identification, testing and treatment
		Secondary data analysis: CTC2	Case: selected CoE and BIPAI-supported clinics Control: individuals involved (directly or indirectly) in HIV testing and counseling	Comparative analyses: (1) pre- and post-interventions; (2) case sites compared to matched control sites
		KII		Thematic analysis
		FGD	Parents of at-risk children	Thematic analysis
	Proportion of children tested who are HIV-positive who receive treatment	documents: annual reports, PMP indicators; secondary data analysis with CTC2		Review of existing reports, narrative and indicator results regarding referrals and treatment
	Quality of HIV testing and counseling and CTC services	Observations	CTCs and CoEs supported by BIPAI	Descriptive statistics of checklist data and qualitative review of comments
		Patient satisfaction exit interview	Parents with children who are seen at CTCs or CoEs supported by BIPAI	Descriptive statistics for categorical data and thematic review of open-ended questions.
		KII	Individuals involved in HIV testing and counseling and CTCs	Thematic analysis and insights
		FGD	Parents of at-risk children	Thematic analysis and insights

<b>Evaluation questions</b>	<b>Illustrative indicators or other assessment criteria</b>	<b>Data source/ collection methods</b>	<b>Sampling/ selection criteria</b>	<b>Data analysis method</b>	
2. How effective is the HCW training program (clinical attachment, mentoring) at the CoEs and outreach sites?	HCWs trained in specified topics	Documents: annual reports, PMP indicators		Review of existing reports, narrative and indicator results regarding referrals and treatment	
	Quality of services by trained HCWs in comparison with guidelines provided in the BIPAI curriculum and those provided by WHO and PEPFAR	Observations	CTCs and CoEs supported by BIPAI	Descriptive statistics of checklist data and qualitative review of comments	
		Patient satisfaction exit interview	Parents with children who are seen at CTCs or CoEs supported by BIPAI	Descriptive statistics for categorical data and thematic review for open-ended questions	
		KIIs	Individuals involved in counseling and testing and CTCs	Thematic analysis and insights	
	Range and number of services delivered in BIPAI-supported sites versus other matched sites	Document review: annual reports, PMP indicators		Review of existing reports, narrative and indicator results regarding referrals and treatment	
		Observations	CTCs and CoEs supported by BIPAI	Descriptive statistics of checklist data and qualitative review of comments	
		KII	Individuals involved in counseling and testing and CTCs	Thematic analysis and insights	
	3. How satisfied are different stakeholders with the program?	Parents of pediatric HIV patients satisfied	Patient satisfaction exit interview	Parents with children who are seen at CTCs or CoEs supported by BIPAI	Statistical analysis of categorical data, thematic review of open-ended questions
		Satisfaction of MoHSW, health providers, local NGOs and implementing partners of BIPAI and USAID	KIIs	Individuals involved in HIV counseling and testing and CTCs	Thematic analysis and insights

Evaluation questions	Illustrative indicators or other assessment criteria	Data source/ collection methods	Sampling/ selection criteria	Data analysis method
4. What are the best practices that can be learned from the program, and what is the evidence that these best practices have been implemented, not just learned?	Successes with elements thought to contribute to these successes (planned and unplanned)	Documents: annual reports, PMP indicators		Review of existing reports, narrative and indicator results regarding identification, testing and treatment
	Evidence of implementation of lessons learned about best practices	KIIs	Individuals who are involved (directly or indirectly) in HIV counseling and testing	Thematic analysis
			Parents of at-risk children	Thematic analysis
		Quantitative findings from this evaluation		Summary of findings triangulated with qualitative findings
5. How could the program's implementation be improved?	Shortcomings and obstacles faced with recommendations to address these limitations	Document review: annual reports, PMP indicators		Review of existing reports, narrative and indicator results regarding identification, testing and treatment
		KIIs	Individuals who are involved (directly or indirectly) in HIV counseling and testing	Thematic analysis
		FGDs	Parents of at-risk children	Thematic analysis
		Quantitative findings from this evaluation		Summary of findings triangulated with qualitative findings

### DESIGN STRENGTHS (MIXED METHODS AND TRIANGULATION)

- The design would have allowed for triangulation where quantitative data from partners could be complemented by qualitative accounts from consultations as part of the performance evaluation.
- The evaluation questions required a variety of methods (record reviews, interviews and observations), and some of the questions required more than one method to sufficiently answer all components.
- The performance evaluation aimed to apply a combination of qualitative and quantitative methods to answer the same elements of a single question in order to increase confidence in the validity and reliability of the evaluation results.

## DESIGN LIMITATIONS AND ISSUES

Some weaknesses are inherent to the overall design of this evaluation, mainly as a result of limited time and other resources, delays in access to records and lack of documents. These have the potential of threatening the internal validity of the evaluation. Because this was a performance evaluation, the team was not required to establish plausible counterfactuals against which to measure the effectiveness of the various approaches used by BIPAI. However, by evaluating all five of the specific aims of BIPAI's program in a convenience sample of settings, the evaluation team was able to examine the range of BIPAI's approaches and thereby to address the evaluation questions. Sampling of sites and events was by a purposively selected convenience sample as explained below, which limited the generalizability of findings and did not provide the same level of the rigor that random sampling would provide, resulting in potentially biased or skewed results. Because limited resources prevented the collection of representative and generalizable primary data, the team relied on secondary quantitative data provided by the BIPAI and PEPFAR Recording Organization Management Information Systems (PROMIS) and primary data collected in qualitative KIIs, FGDs and clinical observations that were carried out among a small number of purposively selected individuals, facilities and communities.

Constraints and limitations of the evaluation include:

- **Time:** The original scope of work included only 12 days (including travel) for site visits in four regions (Mwanza, Mara, Mbeya and Rukwa). Given the amount of work required in each region, the team consulted with USAID and proposed 18 days for data collection, which was approved by USAID.
- **Document availability:** There was a lack of key project documents, such as a project-specific baseline study, cohort-based system of monitoring and evaluating the clinical status of enrolled children, mid-term evaluation and project performance monitoring framework. Only one USAID project officer quarterly assessment was available from seven years of BIPAI quarterly reports. The evaluation team had to request other project-related documents, which were provided but often much delayed (e.g., BIPAI quarterly reports, levels of training coverage and results of pre- and post-testing). These problems delayed the start of the team's field work and constrained the team's ability to measure the efficiency and effectiveness of BIPAI's progress. Some of the above-mentioned limitations (lack of baseline studies, mid-term evaluation, cohort outcome data and USAID responses to BIPAI quarterly performance reports) could not be overcome and therefore adversely affect the team's ability to provide the highest quality results. Other limitations were overcome with delays, e.g., the need to define some key BIPAI performance indicators and work with BIPAI to use these to calculate better quality data on the performance and coverage of clinical services, outreach services, training and training test results.
- **Limited availability of key personnel:** In a small number of cases, there were no-shows or less-than-expected numbers of participants in scheduled appointments with key informants, observations of clinical activities, exit interviews and FGDs. In all such cases, the team attempted to re-schedule or follow up with phone or email interviews with key respondents. Nevertheless, during the 10-day field work period, members of the team were able to visit the two CoEs and 24 other facilities and to interview 66 key informants.

- Potential sampling bias:** Due to time and resource limitations, the team was only able to visit two regions out of 14, and these two were purposefully selected. Comprehensive information was gathered from these regions to gather the broadest understanding of BIPAI’s performance. Furthermore, interviews with BIPAI, USAID and MoHSW provided a broad understanding of project interventions and performance across the selected implementation sites. However, due to resource constraints that affected the sample frame and sample selection, as well as the limited availability of documentation, data from this evaluation cannot be used to generalize the findings or the recommendations.

## SAMPLING

The BIPAI program has been operating in the two zones that have the highest population of people living with HIV/AIDS: the Lake Zone, composed of eight regions (Mwanza, Mara, Kagera, Geita, Simiyu, Shinyanga, Kigoma, Tabora and Singida), and the Southern Highlands Zone, composed of six regions (Mbeya, Rukwa, Katavi, Ruvuma, Iringa and Njombe).

The two regions where the CoEs are located – Mwanza (Lake) and Mbeya (Southern Highlands) – were purposefully selected for the evaluation. In each region, three health facilities (the regional or referral hospital and the district hospital and health center closest to the CoE) were purposefully selected to represent high-, moderate- and low-volume facilities, respectively. As a result, six health facilities were selected and visited in the two zones, as shown in the table below.

**Table 2. Selected Sites and Facilities**

Region and Zone	Selected health facilities
Mwanza, Lake Zone	Center of Excellence, Mwanza Nyamagana District Hospital Igoma health center
Mbeya, Southern Highlands Zone	Center of Excellence, Mbeya Ifisi District designated hospital Igawilo City upgraded health center

## DATA COLLECTION METHODS & TOOLS

Annex II provides details on all tools and methods described in this section, and Annex III provides a list of sites visited and informants interviewed.

### Key Informant Interview Guide

In consultation with USAID and GH Pro, the evaluation team developed KII guides to collect information from respondents in strategic or leadership positions who could provide critical insights around project effectiveness and learning. The categories of individuals selected as key informants were determined in discussions with USAID during the first week of team planning. In addition to the categories required by USAID, the team used respondent-driven sampling to identify key informants not initially identified. For example, the hospital director and the medical officer in charge at the Mbeya Regional Hospital recommended interviews with the two pediatricians working in the pediatric HIV ward where BIPAI provided treatment and care. Although the approach was the same, there were different interview guides for USAID staff, partner staff, stakeholders and community key informants. Stakeholder overview and analysis

allowed the team to ensure that the breadth of participants was covered. Using the guides facilitated collection of strategic information in a guided but unstructured way.

### **Focus Group Discussion Guide**

In consultation with USAID and GH Pro, the evaluation team developed FGD guides for collecting data with beneficiary groups in the implementation communities. FGDs were used to ensure discussions were not personalized and to allow for deeper exploration of issues. The unstructured nature of the FGD tools allowed respondents to provide critical information within and outside the scope of the evaluation questions. The sampling frame and participant categories are described in the guides in Annex II. The FGD facilitators were native Tanzanians experienced in recognizing and averting biases that might be caused by power differentials. A total of 19 FGDs were conducted in the local language (Swahili) among caregivers (female), village leaders (male), and adolescents (males and females together). The proceedings of FGDs were recorded and later transcribed, translated (only one-way because of time and resource constraints) and typed in English. Analysis of the FGDs was conducted manually, because resource constraints precluded the purchase of ethnographic software and limited the number of focus groups and number of participants in each group.

The team used the discussion guides to develop analysis codes and reviewed all typed notes of FGD facilitators to identify emerging themes and to develop new codes based on participants' own words. A thematic content analysis approach was used with data from the FGDs and KIIs. A matrix was developed to assist in identifying patterns within the data. All of the analyses were done manually as resources were not available to purchase software for qualitative analysis of the data.

### **Exit Interviews**

In consultation with GH Pro, the evaluation team created an exit interview questionnaire for collecting data from caregivers of children who sought pediatric HIV/AIDS services and who had been recently seen by the clinical team at each site. The questionnaire was used to collect data about the caregivers' experience and perceptions of the care they received. The 21 caregivers interviewed were a convenience sample selected on the basis of attendance at the clinics on the days on which the team scheduled its visit.

### **Observations of HCW Clinical Practices and Evaluation of Training**

The evaluation team created an observation tool and consent forms for collecting data about the performance of BIPAI-trained providers during clinical visits. The tool was used to gather data about clinical practices, patient communications and patient education. The team planned to do observations of the performance of clinical practices in a convenience sample consisting of all of the sites visited. However, because time and resource constraints affected the team's ability to coordinate observations with the scheduled visits of patients, and because of concerns over ensuring protection of the confidentiality of medical records for minor children who might be considered to be subjects of research, it was only possible to conduct clinical observations for four types of providers (pediatrician, medical officer, assistant medical officer and clinical officer). These observations were completed while the team was visiting the two CoEs, the Nyamagana District Hospital in the Lake Zone, and the Igawilo Health Center in the Southern Highlands Zone. All visits observed were to initiate ART for pediatric patients.

Despite efforts to schedule observations of HCW training by BIPAI, during the team's visits in Mwanza and Mbeya there were no opportunities to observe the classroom, attachment and mentoring activities that comprise the package of BIPAI training. However, the team did create KII questionnaires for use with providers who had participated in the training package, and the team reviewed BIPAI's M&E data on the number and types of cadres trained as well as the results of pre- and post-training examinations.

### **Consultative Meetings**

The evaluation team conducted consultative meetings at all levels: national, regional, district and community. They included respondents from institutions such as the Government of Tanzania (MoHSW, regional and council health management teams in both regions), UN agencies and donors (WHO, UNICEF, CDC), international NGOs (Henry J. Kaiser Foundation and Walter Reed Program in Mbeya), national NGOs, faith-based organizations, and civil society organizations.

### **Secondary Data**

The evaluation team did not collect quantitative primary data and therefore relied on BIPAI's performance monitoring data and reports submitted to the PEPFAR Reporting and Organizational Management Information System (PROMIS). To facilitate systematic secondary data extraction, the team developed a template with the specific indicators and data requirements relevant to the five specific aims of the BIPAI program.

### **Informed Consent**

The evaluation team obtained written informed consent from key informants and FGD participants for their participation in the evaluation and taking of photos. Participants above 18 years provided their own informed consent. Verbal informed consent for FGD participants under 18 (minors) were provided by their legal guardian and the children (for example, Teen Club members). For children who were present as routine clinic visit patients while the clinical performance of HCWs was under observation, written informed consent was obtained from the children's caretaker or legal guardian.

### **Stakeholder Engagement**

The GH Pro team carried out this evaluation based on the scope of work developed by USAID/Tanzania (Annex I). During the team planning meeting held at the start of the evaluation, USAID/Tanzania checked in with the evaluation team to ensure the methods and evaluation implementation plan met the mission's needs. The team submitted the data collection tools to USAID/Tanzania for review prior to data collection.

## 4. FINDINGS AND CONCLUSIONS

### THE CURRENT OPERATING ENVIRONMENT

#### Tanzania HIV Situation at a Glance<sup>21</sup>

- HIV prevalence among pregnant women: 5.6 percent
- HIV-positive pregnant women giving birth per year: 100,000
- Estimated number of new pediatric HIV infections per year: 14,000
- Estimated number of children (<15 years) living with HIV: 160,000
- Pediatric ART coverage: 26 percent; Adult ART coverage: 68 percent
- HIV prevalence in women 15-49: 6.2 percent
- HIV prevalence in men 15-49: 3.8 percent

In Tanzania, 54.6 percent of all pregnancies each year are from the two zones in which BIPAI has been operating. The Tanzania Demographic and Health Survey (2010) indicates that fertility rates are quite high in these zones compared to others. Such high fertility when coupled with higher unmet need for family planning, high adult HIV prevalence and lower rates of male circumcision results in high numbers and proportions of HIV-exposed and HIV-infected infants and children. An estimated 14,000 children are newly infected with HIV every year nationwide. Of these, 8,581 (61.3 percent) are from these two zones.

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<sup>21</sup> MoHSW, *Antenatal Care Surveillance Report No 5, 2014*; MoHSW and UNICEF, *Final Report of a Rapid Assessment of Pediatric HIV Treatment Service Delivery in Tanzania* (January - May 2014); MoHSW, THMIS 2011-2012.

**Table 3: Estimates of HIV Prevalence in Tanzania, 2014**

Zone/ Location	Region	Estimated number of pregnant women	Antenatal care HIV prevalence	Estimated number of HIV- positive pregnant women	Estimated number of HIV-exposed infants	Estimated number of newly HIV- infected children
Tanzania		1,772,429	5.60%	99,256	99,256	14,000
Lake Zone	Mwanza (including Geita)	183,248	4.20%	7,696	7,696	1,086
	Mara	72,305	4.20%	3,037	3,037	428
	Kagera	100,188	4.60%	4,609	4,609	650
	Shinyanga (including Simiyu)	128,659	5.80%	7,462	7,462	1,053
	Kigoma	87,915	1.30%	1,143	1,143	161
	Tabora	92,951	4.70%	4,369	4,369	616
Southern Highlands Zone	Rukwa (including Katavi)	64,172	8.40%	5,390	5,390	760
	Mbeya	112,774	11.30%	12,743	12,743	1,797
	Ruvuma	56,657	7.40%	4,193	4,193	591
	Iringa (including Njombe)	68,954	14.80%	10,205	10,205	1,439
Total for both zones		967,823	6.3%	60,847	60,847	8,581
Both zones as a proportion of Tanzania total		54.6%		61.3%	61.3%	61.3%

### **EVALUATION QUESTION 1: HOW EFFECTIVE IS THE PROGRAM IN IDENTIFICATION, TESTING AND TREATING HIV INFECTED CHILDREN IN THE LAKE AND SOUTHERN HIGHLANDS ZONES?**

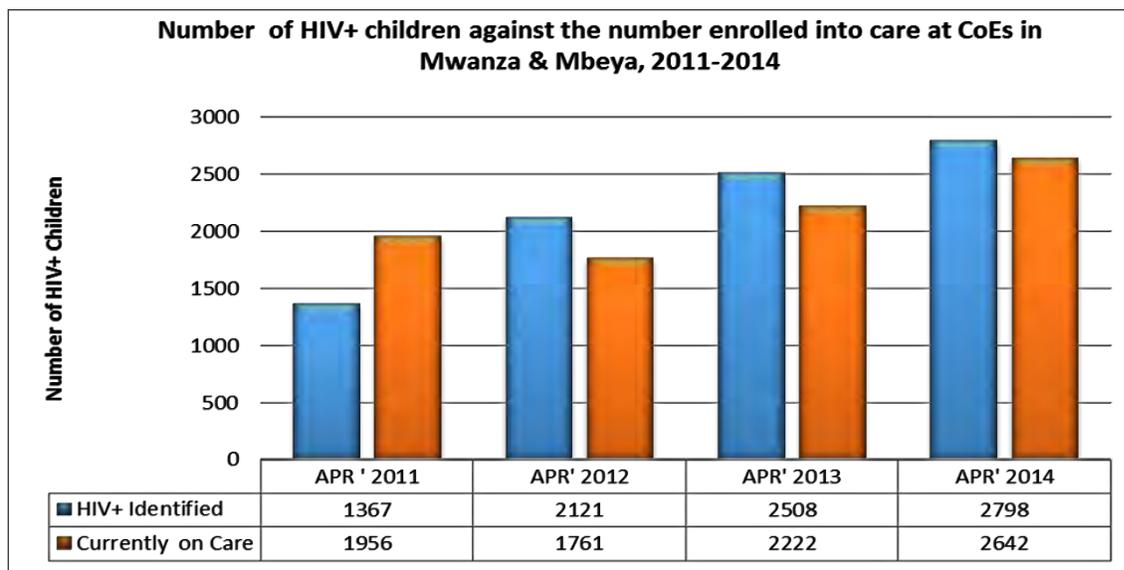
To address this question, the evaluation team assessed the performance of BIPAI’s first two specific aims: “to provide comprehensive, family-centered pediatric HIV/AIDS prevention, care and treatment services,” and “to expand case finding for children who are HIV-positive through strengthened pediatric HIV/AIDS counseling and testing using a family-centered testing model.”

BIPAI uses a Balanced Scorecard system to monitor its performance on services and case-finding. This system is focused on outputs and counts services provided and children tested and counseled. It does not take a public health approach to following the outcomes of cohorts of enrolled children in order to monitor and evaluate the impact of BIPAI services on the target population.

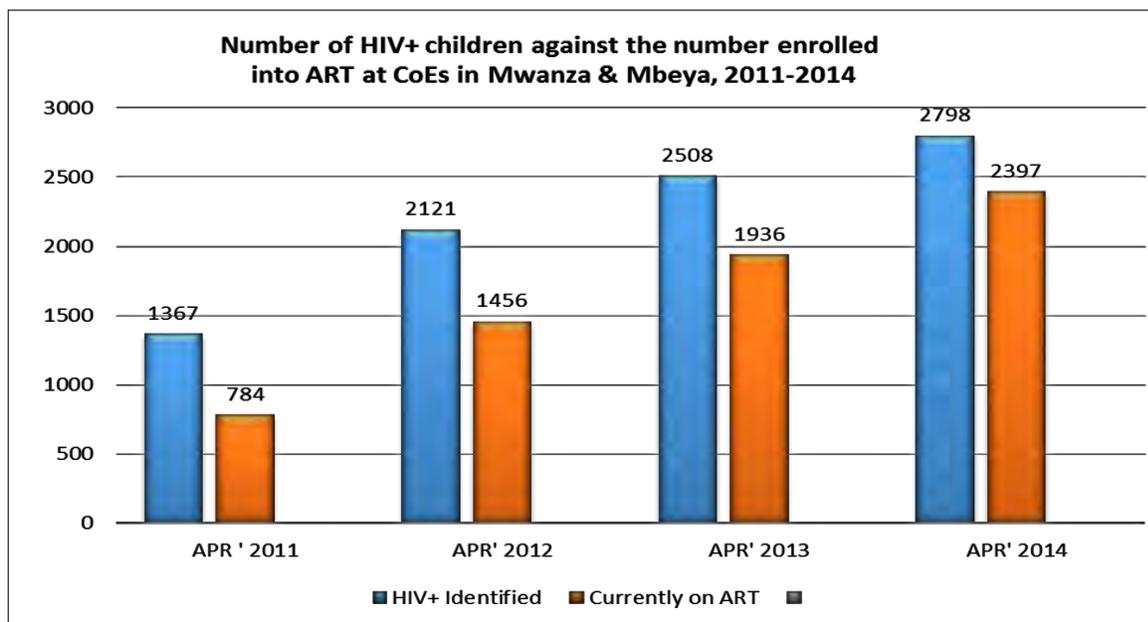
As illustrated in the following two figures, secondary analysis of BIPAI’s CoE service data has shown that the number of HIV-exposed and infected infants and those enrolled into care and

treatment services has been increasing continuously at the CoE and outreach sites in Mbeya and Mwanza. This increase has been attributed in KIIIs to a number of BIPAI's initiatives, which include strengthened provider-initiated testing and counseling at the pediatric wards, malnutrition wards and RCH clinics and through the KYCS campaign, as well as increasing the confidence among trained health care providers who attend HIV-exposed and infected infants and children.

**Figure 2. HIV-positive Children Enrolled in Care, Mwanza and Mbeya 2011-2014**



**Figure 3. HIV-positive Children Enrolled in ART, Mwanza and Mbeya, 2011-2014**



### Achievements specific to the Lake Zone

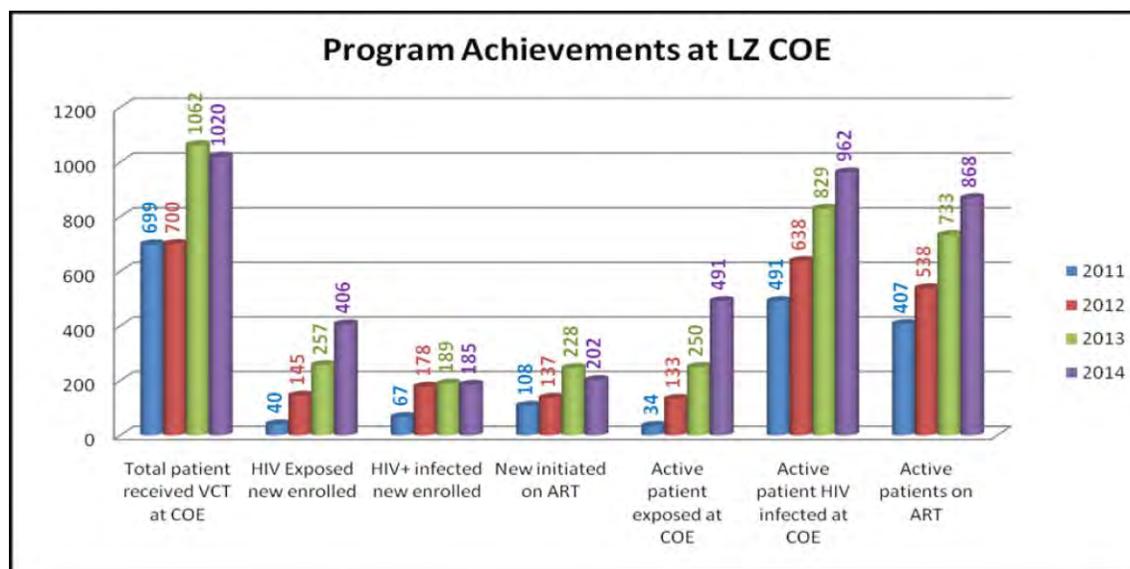
Qualitative data from KIIIs and FGDs, together with BIPAI service statistics, indicate that a combination of initiatives, including KYCS and provider-initiated testing and counseling through

a family-centered approach, has led to increased access to HIV services for children and adults. As illustrated in Figure 4 below, BIPAI service statistics in the Lake Zone indicate that there has been a yearly increase in the number of clients accessing voluntary counseling and testing services, from 699 in 2011 to 1020 in 2014, which is almost a three-fold increase within three years. Likewise, the figure indicates that in the Lake Zone the number of HIV-exposed and HIV-infected children enrolled into HIV care and ART has been increasing over time.

The numbers of children who were retained in HIV care (active on care) and on ART (current on ART) among BIPAI patients enrolled at the Lake Zone CoE have remained relatively high and have been increasing every year. Although this performance evaluation does not include comparative data from non-BIPAI sites, it is conceivable that these results are in part attributable to the quality and satisfaction of the services provided at the CoEs as expressed in comments received during KIIs. Mwanza Lake Zone CoE service data illustrated in Figure 4 indicate that over the period of 2011-2014, the number of active patients increased from 491 in 2011 to 962 in 2014. The service data indicate that for those children currently on ART the trend has been similar, from 407 in 2011 to 868 in 2014.

Figure 4, based on BIPAI Lake Zone service data, indicates that the proportion of children who are currently on ART as a percentage of those who were in HIV care (pre-ART and ART) rose from 82.9 percent in 2011 ( $407/491 \times 100$ ) to 90.2 percent in 2014 ( $868/962 \times 100$ ). This indicates that an increasingly large percentage of children who were identified as HIV-positive were enrolled into care and treatment and started on ART as a result of the BIPAI program.

**Figure 4. BIPAI Program Achievements at the Lake Zone Center of Excellence, 2011-2014**



As indicated in the following table, BIPAI Lake Zone CoE service statistics indicate that the KYCS outreach campaign and provider-initiated testing and counseling services implemented in CoE-supported facilities reached a total of 13,053 individuals with counseling and testing services. Of these, 600 were identified as HIV-positive, translating to an HIV prevalence (for all ages among those influenced by the campaign) of 4.6 percent ( $600/13,053 \times 100$ ). HIV prevalence

was highest among those influenced by the campaign in Geita sites (7.2 percent) and lowest in Kigoma sites (2.1 percent).

**Table 4. Testing for Adults and Children through KYCS at Lake Zone CoE-supported Facilities**

Site	Total tested	Total HIV-positive	HIV prevalence (All ages)	Adults tested	Adults HIV-positive	Adult HIV prevalence
Mwanza	5,170	290	5.6%	1,662	172	10.3%
Mara	4,002	175	4.4%	1,271	110	8.7%
Kigoma	1,178	25	2.1%	382	17	4.5%
Kagera	796	24	3.0%	500	16	3.2%
Geita	432	31	7.2%	82	14	17.1%
Tabora	717	24	3.3%	156	11	7.1%
Shinyanga	758	31	4.1%	214	5	2.3%
<b>Total</b>	<b>13,053</b>	<b>600</b>	<b>4.6%</b>	<b>4,267</b>	<b>345</b>	<b>8.1%</b>

Of the 13,053 clients tested through KYCS campaigns, 4,267 (32.7 percent) were adults (above 15 years of age). Of the adults tested, 345 were identified as HIV-infected (8.1 percent). The highest HIV prevalence in adults was observed in Geita (17.1 percent), followed by Mwanza (10.3 percent) and Mara (8.7 percent), and the lowest was Kagera (3.2 percent). Adult HIV prevalence was significantly higher in all regions as compared to the THMIS 2011/12 data for the same regions except for Shinyanga (7.4 percent) and Kagera (4.8 percent).

There were 8,786 children below 15 years of age who were provided with counseling and testing services during KYCS campaigns, representing 67 percent of total participants ( $8,786/13,053 \times 100 = 67.3$  percent). Of those tested, 326 were exposed to HIV and 255 were found to be HIV-infected. This translates to an overall HIV prevalence of 2.9 percent ( $255/8,786 \times 100$ ). The prevalence was highest for children tested in Geita sites (4.8 percent) and lowest in Kigoma (1.0 percent). As would be expected, there is an observable correlation between HIV prevalence among adults and their children, thus geographical population-based differences in HIV prevalence among adults may be used to prioritize outreach activities aimed at early identification, testing, counseling and initiation of ART in their children.

**Table 5. Testing for Children under 15 through KYCS at Lake Zone CoE-supported Facilities**

Sites	Children tested (under 15 years)	Children HIV-positive	Pediatric HIV prevalence	Exposed infants
Mwanza Sites	3,508	118	3.4%	143
Mara Sites	2,731	65	2.4%	63
Kigoma Sites	796	8	1.0%	9
Kagera Sites	296	8	2.7%	14
Geita Sites	350	17	4.9%	44
Tabora Sites	561	13	2.3%	22
Shinyanga sites	544	26	4.8%	31
<b>TOTAL</b>	<b>8,786</b>	<b>255</b>	<b>2.9%</b>	<b>326</b>

## Achievements specific to the Southern Highlands Zone

In the Southern Highlands Zone, BIPAI service statistics indicate that early identification, testing and enrolment into services for HIV care and treatment have been gradually increasing every year. The number of children counseled and tested at the Mbeya CoE increased from 241 in 2011 and peaked in 2013 when a total of 1,603 accessed HIV testing and counseling services. However, there was a slight decline of the number of children who accessed counseling and testing in 2014 (1,124). Enrolment into HIV care increased from 435 (2011) to 673 (2014), and enrolment into ART increased from 156 (2011) to 382 (2014).

Service statistics from the Mbeya CoE on the number of children retained in HIV care and treatment indicate that the absolute numbers of those actively in care at the Mbeya CoE have been increasing over the life of the project, from 654 (2011) to 2,042 (2014), and for those currently on ART from 528 (2011) to 1,284 (2014). However, unlike in the Lake Zone, where a majority of the clients who were active in HIV care were also receiving ART (82.9 percent in 2011 to 90.2 percent in 2014), the situation is different in the Mbeya CoE, where the proportion of clients who are on ART has been fluctuating from 80.7 percent in 2011 ( $528/654*100$ ) to 59.6 percent in 2012 ( $884/1482*100$ ), and from 67.5 percent in 2013 ( $1142/1691*100$ ) to 62.9 percent in 2014 ( $1284/2042*100$ ).

As indicated in Table 6 below, the Southern Highlands Zone BIPAI CoE service statistics indicate that the KYCS outreach campaign and provider-initiated testing and counseling services implemented in BIPAI CoE-supported facilities reached a total of 16,516 people, which is slightly higher as compared to that in the Lake Zone (13,053), with the majority (13,443 or 81.3 percent) being children compared to 67 percent in the Lake Zone. The access to HIV counseling and testing services has been increasing annually from 744 individuals in 2011 to 5,718 in 2014.

Over the 5-year period of BIPAI Southern Highlands Zone CoE services, there has been an increase in the absolute numbers of clients (adults and children) tested, and the HIV prevalence has been decreasing in all age groups. HIV prevalence in all age groups was the highest in 2011 and has been declining gradually (Table 6). It is very complicated, and beyond the scope of this performance evaluation, to determine the root causes for a decreasing trend in HIV prevalence in a population, but possible reasons that deserve more detailed investigation could involve a decrease in the number of new HIV infections as a result of changes in risk behaviors, a lack of efficiency in the care and treatment program, or both, leading to more deaths among HIV-infected individuals and thus reducing the numerator. Generally, these service statistics results for the population served by BIPAI are quite low compared to THMIS data for the Southern Highlands, which bears the highest burden of HIV in Tanzania. The table below shows the number of clients (disaggregated by age) who accessed BIPAI HIV counseling and testing services at Southern Highlands Zone outreach sites from 2011 to 2014.

The HIV prevalence among populations served by BIPAI in the Southern Highlands was 2.3 percent (all ages), 1.7 percent (under 15 years), and 4.9 percent (15 years and above). This is an interesting finding as none of the regions in this zone had prevalence this low according to data from the THMIS 2011/12, which shows the following regional prevalence data: Njombe (14.8

percent), Iringa (9.2 percent), Mbeya (9.1 percent), Ruvuma (7.0 percent), Rukwa (6.2 percent) and Katavi (5.9 percent).

**Table 6. HIV Testing and Prevalence at Southern Highlands Zone CoE-supported Facilities, 2011-2014**

Year	Total clients tested through KYCS			Total clients tested positive			HIV prevalence		
	Grand Total	<15 Years	15+ Years	<15 Years	15+ Years	All ages	All ages	<15 Years	15+ Years
2011	744	411	333	30	39	69	9.3%	7.3%	11.7%
2012	4,630	3,960	670	110	59	169	3.7%	2.8%	8.8%
2013	5,424	4,485	939	56	24	80	1.5%	1.2%	2.6%
2014	5,718	4,587	1,131	33	28	61	1.1%	0.7%	2.5%
Total	16,516	13,443	3,073	229	150	379	2.3%	1.7%	4.9%

According to quantitative data from BIPAI service statistics and qualitative data from KIs and FGDs, the key success factors for increased identification, testing and enrolment into care and treatment have primarily been due to the following:

- KYCS activities have contributed to increasing identification, testing and referral of infected children in both zones and brought them to care.
- The emphasis on provider-initiated testing and counseling for all children at all entry points (pediatric wards, outpatient departments, RCH, etc.) has contributed to increasing identification of HIV-exposed and HIV-infected children.
- Strengthened outreach services have resulted in:
  - timely initiation of ART through Option B+ for HIV-infected pregnant women and cotrimoxazole prophylaxis for HIV-exposed infants; and
  - increasing early infant diagnosis of HIV-exposed and HIV-infected infants leading to timely initiation of ART.

### **Primary Data from 66 Key Informants Interviewed in 26 Facilities (see Annex III)**

#### **Strengths and Achievements (typical quotes from staff at BIPAI-supported facilities):**

- “Through direct care, training and outreach, BIPAI has increased the early identification, testing and treatment of HIV-exposed and HIV-infected children.”
- “Clinic flow and community demand have been increasing.”
- “Pediatric-focused testing such as KYCS has been successful in increasing case finding.”
- “Community awareness and attitudes toward pediatric testing and treatment have been positively influenced by the program.”
- “Parents did not want to test before because they did not know how they would manage if their child was positive.”
- “The BIPAI family-centered care model has introduced to families a comprehensive approach for HIV and AIDS treatment, care and supportive services in a continuum.”

- “Use of community supporters such as Expert Moms is a good link between the facility and community.”
- “Caregivers reported satisfaction with the BIPAI family-centered care model and services provided by BIPAI and outreach sites.”
- “Outreach sites have made improvements in service delivery such as adding a pediatric HIV clinic day, which didn’t exist before BIPAI’s program.”
- “The quality of care and the breadth of treatment at the CoE far exceed what can be offered at MoHSW sites at the present time, but serves as a model or incentive to which other facilities may aspire.”
- “The Baylor program has been very useful. Baylor has helped the region in many areas because pediatric HIV is complicated. Baylor has increased enrolment in pediatric cases for ART. Baylor has indirectly decreased infant mortality and child mortality rates.”

### **Weaknesses / Challenges:**

- There have been persistent weaknesses in the data quality of the BIPAI M&E system, including double-counting of coverage figures for BIPAI when compared with the coverage of other implementing partners (i.e., Christian Social Services Commission in Mwanza and the Walter Reed program in Mbeya). These have been noted on several occasions during the independent data quality assessments carried out by Macro-DHS, and PEPFAR has provided guidance to the effect that BIPAI should only report service delivery data at the CoEs, while the rest of the sites’ data should be reported by regional implementing partners.
- Implementation of provider-initiated testing and counseling at sites remains challenging due to inconsistent adoption, unreliable supply of test kits and dried blood spot kits and the fact that BIPAI has not reached rural lower-level facilities (dispensaries and health centers).
- Despite the fact that family-centered care at CoEs has enhanced accessibility to HIV counseling and testing services (according to KII data), it remains challenging to accommodate adults at CoEs as they are pediatric centers. Adults identified as HIV-positive are being referred to care and treatment clinics elsewhere, which is contrary to the concept of bringing the whole family to access services in one setting.
- Operationalization of national guidelines is not complete in all of the BIPAI-supported facilities that were visited (especially at lower levels of service delivery).
- Stigma is still a real issue adversely affecting outreach efforts.
- Loss-to-follow-up is complicated and continues to be a challenge.

## **EVALUATION QUESTION NO 2: HOW EFFECTIVE ARE THE HEALTH CARE WORKERS TRAINING PROGRAM AND OUTREACH ACTIVITIES AT THE CENTERS OF EXCELLENCE AND OUTREACH SITES?**

To understand the coverage and the effectiveness of the HCW training component, the evaluators reviewed available data on human resources for health in Tanzania and conducted KIIs with 66 national, regional and district level stakeholders and health care providers at 26

facilities (see Annex III for details). In addition, the evaluation team observed the performance of clinical services by four types of HCWs, including one attachment training session, and reviewed the BIPAI curriculum and reports of HCW training activities.

## **Observations of Clinical Practices by Four HCW Cadres in Four Facilities**

### ***Physical Conditions***

Three of the health centers were equipped with a sink with running water, soap and hand sanitizer in the treatment area. The other center was not appropriately equipped. Gloves were available in the treatment area of two of the four facilities. Visual and auditory privacy for the visit was provided in all facilities. Only one of the facilities had sharps containers available in the treatment areas used for the visit. All facilities had patient records kept in a secure and confidential manner.

### ***Clinical Practices***

The evaluators witnessed clinical visits (examinations, not counseling sessions) of patients with providers. The MoHSW could not provide national level standard operating procedures for clinical practices, so the team could not assess whether a lab coat and gloves should be worn for clinical examinations in accordance with those procedures. However, that should be a standard procedure.

Four providers of different cadres and levels of training were observed. Three of those providers actually touched the client. Two of them washed their hands prior to the interaction and used fresh gloves. The other two did neither. A laboratory coat or apron was worn by three of the four providers. Three of the four facilities had accessible copies of the National Guidelines for PMTCT, early infant diagnosis and HIV available at the facility and seen by researchers. Standard operating procedures for PMTCT, early infant diagnosis, HIV and post-exposure prophylaxis were posted and seen by researchers in three of the four facilities.

### ***Patient Interactions***

In all observations, providers demonstrated positive patient interaction skills. All introduced themselves to the client and appeared attentive to the client. All clients demonstrated positive understanding of treatment options.

### ***Limitations***

Because of limited time and other resources, the number, types and geographic locations of clinical sites visited for this evaluation were too few for the team to carry out any meaningful statistical analysis. While observations were planned for all sites visited during the field visits, not all sites were providing pediatric HIV care on the day of the visit. As a result, only four HCWs of four different cadres (levels of education and training) were observed in four different types of facilities. Accordingly, the findings must be considered as illustrative, not typical, and cannot be generalized to other BIPAI-supported sites.

It was not possible to observe the performance of clinical services at sites that are not supported by BIPAI. Therefore, no comparison in clinical practice could be made between BIPAI-supported and non-supported sites. Finally, because of high turnover in all cadres of HCWs and despite the fact that the facilities visited were those closest to the two CoEs, the

providers observed at the health center and district hospital had not attended the BIPAI attachment program.

Although a statistical analysis was not carried out because of the purposive selection of a small number of sites and participants, the evaluation established that Baylor employed a number of apparently effective outreach programs based in facilities and communities, namely: KYCS, Peer Mothers / Expert Mothers, and Teen Clubs. Other mobilization interventions such as radio announcements, community events, educational workshops for community leaders and Most Vulnerable Children's Committees were implemented.

### **The Quality of Pediatric HIV Services and Health Care Worker Distribution in Tanzania**

According to the 2014 UNAIDS *Gap Report*, there has been a 48 percent reduction in the rate of new HIV infections among children in Tanzania between 2009 and 2013, but the 2010 MoHSW *Baseline Survey on the Quality of Pediatric Care in Tanzania* and the 2014 MoHSW-UNICEF *Rapid Assessment of Pediatric HIV Treatment Service Delivery in Tanzania* indicate that there continue to be widespread weaknesses and disparities in the availability, performance and quality of such services. Among the root causes for their persistence is the fact that the density (number per 10,000 population) of physicians and nurses in Tanzania is about one-fifth of that in other countries in Africa,<sup>22</sup> and there are very few pediatric specialists in the country (more than 40 percent of regions in Tanzania do not have a pediatrician).<sup>23</sup>

In 2013 there were 6,876 health facilities in the country: 5,913 dispensaries, 711 health centers, 219 district-level hospitals, 25 regional referral hospitals, and eight national, zonal and specialized hospitals. According to the new MoHSW staffing levels guideline (2014),<sup>24</sup> the minimum number of HCWs required to provide quality health services in these facilities is 145,454. The actual number of HCWs available is 63,447, a shortage of 82,007 or 56.38 percent.

As illustrated in the figure below, among member nations in the African Region of the World Health Organization (WHO/AFRO), Tanzania continues to have a relatively weak health workforce in terms of the number, distribution and types of HCWs. The WHO/Tanzania web site indicates that as of 2010, there were only about 0.4 medical doctors per 10,000 population or about 2,000 in all of Tanzania (using the current population estimate of about 50 million).<sup>25</sup>

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<sup>22</sup> World Health Organization. *United Republic of Tanzania Health Statistics Profile 2010*. Available at: [http://www.who.int/profiles\\_information/images/aa/Tanzania-Statistical\\_Overview.pdf?ua=1&ua=1](http://www.who.int/profiles_information/images/aa/Tanzania-Statistical_Overview.pdf?ua=1&ua=1) (accessed 10 March 2015).

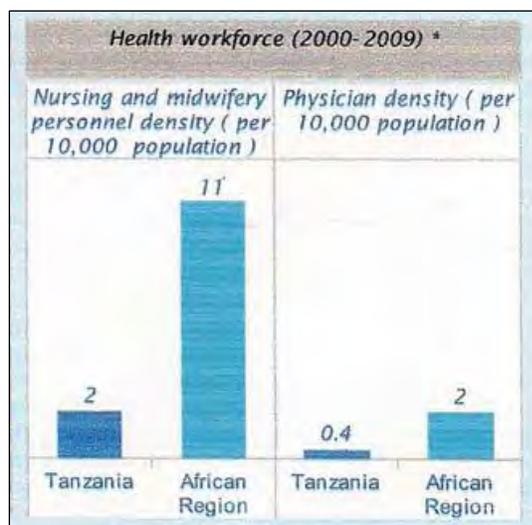
<sup>23</sup> Personal communication based on the experience of Dr. Sylvester Nandi, the team's evaluation specialist.

<sup>24</sup> United Republic of Tanzania Ministry of Health and Social Welfare. *Staffing Levels for MoHSW Departments, Health Service Facilities, Health Training Institutions and Agencies 2014-2019*. September 2014.

<sup>25</sup> U.S. Bureau of the Census International Database:

<https://www.census.gov/population/international/data/idb/region.php?N=%20Results%20&T=I3&A=separate&RT=0&Y=2015&R=-I&C=TZ> (accessed 9 March 2015).

**Figure 5. Density of Health Care Workers in Tanzania Compared to Other African Nations<sup>26</sup>**

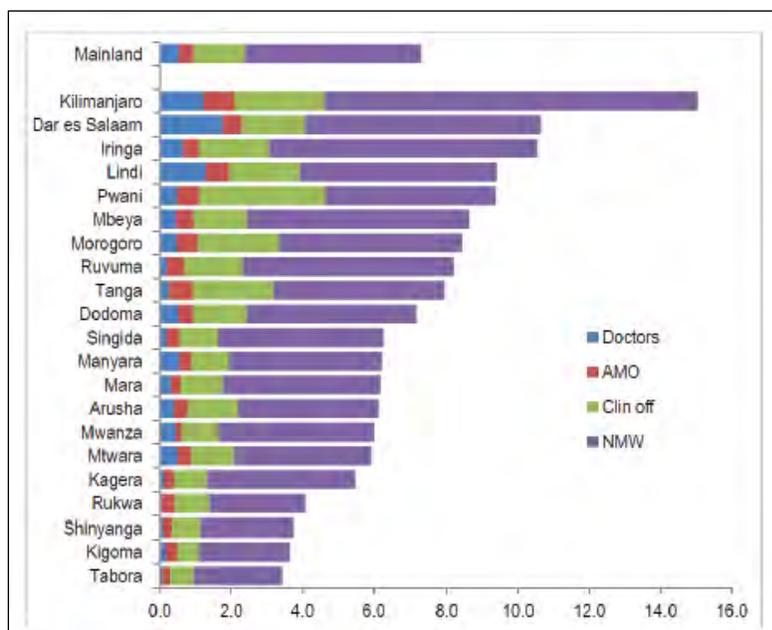


In 2013, MoHSW published more recent denominator data on the number and distribution of physicians and other HCWs in Tanzania, ranging from 4 per 10,000 population to 10 per 10,000 population (Figure 6),<sup>27</sup> but because the distribution by specialty for physicians is not yet available, it is difficult to determine with confidence the extent to which BIPAI has provided training to those in need. There are substantial disparities in the regional distribution of the existing workforce, and the situation is worst in dispensaries because many staff prefer to work in urban rather than rural areas due to the relatively poor working and living environments in rural areas. The regions of Kilimanjaro, Dar es Salaam, Iringa, Lindi and Pwani are better off compared to regions such as Kagera, Rukwa, Tabora, Kigoma and Shinyanga.

<sup>26</sup> WHO/Tanzania web site: [http://www.who.afro.who.int/profiles\\_information/images/a/aa/Tanzania-Statistical\\_Overview.pdf?ua=1](http://www.who.afro.who.int/profiles_information/images/a/aa/Tanzania-Statistical_Overview.pdf?ua=1) (accessed 9 March 2015).

<sup>27</sup> United Republic of Tanzania Ministry of Health and Social Welfare. *Health Sector Strategic Plan III Midterm Evaluation*. Dar es Salaam, 2013 (Figure 4, page 13).

**Figure 6. Health Care Worker Density by Region and Cadre**



BIPAI has been extensively involved in training HCWs in pediatric HIV testing, care and treatment in Tanzania. Essential aspects of the program’s work from the national level (developing guidelines, standard operating procedures and training curriculum materials) to the local level (pre-service, post-graduate, continuing medical education, attachment, mentoring and ad hoc materials for seminars) have helped strengthen the health care system and improved care delivery in the country. With more than 7,000 HCWs trained in pediatric HIV diagnosis, treatment and care by BIPAI from 2011-2014, the program has become a major contributor to the education and on-the-job training of HCWs in Tanzania.

A regional medical officer familiar with the program stated, “Baylor has increased the capacity of HCWs by training, continuous medical education, lectures, mentoring, clinical attachment and supportive supervision.”

In the following tables, highlighted in yellow are the percent training coverage levels for various cadres, which have been calculated by BIPAI. In evaluating these coverage results, it is important to keep in mind that the region-specific denominator data (i.e., the target population in each HCW cadre that requires this training) are only estimates. The accuracy in each individual region and for each type of cadre depends on a number of factors for which the levels and ranges of uncertainty are unknown. The numerator data on the number of HCWs of various cadres in each region who received BIPAI training (highlighted in blue) are a matter of record from BIPAI’s training records. Therefore, while the coverage levels for the full package of BIPAI training appear to be relatively low (and in some cases more than 100 percent) in some of the regions where BIPAI has been working, it will be very important going forward to track the actual denominators (target populations) and coverage levels in a modified M&E approach, such as the kind of approach the evaluation team has discussed with Mr. Moses Chodota, the M&E coordinator for BIPAI.

**Table 7. Clinical Attachment Training, Both Zones**

<b>Other Training Activities, Lake Zone (2012/2013 and 2013/14)</b>																	
<b>Lake Zone (LZ) Regions</b>	<b>Pop'n (2012 census)</b>	<b>Physicians (MD)</b>				<b>Assistant Medical Officers (AMO)</b>				<b>Clinical Officers (CO)</b>				<b>Nurse Midwives (NMW)</b>			
		HR per 10K pop*	Estim. No. MDs	Baylor Trained MDs	Estim. Baylor Cover MDs	HR per 10K pop*	Estim. No. AMOs	Baylor Trained AMOs	Estim. Baylor Cover AMOs	HR per 10K pop*	Estim. No. COs	Baylor Trained COs	Estim. Baylor Cover COs	HR per 10K pop*	Estim. No. NMWs	Baylor Trained NMWs	Estim. Baylor Cover NMWs
<b>DIDACTIC TRAINING - LAKE ZONE</b>																	
Mwanza	2,772,509	0.2	55	19	35%	0.1	28	43	155%	0.5	139	52	38%	2.19	607	201	33%
Shinyanga	1,534,808	0.07	11	5	45%	0.1	15	4	26%	0.4	61	17	28%	1.3	200	20	10%
Mara	1,743,830	0.15	26	7	27%	0.1	17	20	115%	0.6	105	27	26%	2.2	384	90	23%
Kagera	2,458,023	0.08	20	3	15%	0.11	27	5	18%	0.45	111	5	5%	2.05	504	67	13%
Kigoma	2,127,930	0.1	21	8	38%	0.15	32	9	28%	0.3	64	7	11%	1.26	268	48	18%
Tabora	2,291,623	0.05	11	3	27%	0.1	23	9	39%	0.3	69	12	17%	1.22	280	38	14%
<b>Total for LZ</b>			<b>144</b>	<b>45</b>	<b>31%</b>		<b>142</b>	<b>90</b>	<b>63%</b>		<b>549</b>	<b>120</b>	<b>22%</b>		<b>2243</b>	<b>464</b>	<b>21%</b>
<b>PHYSICIAN-INITIATED TESTING &amp; COUNSELING (PITC) TRAINING - LAKE ZONE</b>																	
Mwanza	2,772,509	0.2	55	1	2%	0.1	28	2	7%	0.5	139	3	2%	2.19	607	15	2%
Shinyanga	1,534,808	0.07	11	0	0	0.1	15	0	0	0.4	61	0	0	1.3	200	0	0%
Mara	1,743,830	0.15	26	0	0	0.1	17	0	0	0.6	105	0	0	2.2	384	0	0%
Kagera	2,458,023	0.08	20	0	0	0.11	27	0	0	0.45	111	0	0	2.05	504	0	0%
Kigoma	2,127,930	0.1	21	0	0	0.15	32	0	0	0.3	64	0	0	1.26	268	0	0%
Tabora	2,291,623	0.05	11	0	0	0.1	23	0	0	0.3	69	0	0	1.22	280	0	0%
<b>Total for LZ</b>			<b>144</b>	<b>1</b>	<b>0.7%</b>		<b>142</b>	<b>2</b>	<b>1%</b>		<b>549</b>	<b>3</b>	<b>0.5%</b>		<b>2243</b>	<b>15</b>	<b>1%</b>

**Table 8. Other Training Activities, Southern Highlands Zone**

*Other Training Activities, Southern Highlands Zone (2012/2013 and 2013/14)*

SHZ Regions	Pop'n (2012 census)	Physicians (MD)				Assistant Medical Officers (AMO)				Clinical Officers (CO)				Nurse Midwives (NMW)			
		HR per 10K pop. *	Estim. No. MDs	Baylor Trained MDs	Estim. Baylor Cover MDs	HR per 10K pop. *	Estim. No. AMOs	Baylor Trained AMOs	Estim. Baylor Cover AMOs	HR per 10K pop. *	Estim. No. COs	Baylor Trained COs	Estim. Baylor Cover COs	HR per 10K pop. *	Estim. No. NMWs	Baylor Trained NMWs	Estim. Baylor Cover NMWs
<b>DIDACTIC TRAINING - SOUTHERN HIGHLANDS ZONE</b>																	
Mbeya	2,707,410	0.2	54	93	172%	0.2	54	134	247%	0.7	190	193	102%	3.1	839	569	68%
Ruvuma	1,376,891	0.1	14	1	7%	0.25	34	0	0%	0.82	113	3	3%	2.9	399	179	45%
Rukwa**	1,569,143	0.05	8	5	63%	0.15	24	0	0%	0.5	78	3	4%	1.31	206	30	15%
Iringa***	1,643,335	0.4	66	1	2%	0.2	33	9	27%	1	164	0	0%	3.7	608	34	6%
<b>Total for SHZ</b>			<b>142</b>	<b>100</b>	<b>70%</b>		<b>145</b>	<b>143</b>	<b>99%</b>		<b>545</b>	<b>199</b>	<b>37%</b>		<b>2052</b>	<b>812</b>	<b>40%</b>
<b>PEDIATRIC ART TRAINING - SOUTHERN HIGHLANDS ZONE</b>																	
Mbeya	2,707,410	0.2	54	0	0%	0.2	54	14	26%	0.7	190	10	5%	3.1	839	4	0%
Ruvuma	1,376,891	0.1	14	1	7%	0.25	34	6	17%	0.82	113	18	16%	2.9	399	21	5%
Rukwa**	1,569,143	0.05	8	0	0%	0.15	24	0	0%	0.5	78	0	0%	1.31	206	0	0%
Iringa***	1,643,335	0.4	66	0	0%	0.2	33	0	0%	1	164	0	0%	3.7	608	0	0%
<b>Total SHZ</b>			<b>142</b>	<b>1</b>	<b>0.7%</b>		<b>145</b>	<b>20</b>	<b>14%</b>		<b>545</b>	<b>28</b>	<b>5%</b>		<b>2052</b>	<b>25</b>	<b>1%</b>
<b>ADVANCED PEDIATRIC ART TRAINING - SOUTHERN HIGHLANDS ZONE</b>																	
Mbeya	2,707,410	0.2	54	1	2%	0.2	54	6	11%	0.7	190	5	3%	3.1	839	12	1%
Ruvuma	1,376,891	0.1	14	3	21%	0.25	34	8	23%	0.82	113	6	5%	2.9	399	12	3%
Rukwa**	1,569,143	0.05	8	0	0%	0.15	24	2	8%	0.5	78	3	4%	1.31	206	12	6%
Iringa***	1,643,335	0.4	66	0	0%	0.2	33	0	0%	1	164	0	0%	3.7	608	0	0%
<b>Total SHZ</b>			<b>142</b>	<b>4</b>	<b>3%</b>		<b>145</b>	<b>16</b>	<b>11%</b>		<b>545</b>	<b>14</b>	<b>3%</b>		<b>2052</b>	<b>36</b>	<b>2%</b>
<b>PHYSICIAN-INITIATED TESTING &amp; COUNSELING (PITC) TRAINING - SOUTHERN HIGHLANDS ZONE</b>																	
Mbeya	2,707,410	0.2	54	0	0%	0.2	54	2	4%	0.7	190	16	8%	3.1	839	32	4%
Ruvuma	1,376,891	0.1	14	0	0%	0.25	34	0	0%	0.82	113	0	0%	2.9	399	0	0%
Rukwa**	1,569,143	0.05	8	0	0%	0.15	24	0	0%	0.5	78	0	0%	1.31	206	0	0%
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<b>Total SHZ</b>			<b>142</b>	<b>0</b>	<b>0%</b>		<b>145</b>	<b>3</b>	<b>2%</b>		<b>545</b>	<b>28</b>	<b>5%</b>		<b>2052</b>	<b>97</b>	<b>5%</b>

\* HCWs per 10,000 pop'n by regions (MoHSW Human Resource for Health & Social Welfare Strategic Plan, 2014-2019)

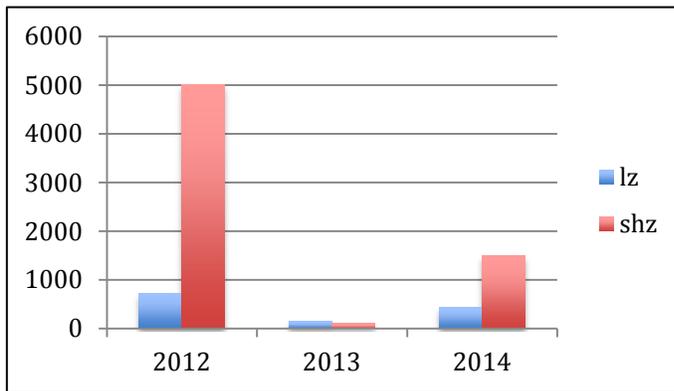
\*\* Combines Rukwa and Katavi

\*\*\* Combines Iringa and Njombe

**Table 9. Other Training Activities, Lake Zone**

<b>Other Training Activities, Lake Zone (2012/2013 and 2013/14)</b>																	
<b>Lake Zone (LZ) Regions</b>	<b>Pop'n (2012 census)</b>	<b>Physicians (MD)</b>				<b>Assistant Medical Officers (AMO)</b>				<b>Clinical Officers (CO)</b>				<b>Nurse Midwives (NMW)</b>			
		HR per 10K pop*	Estim. No. MDs	Baylor Trained MDs	Estim. Baylor Cover MDs	HR per 10K pop*	Estim. No. AMOs	Baylor Trained AMOs	Estim. Baylor Cover AMOs	HR per 10K pop*	Estim. No. COs	Baylor Trained COs	Estim. Baylor Cover COs	HR per 10K pop*	Estim. No. NMWs	Baylor Trained NMWs	Estim. Baylor Cover NMWs
<b>DIDACTIC TRAINING - LAKE ZONE</b>																	
Mwanza	2,772,509	0.2	55	19	35%	0.1	28	43	155%	0.5	139	52	38%	2.19	607	201	33%
Shinyanga	1,534,808	0.07	11	5	45%	0.1	15	4	26%	0.4	61	17	28%	1.3	200	20	10%
Mara	1,743,830	0.15	26	7	27%	0.1	17	20	115%	0.6	105	27	26%	2.2	384	90	23%
Kagera	2,458,023	0.08	20	3	15%	0.11	27	5	18%	0.45	111	5	5%	2.05	504	67	13%
Kigoma	2,127,930	0.1	21	8	38%	0.15	32	9	28%	0.3	64	7	11%	1.26	268	48	18%
Tabora	2,291,623	0.05	11	3	27%	0.1	23	9	39%	0.3	69	12	17%	1.22	280	38	14%
<b>Total for LZ</b>			144	45	31%		142	90	63%		549	120	22%		2243	464	21%
<b>PHYSICIAN-INITIATED TESTING &amp; COUNSELING (PITC) TRAINING - LAKE ZONE</b>																	
Mwanza	2,772,509	0.2	55	1	2%	0.1	28	2	7%	0.5	139	3	2%	2.19	607	15	2%
Shinyanga	1,534,808	0.07	11	0	0	0.1	15	0	0	0.4	61	0	0	1.3	200	0	0%
Mara	1,743,830	0.15	26	0	0	0.1	17	0	0	0.6	105	0	0	2.2	384	0	0%
Kagera	2,458,023	0.08	20	0	0	0.11	27	0	0	0.45	111	0	0	2.05	504	0	0%
Kigoma	2,127,930	0.1	21	0	0	0.15	32	0	0	0.3	64	0	0	1.26	268	0	0%
Tabora	2,291,623	0.05	11	0	0	0.1	23	0	0	0.3	69	0	0	1.22	280	0	0%
<b>Total for LZ</b>			144	1	0.7%		142	2	1%		549	3	0.5%		2243	15	1%

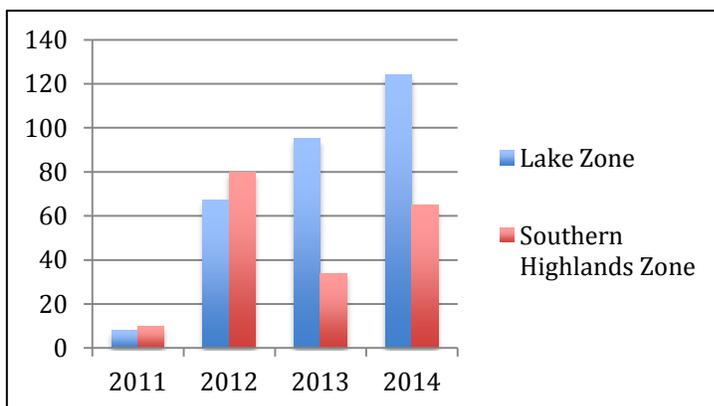
**Figure 7. Health Care Workers Trained in Didactic Trainings by Zone**



During the 2-year period of construction (2009-2011) of the CoE in Mwanza on the campus of the Bugando Consultant Hospital and the CoE in Mbeya on the campus of the Mbeya Regional Hospital, the hands-on training for HCWs started with on-site mentorship and has grown to comprise a program that includes two weeks of case-based didactic training and clinical practice attachments followed by regular site visits for mentoring. This program is a novel learning model in the Tanzanian setting. Respondents from national to local levels widely reported it to be a successful adult learning model with a positive impact on clinical practices. Participants appreciated the ability to work side-by-side with the BIPAI staff and focus on real clinical issues they faced at that site.

Since 2011, 483 HCWs including nurses, clinicians, counselors and other staff have participated in the attachment program. Consistent data were not available on the numbers of each cadre that participated. Follow-up training and mentoring have been conducted at regular intervals at the BIPAI outreach sites, although details of follow-up on performance, retention, career development and competencies have not been tracked regularly for analysis.

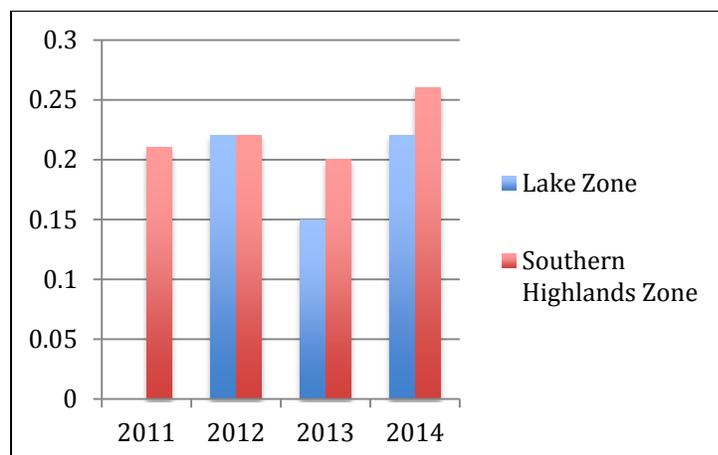
**Figure 8. Health Care Workers Trained in BIPAI Attachment Program**



In interviews, all respondents trained by BIPAI reported increases in knowledge and confidence to treat HIV-positive pediatric patients. Stakeholders and implementing partners regularly send their HCWs for training at the BIPAI CoEs. As part of the attachment program, respondents complete pre and post-tests. Figure 9 illustrates the overall increases in pre and post-test scores.

A clinical officer reported, “Before training, I was really nervous in attending pediatric HIV cases, but now I know for sure what services they want and I feel very confident to attend pediatric cases.”

**Figure 9. Effectiveness of clinical attachment: Percent change in pre- and post-training tests**



While they are on-site for mentoring, the BIPAI staff routinely train other clinical staff on issues related to pediatric HIV care. The number of staff trained in this manner has not been quantified. However, when interviewed these staff were able to recall training topics and reported them to be useful to their daily work.

The BIPAI training curriculum is in line with Tanzanian national guidelines. Respondents of varying cadres expressed satisfaction with the comprehensiveness of the training curriculum.

All attachment participants receive a “Pediatric HIV Handbook” including clinical tools for pediatric care in general, specific HIV-related care and patient and caregiver education. It is intended for this set of tools to be available at the clinical site. These tools were widely reported as comprehensive and simple to use by clinicians. Observers found the tools on site and in use at several sites visited. BIPAI educational resources such as the HIV curriculum<sup>28</sup> and the adherence curriculum<sup>29</sup> are regularly updated in public domain in accessible web-based formats.

BIPAI training extends beyond usual HIV care to advocacy and training around the principles of family-centered care. Several informants reported that the family-centered care model of using the HIV-exposed or infected child as the index case for the whole family had been adopted at their workplace. The model also includes expanded services for the child and family under one roof. While none of the MoHSW respondents have reported being able to offer the breadth of those services at their workplaces due to a lack of qualified human resources and physical

<sup>28</sup> BIPAI web site: <http://www.bipai.org/HIV-curriculum/> (accessed 9 March 2015).

<sup>29</sup> BIPAI web site: <http://www.bipai.org/Adherence-Curriculum/> (accessed 9 March 2015).

space, several reported that they were striving to offer modified aspects of the services. Respondents also reported the BIPAI training influenced other clinical flow practices such as the institution of pediatric HIV clinic days. Several clinicians reported a desire for more training and refresher courses from BIPAI.

### **Effectiveness of the BIPAI Outreach Programs**

The evaluation team learned that BIPAI has implemented the following types of outreach programs to generate demand for its services and provide psychosocial support to teenagers infected with HIV: Vijana Super Groups, KYCS campaigns, Expert/Peer Mothers, and Teen Clubs. The evaluation team inquired about the process leading to the development of the outreach programs and the primary audiences that were involved in the process. Responses from the BIPAI teams both in Mwanza and Mbeya revealed that no systematic formative research had been conducted.

The team learned that the Peer/Expert Mothers program was adapted from Mother to Mother programs, while the other programs were developed as needed. According to the BIPAI director of community liaison at the Mwanza CoE, "In order to come up with messages and outreach activities we brainstormed as a team in the office and considered the information that we had – no formative research or assessments were done." The rest of the programs were not designed or linked to a BCC theory, and members of the target audiences were not involved in the development of the programs, nor were the programs pretested with these audiences.

A total of 19 FGDs were conducted among women who are caregivers, village leaders, and adolescents to obtain an understanding of facilitators and barriers regarding the timely identification, HIV counseling and testing and initiation of ART for infants who are HIV-infected. The FGDs also addressed community perceptions and attitudes towards HIV-testing for children as well as community responses to the efforts of BIPAI to educate and mobilize families on diagnosis, treatment and care for HIV-infected children.

Although the team was told that a Vijana Super Group theater-style outreach intervention had been implemented by Baylor, FGD participants were not familiar with this intervention program. This discrepancy may have been a result of limitations in the evaluation design caused by the required use of a purposively selected convenience sample of sites that were visited. During FGDs and KIIs, the team was not able to discern a clear role for Most Vulnerable Children's Committees, perhaps a result of the above-mentioned design limitation. On the basis of qualitative data from FGDs and KIIs, it was clear that community awareness and attitudes toward pediatric HIV testing, treatment and care have been positively influenced by Baylor's outreach programs.

### **Know Your Child's Status (KYCS)**

KYCS is a facility-based outreach program implemented to create demand for infant HIV-testing. When FGD participants were asked if they had ever heard of the program, responses varied from no knowledge of the program, to having heard of it, to knowing what it is. None of the respondents at the community level knew who had initiated the KYCS program, or who had been implementing it. A frequently heard response was: "We have seen the promotions but we don't know if the campaign was initiated by Baylor." Nevertheless, when asked "what were

some of the ways through which HIV treatment and care information had been provided to community members in the past year?" most of the FGD respondents indicated that they "got most of this kind of information from KYCS and from Expert Mothers." In general, the community participants had a basic understanding about the KYCS program. They obtained their knowledge about the program through committees that were formed to educate and sensitize the community in categories such as breastfeeding, HIV-testing, ART and related matters, and they also got information through various media and at public rallies.

### **Expert/Peer Mothers**

Baylor has trained HIV-positive women who are called Expert Mothers or Peer Mothers to conduct education and sensitization at facilities and in the community. The Mwanza CoE has employed Expert Mothers who are based there on a full-time basis. Several FGD participants stated that Expert Mothers are seen to be a positive role model in their community, in part because of their positive HIV status and in part because some of them have had children who were born HIV-negative. One FGD respondent in Nyamagana stated that making positive changes in the health-seeking behavior of HIV-positive women "has been made easier because of the testimony given from Expert Mothers who are also HIV-positive and they still bore children and have living children who are HIV-negative." Baylor's use of community supporters such as Expert Mothers functioned as a good link between the facility and community, as was opined by one village leader FGD participant in Nyamagana: "Nowadays the community has the understanding of HIV-testing because of the promotions and education provided in the community by the home-based care people and the Expert Mothers." Despite the apparent general success of community outreach provided by peer mothers, some community members regard them as "free masons" and do not accept them. For this reason, the Peer Mothers sometimes are chased away from the community.

### **Teen Clubs**

The 2013 UNICEF *Global Stocktaking Report*<sup>30</sup> makes it clear that adolescents as well as children are underserved with respect to reducing risks, early identification, diagnosis, treatment and care for HIV/AIDS. In response, Baylor's Teen Clubs are an outreach program targeting HIV-infected adolescents. Baylor provides psychosocial support and counseling, health education, treatment and adherence counseling for adolescents. Adolescent FGD respondents in both Mbeya and Mwanza reported that the Teen Club had contributed to increasing their knowledge on health-seeking behaviors, because after participating, they felt confident to manage their medication and they can now protect others and themselves without putting anyone at risk of HIV infection. One adolescent in Mwanza stated that "Teen Club has changed my life; now I understand well my health condition and I can't spread it to others."

The evaluation findings show that Baylor's work with teens is providing valuable resources for them and helping them to acquire coping skills and improve their knowledge on the importance of adherence to medication. Responses from most of the teenagers indicated that they perceived the CoE to be a safe place for them to congregate and share their concerns with each other.

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<sup>30</sup> [http://www.unicef.org/publications/files/Children\\_and\\_AIDS\\_Sixth\\_Stocktaking\\_Report\\_EN.pdf](http://www.unicef.org/publications/files/Children_and_AIDS_Sixth_Stocktaking_Report_EN.pdf) (accessed 9 March 2015).

The CoE is said to be the only place where they felt comfortable to discuss their HIV status without fear of stigmatization or discrimination.

One Teen Club participant in Mbeya stated that: "It was hard from the start to take care of my health. I never liked to take medications and I felt so abandoned. My parents both died from HIV and other family members did not show any support, so I felt that living had no meaning. But now that has changed because when I meet with my fellow youth here at the clinic in the Teen Club I feel hopeful and I started caring about my health and adhering to my ARVs (anti-retroviral medications)."

Participants in the adolescent FGDs were asked to describe their interaction with healthcare providers at the CoE. One respondent stated that: "Doctors as well as other health workers here have been more like friends, and this makes it easier for us to tell what we are experiencing because we see them as people we can trust, and so we can be confident as if talking to a friend." All Teen Club participants agreed that they have good interaction with BIPAI healthcare providers. In general, all respondents felt the Baylor staff understood their needs as adolescents.

Typical responses from adolescents in Mbeya were:

- "Here there is a very friendly interaction between us and healthcare providers; they care about our situation and make us feel like we are their children. I get joy and hope whenever I come here for clinic. We talk, we laugh, and they educate us and counsel us about how to live a healthy and happy life."
- "They teach us to use the medicines in a good manner, they advise us on how to eat nutritional foods and fruits, and they are not only doctors but also our friends."

Despite most teenagers being happy and satisfied with the Teen Club, there are some who felt that Baylor has not prepared them adequately for life after secondary school. Some feel they do not have the skills to take care of themselves, stating that there is a need for Baylor to help prepare them for when they graduate. A typical statement of this kind came from an adolescent in Mbeya:

"I would like Teen Club to provide us with skills on how we can face life after school as most of us are still in school for now, but there is a challenge with employment so Teen Club could help prepare us to become self-employed as entrepreneurs by providing working skills in different working aspects while we are still at school. Now, these skills are provided only to those youths who are not in school."

### **Timely Pediatric HIV-Testing**

Focus group facilitators asked participants what would motivate them to take their infant for testing. Participants felt there was now a reason for taking children for testing, because now something can be done.

A village leader in Mbeya stated that, "In the past there were no options and people felt there was no need to test if nothing could be done for the child." Another village leader in Mwanza stated his opinion this way: "People are more afraid to get sick with malaria than HIV as with HIV you might live 20 years, while malaria can take your life in a minute." The community

members now see the benefits of testing children, as expressed by one respondent, "First is for the care of the child – if you test him earlier you will know exactly what the problems are so that the child will live in a better environment."

Increased knowledge among pregnant women empowers them to get tested while they are pregnant and when they give birth, and their infant is tested within a month after birth at Baylor. Before they received messages from Baylor, they did not see the need to get tested, or to have their infants tested. Another motivation for testing infants is spousal involvement in care. The community sees spouses as facilitators for HIV testing for both adults and infants. A pregnant woman will be more likely to seek HIV testing if she has the understanding and support of her spouse.

Gender-based violence was mentioned as a barrier to seeking timely pediatric HIV-testing. It was reported that women have been divorced or beaten by their spouses for testing or disclosing their status. If her spouse is not supportive, a wife is unlikely to go for HIV testing while pregnant, and once she knows her status, she may not disclose it. In a KII with a clinician in Nyamagana, it was reported that, "Some women end up being divorced by their spouses once they share their HIV status."

Other respondents reported that sometimes results are not given in a timely manner and, as a result, women become discouraged about testing. Lack of knowledge and lack of familiarity with counseling methods suitable for children also appeared to be barriers to pediatric HIV testing.

### **Stigma and Discrimination**

Stigma is still prevalent and an issue that adversely affects early infant diagnosis, care and outreach efforts and the initiation, adherence and effectiveness of treatment. Findings from FGDs with village leaders indicated that they did not perceive stigma to be a problem. However, findings from FGDs with caregivers and adolescents show that stigma and discrimination is still prevalent. An adolescent in Mbeya stated that, "The community still stigmatizes us and sees us as being different from other youths. They consider us to be people who have no future and can die anytime. Some do not even provide us with education saying it is a waste of money." Further, our FGD findings revealed that parents who did not disclose the HIV status of their child to their other children after the diagnosis did so because they "did not know how to discuss this and they did not want their child to be stigmatized." Other parents who did not disclose their HIV status with their children after diagnosis did so because they "preferred that the children get to know about their status at the CoE."

Since stigmatization and discrimination can adversely affect attitudes and behaviors toward those infected with HIV, as well as adversely influence the health outcomes of HIV-infected children and caregivers, there is a need for Baylor to focus greater attention on addressing these issues.

### **EVALUATION QUESTION 3: HOW SATISFIED ARE DIFFERENT STAKEHOLDERS WITH THE PROGRAM?**

The evaluation team collected information from multiple stakeholders in response to this evaluation question.

- Primary beneficiaries (clients/caregivers) repeatedly expressed appreciation for BIPAI’s work, both on the annual patient satisfaction surveys and in exit interviews at both CoEs.
- Other implementing partners such as the Christian Social Services Commission, the International Center for AIDS Control Programs, Management Development for Health and the Ariel Glaser Pediatric HIV Initiative have been eager to send technical advisors and clinical staff from their outreach sites for clinical attachment at BIPAI and were very satisfied by the BIPAI training program.
- At local, regional and national consultative meetings, other partners seek the input of Baylor for all matters related to pediatric HIV and care of exposed infants.
- Government of Tanzania partners of all levels generally ask Baylor to take on more outreach sites, increase their presence at sites, especially at rural health facilities, and train more HCWs on pediatric HIV/AIDS management.
- UNICEF very much appreciates the quality of BIPAI’s work, but expressed concern about the limited levels of coverage and suggested that BIPAI develop a cascading training-of-trainers approach.
- UNICEF would like Baylor’s M&E system to enable UNICEF to have verifiable evidence of attribution in results, i.e., demonstrating a direct relationship between BIPAI training of HCWs and the performance of those workers in increasing provider-initiated counseling and testing, and showing that such an increase is actually resulting in increasing numbers of early-identified, tested, diagnosed, treated and cared-for infants and children who remain in adherence on ART and survive and thrive.

The MoHSW NACP Pediatric HIV Adviser in Dar es Salaam stated that, “We are very satisfied with operations and support given; we get whatever support we need; Baylor has had positive feedback from the regions they support.”

Analysis of exit interviews showed that caregivers are generally satisfied with the services they receive at both levels. A majority of respondents (76 percent, N=21) reported that they are “very satisfied.” Only 24 percent of respondents reported to be “satisfied” and none reported to be “not satisfied.” In terms of provider behavior, all respondents reported that they had the opportunity to ask questions, the provider listened to them, explained things clearly and showed them respect. Ninety-five percent of respondents reported that other staff showed them respect. Most respondents (90 percent) reported that people in this community usually prefer to come to this facility for HIV/AIDS care.

### **Weaknesses**

- CoE and MoHSW pediatricians are inadequately integrated at the zonal consultant hospitals. There is very little professional collaboration and cross-learning among pediatricians and other clinicians in the host institutions and CoEs.
- Since there is a great demand for pediatric HIV/AIDS training, there was unmet need for training at regional hospitals and lower-level health facilities.
- Stakeholders are not aware of plans for sustainability of BIPAI, as they have not been involved in the discussions, even with the host institutions.
- Multiple partners offering similar interventions at the same site create risk of duplication and make it difficult to distinguish specific contributions of partners.

## **EVALUATION QUESTION 4: WHAT ARE THE BEST PRACTICES THAT CAN BE LEARNED FROM THE PROGRAM?**

The following best practice findings are based on a triangulated analysis of information that included qualitative data obtained during the KIIs and FGDs and the qualitative and quantitative data obtained from secondary analysis of BIPAI service statistics and reviews of the BIPAI quarterly reports and other reference documents.

The team discussed its findings and conclusions in a briefing with USAID/Tanzania project management and M&E staff and in a second briefing with a broader range of USAID staff from Tanzania and the Bureau for Global Health. The result of these discussions is the following list of apparent best practices based on the available data, the interviews, and the limited number of sites that the team was able to visit. In addition to the relatively unique BIPAI Pediatric AIDS Corps<sup>31</sup> and the BIPAI HCW training package, the following list of best practices is consistent with those identified by other U.S. Government implementing partners in Tanzania and other African countries and by researchers whose peer-reviewed publications are among those reviewed by the team:

- The emphasis on provider-initiated testing and counseling for all children at all entry points (post-natal care, pediatric wards, outpatient departments, RCH, etc.) has contributed to increasing identification of HIV-exposed and HIV-infected children.
- KYCS activities and other creative outreach services (Teen Clubs and Expert/Peer Mothers) have resulted in:
  - increasing identification, testing and referral of infected children for treatment and care;
  - timely initiation of ART through Option B+ for HIV-infected pregnant women and cotrimoxazole prophylaxis for HIV-exposed infants;
  - early dried blood spot testing as per national guidelines to facilitate early infant diagnosis; and
  - increasing early diagnosis of HIV-exposed and HIV-infected infants, leading to timely initiation of ART.
- The BIPAI approach of case-based classroom education plus clinical attachment followed by on-the-job mentoring and follow-up is an excellent adult learning model for pediatric HIV post-graduate training, but a more cost-effective cascading trainer-of-trainers approach should be developed and field-tested to expand the reach, coverage and impact required in Tanzania, which lacks sufficient human resources for health.
- The BIPAI family-centered continuum-of-care model, including advanced TB diagnostic and treatment services, extends beyond care of the child and leads to more

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<sup>31</sup> Kline MW, Ferris MG, Jones DC, et al. *The Pediatric AIDS Corps: Responding to the African HIV/AIDS Health Professional Resource Crisis*. Pediatrics 2009; 123: 134-136. See also: Schutze GE, Ferris MG, Jones DC, et al. *Education and Preparation of Physicians Entering an International Pediatric AIDS Program: The Pediatric AIDS Corps*. AIDS Patient Care and STDs 2009; 22 (9): 709-714.

comprehensive testing, treatment and care of adults and children, but as implemented in the CoEs, the model does not adequately allow for integration of other primary care maternal and reproductive health services.

- The BIPAI online curricula (HIV care and treatment and ART adherence), tool kit, and standard operating procedure charts are useful job aids that increase the performance and quality of services.
- BIPAI continues to make important contributions to strengthening the policies, programs and practices of the Tanzania National AIDS Control Program, the Program for Prevention of Mother-to-Child Transmission of HIV, and the TB Control Program through advocacy for greater attention to high-quality services for prevention, diagnosis, treatment and care of pediatric and adolescent HIV.

### **EVALUATION QUESTION 5: HOW CAN PROGRAM IMPLEMENTATION BE IMPROVED?**

As in the team's response to question 4, the following recommendations are based on a triangulated analysis of information that included qualitative data obtained during KIs and FGDs and the qualitative and quantitative data obtained from secondary analysis of BIPAI service statistics and reviews of reference documents.

The team discussed the findings and conclusions of this triangulated analysis in a briefing with USAID/Tanzania project management and M&E staff, and in a second briefing with a broader range of USAID staff from Tanzania and from the Bureau for Global Health. The result of these discussions is the following list of what appear to be feasible and likely effective ways to improve the BIPAI program.

- Strengthen collaboration with management and providers at consultation hospitals and CoEs.
- Consider collaboration with Tanzanian and Aga Khan medical schools to strengthen pre- and post-graduate pediatric education and training (on 14 February 2015, the Government of Tanzania announced that the Aga Khan Medical School is the first and only international medical school that has been approved to conduct undergraduate and post-graduate medical education programs in Tanzania).
- Apply rapid quality improvement survey methods (e.g., lot quality assurance sample surveys<sup>32</sup>) to supplement the Balanced Score Card approach currently used by Baylor, and in doing so assist the MoHSW to strengthen the practice of M&E beyond

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<sup>32</sup> Hedt BL, Olives C, Pagano M, Valadez JJ: Large Country-Lot Quality Assurance Sampling (LQAS): A New Method for Rapid Monitoring and Evaluation of Health, Nutrition and Population Programs at Sub-National Levels. Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network. May 2008. Available at: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/LCLQAS.pdf> (accessed 10 March 2015). Robertson S and Valadez JJ: Global review of health care surveys using lot quality assurance sampling (LQAS), 1984–2004. *Social Science & Medicine* 63 (2006) 1648–1660.

applications in clinical effectiveness to applications aimed at strengthening health system effectiveness.

- Apply lessons and tools from the USAID Center for Accelerating Innovation and Impact to develop a strategy for transition to Tanzanian ownership.
- Develop a detailed exit strategy and sustainability plan for turning over project activities in a dialogue that includes MoHSW, regional authorities and medical schools.
- Collaborate with implementing partners that are experienced in formative research and social and behavioral change communication methods in order to review and improve the content and targeting of audiences and messages for outreach programs.

## **CONCLUSIONS**

Based on the findings of this evaluation, and taking into consideration its methodological constraints, the team has concluded that the performance and quality of the work carried out by Baylor University's International Pediatric AIDS Initiative (BIPAI) have met or exceeded the expectations of USAID/Tanzania in regard to the questions posed for this performance evaluation.

As pointed out during briefings for USAID and other stakeholders on February 23-24, 2015, the team is unable to generalize its findings beyond the limited number of sites that were visited. In addition, possible overlaps in the performance of similar services by other implementing partners, resource constraints and the lack of easily accessible population-based cohort data made it impossible for the team to evaluate the effectiveness of BIPAI's work in terms of the situation and trends in health outcomes and impacts that could be directly attributed to the performance and quality of the work of BIPAI.

## 5. RECOMMENDATIONS

### RECOMMENDATIONS FOR EVALUATION QUESTION 1

Since the burden of pediatric HIV in the two zones remains high (61 percent of all new pediatric infections in Tanzania occur in the two zones), it is recommended to scale up and strengthen the outreach services by (a) implementing a cascading training-of-trainers approach to expanding its training coverage and (b) developing a methodology for the establishment, monitoring, evaluation and continuing improvement through supportive supervision and mentoring of mini- and micro-CoEs in selected high-performing district hospitals and health centers respectively.

The family-centered care at CoEs is highly appreciated by various stakeholders, including primary beneficiaries; however, older siblings and adults who are identified through this approach do not get an opportunity to access comprehensive care at CoEs due to fragmentation of services. This is contrary to the concept of addressing the family in one setting. It is the evaluation team's recommendation for BIPAI to ensure that all individuals identified through family-centered care at CoEs receive required services in one setting as a family. Also, the team recommends that BIPAI consider using tools developed by the USAID Center for Accelerating Innovation and Impact to work with MoHSW and regional hospitals in order to take their best practices to scale in Tanzania.

Due to limitations in reporting outside CoEs and potential duplication, Baylor's unique contribution cannot currently be quantified. There is significant investment in terms of training, supportive supervision, coaching, mentoring and on-the-job training at outreach sites, yet reporting on the service delivery from these outreach services is mandated to regional care and treatment partners. We recommend that the Interagency Technical Team consider requesting PEPFAR financial support to conduct an impact evaluation that will examine evidence for the attribution and impact of best practices among implementing partners.

### RECOMMENDATIONS FOR EVALUATION QUESTION 2

According to the qualitative findings of KIIs, high levels of staff turnover have been a challenge to the program. BIPAI has often found that trained staff rotate positions or sites after training. This has negatively affected continuity at the sites. Respondents reported a desire for training of more staff across cadres. While BIPAI has expressed an interest in monitoring and evaluating the retention and career development of graduates of their training program in MoHSW facilities, it was reportedly discouraged from doing so in the expectation that an independent evaluation would accomplish this important task. Unfortunately, that task was not supported with available resources for this evaluation. BIPAI should be provided with resources to allow tracking of competencies, retention, transfer, promotion and other career development aspects of trainees. Baylor should explore opportunities to work with the Aga Khan University, the

Pediatric AIDS Corps<sup>33</sup> and other U.S. universities operating in Tanzania (e.g., Harvard, Duke and Columbia) to strengthen undergraduate medical and graduate pediatric medical education in Tanzania.

Based on the results of KIIs, the BIPAI model requires clinician trainers at the CoEs to spend a lot of time away from clinical care, creating a burden on already strained staff. A pilot program to use a training-of-trainers model for mentorship visits has been instituted. The Baylor training approach should be expanded, and other ways of capacitating MoHSW staff to participate in the training should be explored through the establishment of criteria for identifying high-performing district hospitals and health centers that could be developed into mini- and micro-CoEs, respectively.

During the observation of a training session, current trainees reported an intention to share knowledge gained with other staff when they returned to their site. While the development of an action plan is included in the BIPAI training program<sup>34</sup>, the program lacks a formalized way to evaluate the extent of knowledge shared at the trainees' work sites after training is received. Therefore, the BIPAI should create a plan of action for a training-of-trainers model and implement a formal M&E system.

The evaluation team learned that in developing outreach programs, Baylor did not make use of formative research studies to inform the development of the strategies, campaigns and interpersonal communication messages and media channels. Baylor's outreach programs continue to employ traditional information, education and communication approaches rather than the more modern approach of social and behavior change communication. With the exception of Teen Club activities, none of the outreach programs went beyond just presenting facts and telling people what they should or should not do. None of the outreach intervention strategies appeared to have been developed through a process of consultation with the target audiences. Baylor should develop a strategy to address stigma and discrimination in the community, using formative research to develop appropriate messages and channels of communication. As Baylor develops further community outreach interventions, it should use an interactive systematic process with targeted communities and audiences to develop tailored messages and approaches. It can do so by exploring opportunities for collaboration with other implementing partners that have greater expertise in the design, implementation and M&E of social and behavior change communication approaches.

### **RECOMMENDATIONS FOR EVALUATION QUESTION 3**

All 66 key informants interviewed, and similarly all participants in the 19 FGDs, had mostly positive expressions of satisfaction and appreciation for the clinical services, educational

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<sup>33</sup> Baylor/BIPAI Capacity-Building - Kline MW, Ferris MG, Jones DC, et al: The Pediatric AIDS Corps: Responding to the African HIV/AIDS Health Professional Resource Crisis. *Pediatrics* 2009; 123: 134-136. See also: Schutze GE, Ferris MG, Jones DC, et al: Education and Preparation of Physicians Entering an International Pediatric AIDS Program: The Pediatric AIDS Corps. *AIDS Patient Care and STDs* 2009; 22 (9): 709-714.

<sup>34</sup> BIPAI Training Materials – Available in Southern Highlands (SHZ) CoE Folder in DropBox.

programs, training attachments, mentoring and contributions to national, regional and local policies and practices provided by BIPAI's CoEs in the Lake and the Southern Highlands zones. A set of illustrative quotes is attached separately in the form of PowerPoint slides.

As described in the Findings section, expressions of dissatisfaction were largely in the form of preferences or requests for more BIPAI assistance, rather than less:

- Dissatisfied implementing partners (e.g., UNICEF) made requests for more assistance focused on the need to expand the reach and the coverage of BIPAI's technical assistance and services, respectively. Regarding reach, informants mentioned the need for Baylor to increase its contributions to pre-service undergraduate education and post-graduate education and training in schools of medicine and nursing. Regarding coverage, informants mentioned the high cost and relatively low proportion of eligible HCWs who received training through the BIPAI CoE model package when compared with a cascading, training-of-trainers approach that might suffer initially from lower quality but over time would have a greater impact and could continuously be managed to improve quality.
- Dissatisfied MoHSW counterparts (e.g., in the Bugando and Mbeya hospitals where BIPAI pediatricians managed their pediatric HIV/AIDS patients) wanted more time for mentoring and closer collaborative working relationships between the CoE clinicians and themselves.
- Dissatisfied clinical clients (caretakers of HIV-exposed and HIV-infected children) wanted shorter wait-times for clinical care at the CoEs and opportunities for infected mothers and fathers to receive care and treatment at the CoEs rather than be referred to other facilities.
- UNICEF wants BIPAI to be able to provide a cascade of evidence through individual and cohort-based medical record M&E that there is a clear relationship between training that increases HCW competency, resulting in improved performance and quality of pediatric HIV services, leading to increasing early infant diagnosis and initiation of ART in HIV-infected children, leading to increased adherence to ART, and ultimately resulting in decreased morbidity and decreased mortality. The team provided M&E advice to Baylor and suggested to USAID that the Interagency Technical Team on Pediatric HIV consider seeking PEPFAR or other support to design and carry out an impact evaluation of PEPFAR-funded pediatric and adolescent HIV/AIDS interventions in Tanzania.

## **RECOMMENDATIONS FOR EVALUATION QUESTIONS 4 AND 5**

These recommendations have been provided in Section 4 because these two evaluation questions specifically sought recommendations based on the team's findings.

## **RECOMMENDATIONS FOR TECHNICAL AND ADMINISTRATIVE ISSUES IDENTIFIED**

The team's evaluation specialist, Dr. Sylvester Nandi, spent many hours in coordination with the M&E staff at each of the two CoEs in order to assist them with improvements in the organization and indicators of their M&E system. An important analytical approach that BIPAI should embark upon is the establishment and analysis of the health outcomes for population-

based cohorts of infants, children and adolescents who undergo diagnostic, treatment and care services at the CoEs. Such analyses would be of interest to USAID and PEPFAR, and resources should be allocated to enable BIPAI to make the necessary changes in their record-keeping systems.

The Balanced Score Card approach to management is a valuable and well-established tool. In addition to continuing and expanding the use of that approach, it would be cost-effective to build capacity at the CoEs and at other facilities (regional and consulting hospitals, district hospitals, and clinical treatment centers) to make use of rapid survey methods like lot quality assurance sample surveys for measuring and improving the performance, quality and results of both training and service delivery.

BIPAI should review the literature on the application of lot quality assurance sample<sup>35</sup> surveys and other rapid survey methods in health services research, and consult with public health statisticians on how such surveys could be used to audit and improve the performance, quality and results of their clinical and training activities.

## **FUTURE DIRECTIONS**

Given the persistent weakness in the number and distribution of various types of HCWs in Tanzania, and the interest of Baylor University and several other excellent U.S. medical schools in building medical capacity in Tanzania, it would seem timely for USAID to consult with other donor agencies (including the Aga Khan Foundation) on developing a consortium approach to strengthening undergraduate and post-graduate education in the fields of medicine, nursing, pharmaceutical practice and laboratory science.

The team recommends that USAID consult with other members of the Interagency Technical Team on the most appropriate types and levels of further support to provide for continuation, expansion or transition of the BIPAI program. It is clear from the language of the memoranda of understanding that BIPAI has signed with MoHSW and the regional health and hospital authorities in the Lake and Southern Highlands zones that the Government of Tanzania would like to have Baylor continue to assist in building human and institutional capacity for pediatric HIV/AIDS services. It is also clear from these MoUs that Baylor would like to obtain continuous public-private partnership support to enable the BIPAI to continue to carry out training, clinical and research activities in Tanzania. In the short run, the team recommends that USAID should continue to partner with BIPAI, but that any further grant support should include the development and testing of more cost-effective training-of-trainers models for expanding the coverage of training efforts.

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<sup>35</sup> See for example: (1) Bethany L. Hedt, Casey Olives, Marcello Pagano, Joseph J. Valadez. Large Country-Lot Quality Assurance Sampling: A New Method for Rapid Monitoring and Evaluation of Health, Nutrition and Population Programs at Sub-National Levels. Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network. May 2008; (2) Susan Robertson and Joseph Valadez. Global review of health care surveys using lot quality assurance sampling (LQAS), 1984–2004. *Social Science & Medicine* 63 (2006) 1648–1660.

## **6. EVALUATION DISSEMINATION PLAN**

This evaluation will be made available to the public through posting on USAID's Development Experience Clearinghouse web site. The results were presented to USAID/Tanzania and to a wider group of stakeholders in briefings held in Tanzania in February 2015.



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Note: USAID/Tanzania and GH Pro will be provided with access to the drop box in which most of these documents have been stored.

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# ANNEX I. SCOPE OF WORK

Global Health Program Cycle Improvement Project -- GH Pro  
Contract No. AID-OAA-C-14-00067

## ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 12/15/2014

INSTRUCTIONS: Complete this template to develop a SOW for an evaluation, assessment, or other analytic activity. Please be as thorough as possible in completing this SOW, but if you are unsure your GH Pro technical advisor and project management team can assist you in developing your final SOW.

**TITLE: Evaluation of Tanzania Baylor International Pediatrics AIDS Initiative (BIPAI); Activity #006**

**Requester / Client:** (select by using pull-down menu) **Country Mission**

If Mission (select by using Region pull-down menu) –

Africa: **Tanzania**

**Primary Funding Account Source:** (Click on box(es) to indicate who is paying for the assignment)

- |  |   |
|--|---|
| <input type="checkbox"/> 3.1.1 HIV                         | <input type="checkbox"/> 3.1.6 MCH  |
| <input type="checkbox"/> 3.1.2 TB                          | <input type="checkbox"/> 3.1.7 FP/RH                                      |
| <input type="checkbox"/> 3.1.3 Malaria                     | <input type="checkbox"/> 3.1.8 WSSH                                       |
| <input type="checkbox"/> 3.1.4 PIOET                       | <input type="checkbox"/> 3.1.9 Nutrition                                  |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input checked="" type="checkbox"/> 3.2.0 Other (specify): <u>Mission</u> |

**GH Pro Cost Estimate:** \$339, 310

**Performance Period:** (Use pull down to indicate expected start and end dates – *choose any day in the month and year on pull down calendar*)

Expected Start (on or about): 12-Dec-2014      Anticipated End (on or about): 1-Jun-2015

**Location(s) of Performance Period:** (Indicate locations where work will be performed to implement this analytic activity)

At least four regions in Lake and Southern Highlands zones. This would include: 1) Mbeya plus Rukwa and/or Ruvuma; and 2) Mwanza plus Mara, Shinyanga, Kagera and/or Tabora.

**Type of Analytic Activity** (Check the box to indicate the type of analytic activity)

**Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

**Performance Evaluation** (Check timing of data collection)

Midterm       Endline       Other (specify):

*Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.*

*Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)*

## **Background**

Background of project/program/intervention:

The project to be evaluated is:

- |                                  |  |
|----------------------------------|--|
| 1. Project/Activity Title:       | <b>Baylor International Pediatrics AIDS Initiative</b> |
| 2. Award Number:                 | <b>621-A-00-08-00022-00</b>                            |
| 3. Award Dates:                  | <b>August 28, 2008 – August 27, 2015</b>               |
| 4. Project/Activity Funding:     | <b>GH-H/2012/2016</b>                                  |
| 5. Implementing Organization(s): | <b>Baylor College of Medicine</b>                      |
| 6. Project/Activity COR/AOR:     | <b>Jema Bisimba</b>                                    |

### **A. Development context**

#### **• Problem or Opportunity Addressed by the Project/Activity Being Evaluated**

The HIV/AIDS epidemic has had a devastating impact on children and families worldwide. This was especially so in sub-Saharan Africa, where a large proportion of deaths of children under age 5 years were caused by HIV/AIDS. However the coverage of pediatric HIV care and treatment in Tanzania, relative to the need, was inadequate. This inadequate coverage was primarily because of difficulty in identifying children who have been exposed to HIV, and also the dearth of health workers trained and confident in the complex aspects of treating children who are HIV-infected posed a formidable challenge.

The Baylor College of Medicine International Pediatric AIDS Initiative (BIPAI), through a public-private partnership, was initiated to strengthen pediatric HIV/AIDS services in Tanzania. The proposed program aimed at developing two Pediatric Centers of Excellence to catalyze access to HIV/AIDS care and treatment for children. In addition to the Centers of Excellence, the program aimed to develop a network of services around the Centers so that children are easily identified in communities and lower-level health facilities, and providers' skills are strengthened to identify children who are HIV-positive.

#### **• Target Areas and Groups**

The Centers of Excellence and surrounding networks were to be developed in and around two zonal referral hospitals in regions that were particularly hard hit by the HIV/AIDS epidemic: Mbeya region, which had a population of over 2 million with HIV prevalence of 13.5 percent (THMIS 2008), and Mwanza region, which had a population of nearly 3 million with HIV prevalence of 7.2 percent. The zones these referral hospitals serve include over 19 million persons. In collaboration with the Government of Tanzania, this program was planned to serve at least 15,000 children over five years. In addition, the BIPAI program aimed to increase human resources for the care and treatment of HIV-positive children through providing technical assistance and capacity building initiatives for health professionals.

#### **• Intended Results of the Project/Activity Being Evaluated**

In developing the BIPAI program, the general hypothesis was that by improving health care workers' skills and knowledge on managing pediatric HIV and increasing access to quality pediatric HIV care

and treatment, HIV morbidity and mortality among children will be reduced.

To achieve these objectives of clinical work, there are five main aims:

**Specific Aim #1:** To provide comprehensive, family-centered pediatric HIV/AIDS prevention, care and treatment services

**Specific Aim #2:** To expand case finding for children who are HIV-positive through strengthened pediatric HIV/AIDS counseling and testing using a family-centered testing model

**Specific Aim #3:** To strengthen the local human resource and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services

**Specific Aim #4:** To sensitize and mobilize people living with HIV/AIDS (PLWHA) and the general population to support the provision of pediatric and family-centered pediatric HIV/AIDS prevention, care and treatment services

**Specific Aim #5:** To contribute to elimination of HIV infections in children and reducing deaths among HIV-infected mothers and children through strengthening of post-partum care in Mbeya City (SHZ, as part of PHFS program)

- **Approach and Implementation**

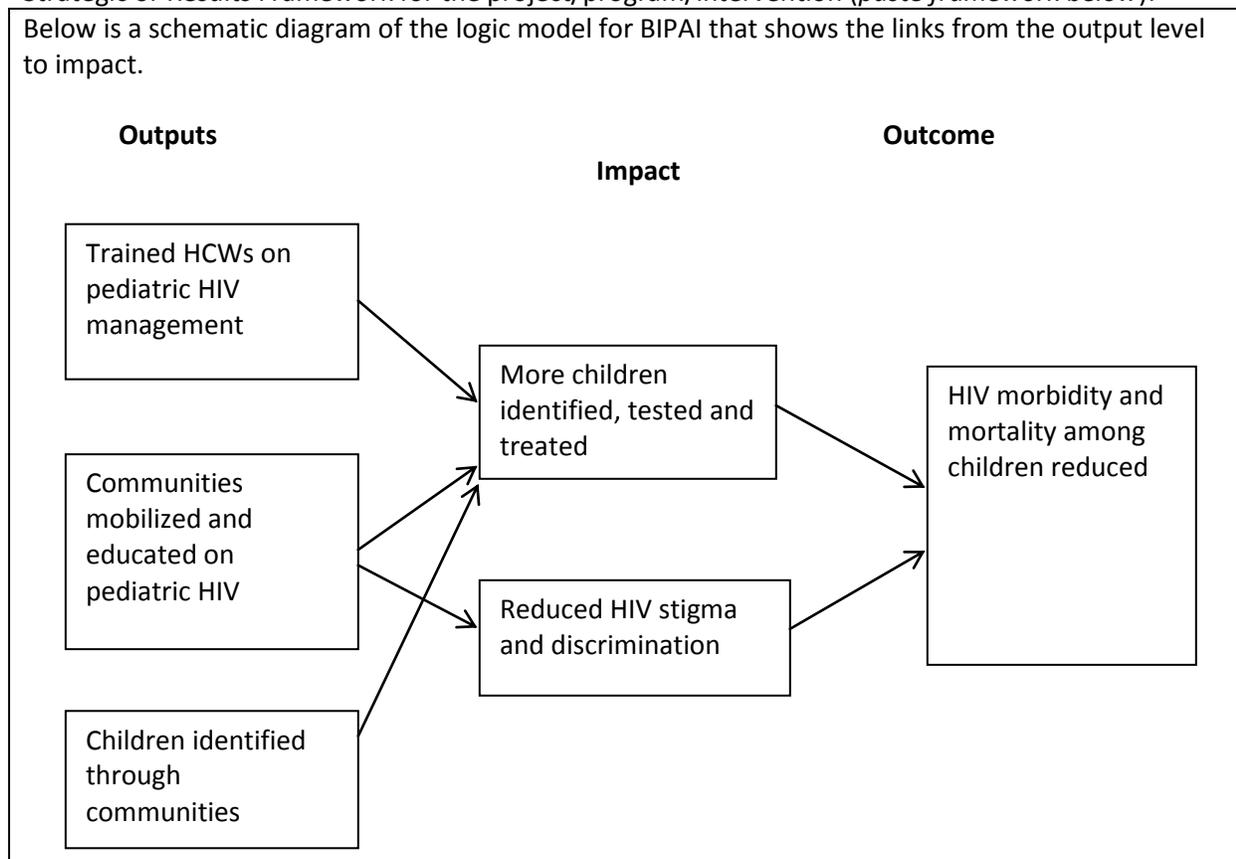
USAID was poised to build on existing programs and leverage existing investments to strengthen pediatric HIV/AIDS case-finding and care of exposed infants and children. USAID had significant strengths in Maternal/Child Health at lower-level facilities, the platform on which pediatric HIV/AIDS services were to be based. It was also intended that HIV-exposed children could be identified and could receive quality services at lower-level facilities that are part of a referral network with the Pediatric AIDS Center of Excellence at the hubs.

Describe the theory of change of the project/program/intervention.

See Results Framework below. HIV morbidity and mortality among children will be reduced with more children identified, tested and treated for HIV, and by reducing HIV stigma and discrimination. These intermediate outcomes will be achieved by: (a) training health care workers on pediatric HIV management; (b) mobilizing and educating communities on pediatric HIV; and (c) working with communities to identify children at risk of HIV/AIDS.

Strategic or Results Framework for the project/program/intervention (*paste framework below*):

Below is a schematic diagram of the logic model for BIPAI that shows the links from the output level to impact.



What is the geographic coverage and/or the target group(s) for the project or program that is the subject of analysis?

HIV infected children in the Lake and Southern Highlands zones, particularly those in and around clinical and community services supported by BIPAI, which include the care and treatment centers (CTCs) and community groups located in Mwanza and Mbeya, as well as supported outreach services in nearby regions of Mara, Kagera, Shinyanga, Tabora, Rukwa and Ruvuma.

#### SCOPE OF WORK

**Purpose:** Why is this analysis being conducted (purpose of analytic activity)?

The purpose of this evaluation is to learn to what extent the project's goals and objectives have been achieved and provide guidance on what modifications need to be done to improve future project effectiveness.

**Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

**USAID/Tanzania\***  
**PEPFAR/Tanzania\***  
 Government of Tanzania  
 Implementing Partners

**Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

The results of this evaluation will be used by USAID/Tanzania and the PEPFAR/Tanzania interagency technical team to inform future decisions regarding pediatric programs. The results will also be used by Government of Tanzania and implementing partners for the purpose of learning best practices in pediatric programming

**Evaluation questions:** Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation questions. USAID policy suggests three to five evaluation questions.

Evaluation Question	
1.	How effective is the program in identification, testing and treating HIV-infected children in the Lake and Southern Highlands zones?
2.	How effective is the health care workers' training program (clinical attachment, mentoring) at the Centers of Excellence and outreach sites?
3.	How satisfied are different stakeholders with the program?
4.	What are the best practices that can be learned from the program?
5.	How could the program implementation be improved?

**Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity.

■ Document Review (*list of documents recommended for review*)

Review BIPAI's annual work plans for the last five years, M&E plan, quarterly progress reports, data quality reports and treatment audit report. There are also national documents that guided program implementation. These include national guidelines for the management of HIV/AIDS (2008 and 2012 versions) and the Tanzania health sector HIV/AIDS strategic plans II and III.

Furthermore, BIPAI performance indicator data will be reviewed to look at changes over time, throughout the almost five years of project implementation, including number of children tested, number of children referred for care and treatment, EIDs, children receiving ARVs, etc.

■ Secondary Analysis of Existing Data (*list the data source and recommended analyses*)

Data Source ( <i>existing dataset</i> )	Description of data	Recommended analysis
Electronic Medical Records (EMR)	BIPAI has established an electronic medical record in the two Centers of Excellence on each pediatric HIV/AIDS client.	Assess who is seen (age, sex, location, etc.), when they are seen (age, seasonal differences, timing related to BIPAI interventions, etc.), what care or treatments is provided, adherence to treatment guidelines and other topics that would provide insights on BIPAI efforts.
CTC2 database	This is a Government of Tanzania database that corresponds to CTC2 cards that document an individual's HIV care and treatment. It contains clinical information per national guidance on management of HIV.	CTC2 data from BIPAI-supported sites will be compared to matched non-BIPAI sites to identify any differences and to test the hypothesis that inputs from BIPAI improved care and treatment for children with HIV.

■ Key Informant Interviews (*list categories of key informants and purpose of inquiry*)

KII will be conducted with BIPAI implementers, Centers of Excellence (CoE) staff, MoHSW partners (i.e., District Health Management Teams), and other major stakeholders. Additionally, community local authorities and leaders (e.g., ward executive officers, ward councilors, village chairpersons/street chairpersons, street executive officers, *balozi*, and religious leaders) who were engaged in community outreach. The main purpose of the KII will be to learn from the interviewees' perspective what worked, what were the shortcomings and obstacles, and what recommendations they have for scale-up, rollout and any follow-on project.

■ Focus Group Discussions (*list categories of groups and purpose of inquiry*)

A limited number of FGD will be conducted with community residents from the catchment areas where BIPAI implements community outreach activities. They will be asked about what they know about screening and testing for pediatric HIV, including who should be tested, where and when they can be tested, where they received their information about testing, etc.

Group Interviews (*list categories of groups, and purpose of inquiry*)

■ Client/Participant Satisfaction or Exit Interviews (*list who is to be interviewed, and purpose of inquiry*)

Parents of children with HIV who are seen at CoE or other health facility supported by BIPAI will be interviewed to assess what services their children received, the information and support provided to them, their satisfaction with the services, and any suggestions they have related to these services. The interview will be semi-structured and will last no more than 15 minutes.

■ Observations (*list types of sites or activities to be observed, and purpose of inquiry*)

Observations will be conducted at the CTCs and CoEs to observe the clinical attachment program and

mentoring visits. Additionally, observations of service delivery among providers trained with support from BIPAI will be conducted. All observations will use a checklist and a semi-structured form.

Observations involving minors can only take place on non-sensitive issues. Only routine and public encounters with a minor can be observed. For any encounter with a minor the observer must obtain consent from the minor (if s/he is able to consent), with assent from his/her parent or guardian, as well as consent from the health care provider.

■ **Data Abstraction** (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

If EMR or CTC2 data are not available or are not adequate, and secondary data analyses of these databases is not feasible, medical records of pediatric HIV/AIDS patients may be abstracted to assess who is seen (age, sex, location, etc.), when they are seen (age, seasonal differences, timing related to BIPAI interventions, etc.), what care or treatments is provided, adherence to treatment guidelines, and other topics that would provide insights on BIPAI efforts.

### **ANALYTIC PLAN**

The plan will include both qualitative and quantitative analysis of the achievements in relation to the objectives and targets for the output indicators for the cooperative agreement. Moreover, all analyses will be geared to answer the evaluation questions.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate. In the report, the evaluators will describe the statistical tests used.

Thematic reviews of qualitative data will be performed. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data does not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., BIPAI performance indicator data, DHS and THMIS) will allow the team to triangulate findings to produce more robust evaluation results.

### **ACTIVITIES**

**Background reading** – Several documents are available for review for this end-of-program evaluation. These include BIPAI’s annual work plans for the last five years, M&E plan, quarterly progress reports, data quality reports and treatment audit report. There are also national documents that guided program implementation. These include national guidelines for the management of HIV/AIDS (2008 and 2012 versions) and the Tanzania health sector HIV/AIDS strategic plans II and III. This desk review will provide background information for the evaluation team and will also be used as data input and evidence for the evaluation.

**Team Planning Meeting (TPM) in Tanzania** – A three-day TPM will be held in Tanzania before the evaluation begins. The TPM will:

- Review and clarify any questions on the evaluation SOW;
- Clarify team members’ roles and responsibilities;

- Establish a team atmosphere, share individual working styles and agree on procedures for resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units;
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report; and
- Assign drafting/writing responsibilities for the final report.

**Briefing and Debriefing Meetings** – Throughout the evaluation the team lead will provide briefings to USAID. The in-brief and debrief are likely to include all the evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- Evaluation **launch**, a call among the USAID/Tanzania, GH Pro and the team lead to initiate the evaluation activity and review expectations. The mission will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team lead and review the travel schedule.
  - Coinciding with the team’s arrival in the field, the team lead will submit to USAID/Tanzania, an **inception report** with tentative evaluation workplan/schedule indicating which step/activity should occur and when. This report is to ensure that the evaluation team fully understands the assignment approach, and should be approved by USAID prior to international travel and evaluation implementation.
- **In-brief** with USAID/Tanzania, following the TPM. This briefing will include the evaluation team, USAID/Tanzania, AOR, the mission M&E team, the mission gender focal person, and other members of the health team. The evaluation team will present an outline and explanation of the design and tools of the evaluation.
- The team lead will brief the mission **weekly** to discuss progress on the evaluation. As preliminary findings arise, the team lead will share these during the routine briefing and in an email. **Note:** *preliminary findings are not final and as more data sources are developed and analyzed these findings may change.*
- A **final debrief** will be held approximately three days before departure between USAID/Tanzania and the evaluation team. During this meeting a summary of the data will be presented, along with high-level findings and draft recommendations [the findings from the evaluation will be presented in a draft report at a full briefing with USAID/Tanzania]. For the debrief, the team will prepare a **PowerPoint presentation** of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report.
- **Stakeholders’ debrief/workshop** will be held following the final debrief with the mission.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits to BIPAI support sites for data collection. This includes CTCs and CoEs where BIPAI has worked, and communities where BIPAI conducted outreach, demand creation, and case-finding activities. As it is a country-wide program, USAID/Tanzania proposes that field visits be conducted in different regions that will be determined during the TPM in consultation with USAID/Tanzania. The site visits will

involve key informant interviews, focus group discussions, observations and exit interviews with parents of children seen at a BIPAI-supported health facility. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

### DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines
<input checked="" type="checkbox"/> Launch briefing	December (virtual briefing)
<input checked="" type="checkbox"/> Inception report	December (within a week of launch)
<input checked="" type="checkbox"/> Workplan with timeline	Early-Mid January
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	Early-Mid January
<input checked="" type="checkbox"/> In-brief with mission or organizing business unit	Early-Mid January
<input checked="" type="checkbox"/> In-brief with target project / program	weekly
<input checked="" type="checkbox"/> Routine briefings	
<input checked="" type="checkbox"/> Findings review workshop with stakeholders with PowerPoint presentation	End of February
<input checked="" type="checkbox"/> Out-brief with mission or organizing business unit with PowerPoint presentation	Early March
<input checked="" type="checkbox"/> Draft report	March-April
<input checked="" type="checkbox"/> Final report (electronic only)	May
<input checked="" type="checkbox"/> Raw data	May
<input type="checkbox"/> Dissemination activity	
<input type="checkbox"/> Other (specify):	

### Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? **10** business days

### TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

**Evaluation team:** When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Team leaders for external evaluations must be an outside expert with appropriate skills and experience.
- At least one team member should have methodological expertise needed for this analytic activity.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for individual team members, or for the team as a whole.

### **Key Staff 1**

Title: Team leader (**Note:** This person will be selected from among the other key staff, and will meet the requirements of both this and the other position.)

Roles and responsibilities: The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, (3) serving as a liaison between the mission and the evaluation team, and (4) leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience in HIV, preferably pediatric HIV and/or child health interventions
- Excellent skills in planning, facilitation and consensus building
- Demonstrated experience leading an evaluation team
- Excellent interpersonal skills
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline

### **Key Staff 2**

Title: Pediatric HIV clinical advisor

Roles and responsibilities: Serve as a member of the evaluation team, and provide technical expertise on clinical pediatric HIV/AIDS.

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience with pediatric HIV and child health interventions, preferably HIV and other health related, such as maternal and child health programs.
- Clinical skills in HIV: testing and counseling, care and treatment

Number of consultants with this expertise needed: 1

### **Key Staff 3**

Title: Evaluation specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis.

Qualifications:

- At least five years of experience in USAID M&E procedures, project and organizational management
- Strong knowledge, skills and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations

Number of consultants with this expertise needed: 1

### **Key Staff 4**

Title: Health system strengthening and capacity development specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate capacity development among target pediatric HIV/AIDS health care providers in the context of health system strengthening for pediatric HIV/AIDS services.

Qualifications:

- Background and at least five years' experience in health human resources or health systems strengthening
- A degree in human resources management, public health or related field
- Knowledgeable in capacity building assessment and evaluation methodologies of human resources for health programs or health systems
- Extensive experience and demonstrated state-of-the-art knowledge in conducting programmatic evaluations/assessments

Number of consultants with this expertise needed: 1

**Key Staff 5**

Title: Community outreach BCC expert

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate BCC activities, specifically for community outreach and demand creation for HIV testing, screening and care and treatment.

Qualifications:

- At least five years of experience working in the field on BCC programs related to HIV.
- A degree in public health or related field
- Experienced and knowledgeable on evaluation methodologies related to community-based BCC.

Number of consultants with this expertise needed: 1

Other Staff Titles with Roles and Responsibilities (include number of individuals needed):

Approximately three research assistants (local) will be hired to assist with qualitative and quantitative data collection, data entry, data analyses, transcription of qualitative data and logistics.

Will USAID participate as a team member or designate other key stakeholders to participate?

Yes – If yes, specify who:

No

**Staffing Level of Effort (LOE) Matrix Instructions:**

This optional table can help you estimate the LOE needed to implement this analytic activity. You may leave this section blank if you are unsure.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

### Level of Effort in Days for each Analytic Team Member

Activity / Deliverable		Evaluation Team					
		Team Lead / HSS Capacity Development	M&E	Pediatric HIV/AIDS	BCC/ Demand Creation	Logistics / Research Assistant	Research Assistants
<i>Number of persons</i>		1	1	1	1	1	2
1	Launch briefing	1					
2	Inception report	2					
3	Desk review	5	5	5	5		
4	Preparation for team convening in-country	.5				2	
5	Travel to country	2		2			
6	Team planning meeting, ending with workplan	3	3	3	3	3	1
7	In-brief with mission	1	1	1	1		
8	Training data collectors	2	2	2	2	2	2
9	Prep / logistics for site visits	1	1	1	1	2	1
10	Data collection / site visits	12	12	12	12	12	12
11	Data analysis	4	4	4	4		2
12	Debrief with mission w/ presentation	2	2	2	2	1	
13	Findings review workshop with stakeholders	1.5	1.5	1.5	1.5	1.5	1.5
14	Depart country	2		2		1	
15	Draft report	8	5	4	4		
16	GH Pro report quality control review and formatting						
17	Submission of draft report to mission						
18	USAID report review						
19	Revise report per USAID comments	4	2				
20	Submission of final report						
21	508 compliance review						
23	Upload evaluation report to the DEC						
<b>Sub-Total LOE</b>		<b>51</b>	<b>38.5</b>	<b>39.5</b>	<b>35.5</b>	<b>24.5</b>	<b>19.5</b>
<b>Total LOE</b>		<b>51</b>	<b>38.5</b>	<b>39.5</b>	<b>35.5</b>	<b>24.5</b>	<b>39</b>

\*6 day workweek is approved for periods of international travel and field work.

#### **Travel anticipated:** List international and local travel anticipated by which team members.

All evaluation team members who reside outside Tanzania will travel to Tanzania and will require lodging in Dar es Salaam. Once the team has convened in Dar, all will need to travel to field sites for data collection, and these sites will most likely be (1) Mbeya plus Rukwa and/or Ruvuma; and (2) Mwanza plus Mara, Shinyanga, Kagera and/or Tabora. The sites will be finalized in consultation with USAID/Tanzania. Local travel will be arranged by the logistics person on the evaluation team, but may need assistance from BIPAI or USAID/Tanzania regarding hotel selection and hiring of transportation.

#### **GH PRO ROLES AND RESPONSIBILITIES**

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology as needed

- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production: if report is public, then coordination of draft and finalization steps, editing, formatting and 508 compliance are required in addition to submission to the DEC and posting on GH Pro website. If report is internal, then copy editing and formatting for internal distribution are required.

## USAID ROLES AND RESPONSIBILITIES

Provide an outline of the roles, responsibilities and involvement of USAID. An example is listed below.

<b>USAID Roles and Responsibilities</b>	
<p><b>USAID</b> will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:</p>	
<b>Before Field Work</b>	<ul style="list-style-type: none"> <li>• <u>SOW</u>. Respond to queries about the SOW and the assignment at large.</li> <li>• <u>Consultant Conflict of Interest (COI)</u>. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated or assessed and information regarding their affiliates.</li> <li>• <u>Documents</u>. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.</li> <li>• <u>Local Consultants</u>. Assist with identification of potential local consultants, including contact information.</li> <li>• <u>Site Visit Preparations</u>. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.</li> <li>• <u>Lodgings and Travel</u>. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).</li> </ul>
<b>During Field Work</b>	<ul style="list-style-type: none"> <li>• <u>Mission Point of Contact</u>. Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team's work.</li> <li>• <u>Meeting Space</u>. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).</li> <li>• <u>Meeting Arrangements</u>. Assist the team in arranging and coordinating meetings with stakeholders.</li> <li>• <u>Facilitate Contact with Implementing Partners</u>. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and anticipated meetings.</li> </ul>
<b>After Field Work</b>	<ul style="list-style-type: none"> <li>• <u>Timely Reviews</u>. Provide timely review of draft and final reports and approval of deliverables.</li> </ul>

## ANALYTIC REPORT

Provide any desired guidance or specifications for the final report

### A. Evaluation Report Format

The report format should be restricted to Microsoft products and 12-point type should be used throughout the body of the report, with page margins 1" top/bottom and left/right. The report shall not exceed 30 pages, excluding references and annexes.

The format for the evaluation report is as follows:

- Executive Summary: concisely state the most salient findings, conclusions and recommendations (not more than 4 pages);
- List of acronyms

- Table of Contents (1 page);
- Introduction: purpose, audience and synopsis of task (1 page);
- Background: brief overview of Pediatric HIV program in Tanzania, USAID strategies and priorities, brief description of the BIPAI program and purpose of the evaluation (2-3 pages);
- Design and Methodology: describe evaluation design methods, including constraints, limitations and gaps (1 page);
- Findings, Conclusions and Recommendations in separate sections: for each objective area (15-20 pages);
- Issues: provide a list of key technical and administrative issues identified (1-2 pages);
- Future Directions and Recommendations based on gaps or innovation model to be scaled up (2-3 pages);
- References (including bibliographical documentation, stakeholders meetings, key informant interviews and focus group discussions);
- Annexes, which should include:
  - The evaluation scope of work
  - Any statements of differences regarding significant unresolved difference of opinion by funders, implementers, or members of the evaluation team
  - Evaluation design methods and all tools used in conducting the evaluation, such as questionnaires, checklists, survey instruments and discussion guides
  - Sources of information, properly identified and listed
  - Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

## **B. Evaluation Report Contents**

The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.

- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail, and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an annex in the final report.
- Limitations to the evaluation will be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#).

## USAID CONTACT PERSON

	Primary Contact	Alternate Contact
Name:	Jema Bisimba	Moses Busiga
Title:	AOR, BIPAI Program	Monitoring and Evaluation Specialist
USAID Office/Mission (include address)	Health Office, USAID/Tanzania Plot 686 Old Bagamoyo Road, Msasani P.O. Box 9130 Dar es Salaam, Tanzania	Health Office, USAID/Tanzania Plot 686 Old Bagamoyo Road, Msasani P.O. Box 9130 Dar es Salaam, Tanzania
Email:	<a href="mailto:jbisimba@usaid.gov">jbisimba@usaid.gov</a>	<a href="mailto:mbusiga@usaid.gov">mbusiga@usaid.gov</a>
Telephone:	+255 22 2294490 Ext. 4425	+255 22 2294490 Ext. 4595
Cell Phone (optional)	+ 0655 867 600	+255-659 269 188 / 0764 269 188

## REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

BIPAI Agreement  
 BIPAI Quarterly Progress Report Jan-March 2013  
 BIPAI Quarterly Progress Report Oct-Dec 2012  
 BIPAI Quarterly Progress Report July-Sept 2012  
 BIPAI Quarterly Progress Report April-June 2012  
 BIPAI Quarterly Progress Report Jan-March 2012  
 BIPAI Quarterly Progress Report Oct-Dec 2011  
 BIPAI Data Quality Assessment Report  
 Tanzania HIV/AIDS & Malaria Indicator Survey (THMIS) 2007-08  
 Tanzania HIV/AIDS & Malaria Indicator Survey (THMIS) 2011-12  
 Tanzania DHS 2010  
 Tanzania Service Provision Assessment (SPA) Survey 2006

Other documents will be provided by USAID/Tanzania and/or BIPAI upon request.

## Evaluation Design Matrix

The following matrix displays the methods that are designed to answer each evaluation question. Each of the methods employed in this evaluation will obtain evidence to address more than one question. A method is noted by question when it will include specific inquiries and/or result in evidence needed to address this specific question. However, we anticipate that supplementary information may be obtained from methods not listed under a specified question. Any and all significant information obtained through this evaluation that sheds light on the evaluation questions will contribute to addressing the questions and the purpose of this evaluation.

**Note:** In addition to the indicators listed below, evaluation questions 1 & 2 deal with ‘effectiveness’. It is recommended that the Evaluation Team use the Six Building Blocks of a Health System to determine effectiveness. References for this include:

- WHO Everybody’s business: strengthening health systems to improve health outcomes: WHO’s framework for action. ([http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf))
- WHO Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies ([http://www.who.int/healthinfo/systems/WHO\\_MBHSS\\_2010\\_full\\_web.pdf](http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf))

Additionally, MEASURE Evaluation lists resources related to M&E of health systems strengthening ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/hss](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/hss))

## Evaluation Matrix

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
1. How effective is the program in identification, testing and treating HIV infected children in the Lake and Southern highlands zones.	Children tested for HIV through community outreach, EID, clinical services, or other mechanism	Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding identification, testing, and treatment.
		Secondary data analysis: CTC2	Case: Selected Centers of Excellence and BIPAI supported clinics. Control:	Comparative analyses: 1) pre- and post-interventions; 2) case sites compared to matched control sites.
		KII	Individuals who are involved (directly or indirectly) in HTC.	Thematic analysis
		FGD	Parents of at-risk children	Thematic analysis
	Proportion of children tested who are HIV+ who receive treatment	Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding referrals and treatment
		Secondary data analysis: CTC2	Case: Selected Centers of Excellence and BIPAI supported clinics. Control:	Comparative analyses: 1) pre- and post-interventions; 2) case sites compared to matched control sites.
	Quality of HTC and CTC services.	Observations	CTCs and COEs supported by BIPAI	Descriptive statistics of checklist data, and qualitative review of comments
		Patient satisfaction exit interview	Parents with children who are seen at CTCs or COIs supported by BIPAI	Descriptive statistics for categorical data. Thematic review for open ended questions.
		KII	Individuals involved in HTC and/or CTC	Thematic analysis & insights
		FGD	Parents of at-risk children	Thematic analysis & insights
2. How effective is the health care workers training program (clinical attachment, mentoring) at the Centers of excellence and outreach sites.	Health care workers trained in specified topics	Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding referrals and treatment
	Quality of services by trained health workers	Observations	CTCs and COEs supported by BIPAI	Descriptive statistics of checklist data, and qualitative review of comments

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
		Patient satisfaction exit interview	Parents with children who are seen at CTCs or COIs supported by BIPAI	Descriptive statistics for categorical data. Thematic review for open ended questions.
		KII	Individuals involved in HTC and/or CTC	Thematic analysis & insights
	Range and number of services delivered in BIPAI supported sites versus other matched sites	Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding referrals and treatment
		Observations	CTCs and COEs supported by BIPAI	Descriptive statistics of checklist data, and qualitative review of comments
		KII	Individuals involved in HTC and/or CTC	Thematic analysis & insights
3. How satisfied are different stakeholders with the program.	Parents of pediatric HIV patients satisfied	Patient satisfaction exit interview	Parents with children who are seen at CTCs or COIs supported by BIPAI	Descriptive statistics for categorical data. Thematic review for open ended questions.
	MOH, health providers, and local NGOs satisfaction.	KII	Individuals involved in HTC and/or CTC	Thematic analysis & insights
4. What are the best practices that can be learned from the program	Successes with elements thought to contribute to these successes (planned and unplanned)	Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding identification, testing, and treatment.
		KII	Individuals who are involved (directly or indirectly) in HTC.	Thematic analysis
		FGD	Parents of at-risk children	Thematic analysis
		Quantitative findings from this evaluation		Summary of findings triangulated with qualitative findings
		Document Review: Annual reports, PMP indicators		Review existing reports, narrative & indicator results regarding identification, testing, and treatment.
5. How the program implementation could be improved.	Shortcomings and obstacles faced with recommendations to address these limitations	KII	Individuals who are involved (directly or indirectly) in HTC.	Thematic analysis
		FGD	Parents of at-risk children	Thematic analysis
		Quantitative findings from this evaluation		Summary of findings triangulated with qualitative findings



# ANNEX 2. EVALUATION TOOLS AND INSTRUMENTS

## WRITTEN INFORMED CONSENT FORM

Title of study: **Evaluation of the Baylor International Pediatric AIDS Initiative (BIPAI) in Tanzania**

Principal BIPAI Investigators: **Dr. Lumumba Francis Mwita and Dr. Bertha Kasambala**

### **Introduction:**

This consent form contains information about the program named above. In order to be sure that you are informed about participating in the evaluation of the BIPAI program, we are requesting that you read (or have read to you) this consent form. You will also be asked to sign it or make your mark – your name will remain confidential and will not be associated with your participation or your comments. We will give you a copy of this form. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you do not understand.

### **Reason for the Evaluation:**

You are being asked to participate in an evaluation to assess the extent to which the BIPAI has achieved the expected results of:

- (1) building health care providers' capacity in effective management of pediatric HIV/AIDS and
- (2) improving pediatric HIV services at the Lake and Southern Highlands zones.

**Sponsorship and Funding:** The United States Agency for International Development (USAID) has been supporting the Tanzania national program of pediatric HIV/AIDS care and treatment since 2008 through two BIPAI Centers of Excellence (CoEs) established in 2011 by the Baylor College of Medicine at the Bugando Medical Center for the Lake Zone and the Mbeya Consultant Hospital for the Southern Highlands Zone.

**The BIPAI Program:** BIPAI Tanzania is currently focused on scaling up its operations in the Lake Zone and the Southern Highlands Zone because these two zones are in critical need of additional trained health care personnel and improved services for HIV care and treatment. BIPAI staff currently work in regional and district hospitals and clinics, and also work to develop relationships with partner organizations and health professionals at all levels to enhance care for children infected and affected by HIV/AIDS.

### **The Evaluation Team:**

USAID has contracted the GH Pro Evaluation firm to conduct an evaluation of BIPAI. As part of the evaluation, the GH Pro Evaluation team needs to interview key informants and hold focus group discussions with a variety of stakeholders.

### **Your Part in the Evaluation:**

If you agree to be a participant in the evaluation, you will be asked to respond to questions to help USAID and BIPAI learn about the current status of the performance, quality, and results of the BIPAI program. Your part in the evaluation will last no more than one hour.

### **Possible Risks and Benefits:**

There are no risks expected as a result of your participation in the evaluation. By participating, your answers to our questions will help USAID, BIPAI, and the Ministry of Health and Social Welfare (MoHSW) improve the programs and services for prevention, treatment and care of HIV infections among children in Tanzania.

**If You Decide Not to Participate in the Evaluation:**

You are free to refuse to participate in this evaluation, and you may leave at any time.

**Confidentiality:**

We will protect information about you and your taking part in this evaluation to the best of our ability. If the results of this study are published, your name will not be shown.

**Compensation:**

We are very appreciative of your participation, but you will not be paid for your participation.

**Contacts for Questions:**

If you have any problems or questions about your participation in this evaluation, please call the GH Pro team (Dr. Nandi: 0753-983-633 or Dr. Bernstein: 0758-768-714) or USAID (Ms. Bisimba: 0655-867-600)

The above document describing the benefits, risks and procedures for my participation in the **Evaluation of the Baylor International Pediatric AIDS Initiative (BIPAI) in Tanzania** has been read, and explained to me. I agree to participate as a volunteer.

\_\_\_\_\_  
Date \_\_\_\_\_ Signature or mark of volunteer

**If volunteer cannot read the form himself/herself, a witness must sign here:**

I was present while the benefits, risks, and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the evaluation.

\_\_\_\_\_  
Date \_\_\_\_\_ Signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this evaluation have been explained to the above individual.

\_\_\_\_\_  
Date \_\_\_\_\_ Name and signature of person obtaining consent

KII or FGD  
Location: Mwanza    Mara    Mbeya    Rukwa  
Institution or facility:  
Respondent: Gender F or M    Designation/position:  
Notes:

## CAREGIVER EXIT INTERVIEW

Date: \_\_\_\_\_  
Start time \_\_\_\_\_ End time: \_\_\_\_\_  
Region: \_\_\_\_\_  
District: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Facility type/level: (circle the appropriate option)

- a. COE
- b. Regional hospital
- c. Health center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

### RESPONDENT TYPE: (CIRCLE ONE)

- Doctor
- Pediatric Specialist
- In-charge of Health Center
- Midwife
- H/C Nurse
- PMTCT
- Laboratory
- Pharmacy
- Program Manager

Other: \_\_\_\_\_  
(SPECIFY)

**SEX OF RESPONDENT:** Male      Female  
(CIRCLE ONE)

1. What services did you receive today? (tick all that apply)
  - a. Clinical
  - b. Support
  - c. Lab
  - d. Pharmacy
  - e. Other: \_\_\_\_\_ (specify)
2. How were you referred to this health facility?
  - a. By a healthcare provider
  - b. I referred myself because It is the most convenient for my family
  - c. It is better than others
  - d. Other
3. How long did you travel (in km) to come here today? \_\_\_Kms
4. How long did it take you to get here today? \_\_\_minutes
5. Is this the closest care and treatment facility for pediatric HIV/AIDS to your home?
  - a. Yes
  - b. No
6. How did you reach the facility today?

- a. Public transport
  - b. Boda
  - c. On foot
7. When you come for a visit, how long do you usually wait (in minutes) to see a provider?  
\_\_\_Minutes
8. How long did you wait (in minutes) to see a provider today? \_\_\_Minutes

If you were served by the following services today, please tell us about the wait time.

	1. I waited too long	2. The wait time was Ok
a. Registration		
b. Clinician		
c. Nurse		
d. Lab		
e. Pharmacy		

9. Do clinic hours meet your needs to care for your child?
- a. Yes
  - b. No
10. Did you have the opportunity to ask questions
- a. Yes
  - b. No
11. At your visit today, do you feel the provider listened to you?
- a. Yes
  - b. No
12. Did the provider explain things clearly to you?
- a. Yes
  - b. No
13. Did the provider show you respect?
- a. Yes
  - b. No
14. Did the other staff show your respect?
- a. Yes
  - b. No
15. In general, how satisfied are you with the services you receive?
- a. Very Satisfied
  - b. Satisfied
  - c. Not satisfied
16. Where do people with in this community usually prefer to go for pediatric HIV/AIDS care?
- a. This facility
  - b. Another facility

## CAREGIVER FOCUS GROUP DISCUSSION

Date: \_\_\_\_\_

Start time: \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility name: \_\_\_\_\_

Facility type/level: (circle the appropriate option)

COE

Regional hospital

Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions.

In particular, there are 3 main approaches to eliciting more information from the respondents:

1. Seek more detail or explanation of a response. For example:

- Tell me more about \_\_\_\_\_
- Can you give an example of \_\_\_\_\_?
- What happened next?

2. Explore the reasons behind a response. For example:

- What makes you say that?
- What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?

3. Seek clarity and check for inconsistencies. For example:

- Can you explain what you mean by....?
- Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines: INTRODUCTION

Suggested time: 10 minutes

- Thank the participants for coming.
- Explain the purpose of the group discussion:
- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is

said in the discussion should not be talked about outside of the group.

- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.
- Ask everyone to speak one at a time.
- Read out the consent script.
- Read the participant instructions
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

Hello, my name is \_\_\_\_\_. We are here on behalf of GH PRO to evaluate the BIPAI program for testing, care and treatment of pediatric HIV/AIDS. The purpose of this FGD is to better understand how the caregivers of families affected with HIV/AIDS feel about the clinical and community-based services they receive. The FGD should last \_\_\_\_\_.

### **ACTIVITY 1: HEALTH FACILITY SERVICES**

Suggested time: 10 minutes

1. Can you please share with us about your connection to this health care facility? When did you start coming here? How did you know to come here? What motivates you to bring your child for care? What are some reasons why someone would not want to come here? Where do most people in your situation prefer to go for care?
2. I'd like to know about how you feel about the services offered at this facility.  
Probe for:
  - a. What type of services do you attend?
  - b. Are you satisfied with the services offered? Why or why not?
  - c. Do the services meet your family's needs?
  - d. Are there additional services you need?

### **ACTIVITY 2: FAMILY CHALLENGES**

Suggested time: 15 minutes

3. Caring for an HIV-infected child can be challenging. What are the major challenges that your family faces?  
Probe for:
  - a. Stigma
  - b. Cost
  - c. Medications: cost, availability, side effects, adherence
  - d. Access to services
  - e. Other
4. What does the community think about caregivers of children who are exposed to or infected with HIV/AIDS?
5. Do male partners encourage or discourage women to access HIV testing and treatment? Why or why not?
6. Do other family members encourage pregnant women to access HIV testing? Which family members encourage pregnant women to HIV testing and treatment? What could be some reasons for encouraging this behavior? Which family members discourage pregnant women from accessing HIV testing and treatment? Please share some reasons the behavior is discouraged?

7. Will [husband] accompany his wife for HIV testing and treatment? Why or why not?

### ACTIVITY 3: CARE OF CHILD

Suggested time: 10 minutes

8. Please tell me how confident you feel to take care of your child's health needs related to HIV?  
Probe for:
- Do you know what medicines your child takes and why?
  - Do you understand when to give the medicines?
  - If your child is on ART, for what symptoms would you bring them to the clinic?
  - What symptoms would you manage at home?
  - Do you feel that you can take care of your child's nutritional needs?
9. It is difficult to take medications perfectly. What are some reasons why your child has not taken their medicines at the correct time or in the correct dose? What did you do to solve the problem?

### ACTIVITY 4: COMMUNITY PERCEPTIONS

Suggested time: 10 minutes

10. Please explain how the community feels about people infected and affected with HIV/AIDS?
11. How do community members' attitudes about HIV testing today compare to community attitudes about a year ago  
Probe for:
- What is the community's perception of children exposed to or living with HIV/AIDS?
  - What does the community think about caregivers of children living with HIV/AIDS?
  - Do you feel comfortable telling people that you care for an HIV-infected child?

### ACTIVITY 5: OUTREACH

Suggested time: 15 minutes

12. Have you ever heard of the "know your child's status" outreach program? Please tell us what you know about this program
- Probe: How active is the program in this community? What topics do they discuss?
  - In your opinion, how effective is this program at promoting infant HIV testing and HIV testing in general in your community?
  - What, if any, effect has the program had on you and your lives?
13. What is the most significant change that has occurred in the community as a result of the "know your child's status" outreach program?
14. Have you ever heard of The "Peer Mothers Program"? Tell me what you know about The Peer Mothers Program. Probe: What do Peer Mothers do in your community?
- What type of information do they educate the community?
  - What do you think about the work Peer Mothers do? What do community members think?
15. What are some of the ways through which HIV treatment and care information has been provided to community members in the past year?
16. What do you think women and families would say are the benefits of HIV testing and treatment behaviors? What do you think they would say are disadvantages of HIV testing and treatment

behaviors? Probe: How involved are community members? How involved are men in HIV testing and treatment activities?

17. Community drama: Are you aware of any community drama activities on HIV testing, treatment?

c. If yes tell me what you know about the drama activities

d. Probe: what was the topic of the drama?

- What did you learn from the drama?
- What did you do with this information?
- Do you have other information about drama, “know your child’s status” activities and behaviors in this community that you would like to share?

<b>ACTIVITY 6: CLOSING</b>
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Suggested time: 5 minutes
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- Thank people for their participation. Remind them that the discussion will be kept confidential.
- Anything said in the discussion should not be talked about outside of the group.

## FOCUS GROUP DISCUSSION GUIDE FOR COMMUNITY CAREGIVERS

Date: \_\_\_\_\_  
 Start time \_\_\_\_\_ End time: \_\_\_\_\_  
 Region: \_\_\_\_\_  
 District: \_\_\_\_\_  
 Facility name: \_\_\_\_\_  
 Facility type/level: (circle the appropriate option)  
     COE  
     Regional hospital  
     Health Center  
 Community: \_\_\_\_\_  
 Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions.

In particular, there are 3 main approaches to eliciting more information from the respondents:

- 1) Seek more detail or explanation of a response. For example:
  - Tell me more about \_\_\_\_\_
  - Can you give an example of \_\_\_\_\_?
  - What happened next?
- 2) Explore the reasons behind a response. For example:
  - What makes you say that?
  - What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?
- 3) Seek clarity and check for inconsistencies. For example:
  - Can you explain what you mean by....?
  - Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines:

#### INTRODUCTION

Suggested time:

- Thank the participants for coming.
- Explain the purpose of the group discussion.

- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is said in the discussion should not be talked about outside of the group.
- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.
- Ask everyone to speak one at a time.
- Read out the consent script.
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

### **ACTIVITY 1 :**

Suggested time:

Discussion questions/prompts:

### **ACTIVITY: Attitudes towards HIV testing/treatment**

1. Please tell us what you know about HIV testing in pregnancy and how it affects the baby.  
Probe: Negative results / positive results.
2. Could you please tell us ways in which a mother can prevent her baby from getting infected with HIV? Probe: PMTCT Methods – testing and counselling, medical treatment, use of condoms
3. When you go to the health center, what does the nurse discuss with you in relation to HIV testing and treatment?
4. Where do most pregnant women in this community go for HIV testing? Where else might they go? What motivates pregnant women to go to these various locations for testing? How do they choose?
5. What do you think are the benefits of HIV testing and treatment behaviors?
6. What do you think they would say are disadvantages of HIV testing and treatment behaviors?
7. How available and accessible are HIV, testing and counseling services?  
Probe: How involved are community members? How involved are men in HIV testing and treatment activities?
8. Do male partners encourage or discourage women to access HIV testing and treatment? Why?
  - Do other family members encourage pregnant women to access HIV testing? Which family members encourage pregnant women to HIV testing and treatment? Why do they encourage this behavior?
  - Which family members discourage pregnant women from accessing HIV testing and treatment? Why do they discourage?
9. Will [husband] accompany his wife for HIV testing and treatment Why or why not?
10. How would you describe your attitude towards scheduled clinic visit today? Probe: How does your attitude today compare to your attitudes about a year ago? How do your behaviors related to scheduled clinic visits today compare to about a year ago?
11. Besides the health center where else would you get information about pregnancy and HIV?

### **ACTIVITY 2 'Know Your Child's Status'**

Suggested time:

- Have you ever heard of the “know your child's status” outreach program? Please tell us what you know about this program
  - Probe: How active is the program in this community? What topics do they discuss?

- In your opinion, how effective is this program at promoting Infant HIV testing and HIV testing in general in your community?
- What, if any, effect has the program had on you and your lives?
- What is the most significant change that has occurred in the community as a result of the “know your child’s status” outreach program
- Have you ever heard of The “Peer Mothers Program”? Tell me what you know about the Peer Mothers Program. Probe: What do Peer Mothers do in your community?
  - What type of information do they educate the community?
  - What do you think about the work Peer Mothers do? What do community members think?

#### **ACTIVITY 4 : Peer Mothers**

- Have you ever heard of the “Peer Mothers Program”? Please tell me what you know about Peer Mothers Program
  - Probe: What do Peer Mothers do in your community?
  - What topics do they sensitize/inform the community on?
- What do you think about the work Peer Mothers do? What do community members what are some of the ways through which the “Peer Mothers“ have provided information about HIV treatment and care information has been provided to community members in the past year?

#### **ACTIVITY 4 : Community Drama**

##### **Community drama**

- Are you aware of any community drama activities on HIV testing, treatment?
- Have you ever watched one of these dramas?
- If yes tell me what you know about the drama activities
- Probe: the topic of the drama at the time of watching
- What did you learn from the drama?
- What did you do with this information?
- Do you have other information about drama, “know your child’s status” activities and behaviors in this community that you would like to share?

#### **ACTIVITY 4 : Vijana Super Group (VSG)**

Have you ever heard of a youth group called Vijana Super Group (VSG)? If so, what do you know about it?

- Probe: Have you ever watched them perform? If so, how many times? If not why not?
- What topics have you learned about from watching VSG or listening to them on the Radio?
- Probe for: HIV, nutrition
- How useful was the information you heard?
- What actions did you take after hearing this information? Did you discuss it with someone? Who?
- What role have you played in relation to the VSG to encourage the community listen/watch?

#### **CLOSING**

- Thank people for their participation.
- Remind them that the discussion will be kept confidential. Anything said in the discussion should not be talked about outside of the group.

## FOCUS GROUP DISCUSSION GUIDE FOR EXPERT/PEER MOTHERS

Date: \_\_\_\_\_

Start time: \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility name: \_\_\_\_\_

Facility type/level: (circle the appropriate option)

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions.

In particular, there are 3 main approaches to eliciting more information from the respondents:

1. Seek more detail or explanation of a response. For example:

- Tell me more about \_\_\_\_\_
- Can you give an example of \_\_\_\_\_?
- What happened next?

2. Explore the reasons behind a response. For example:

- What makes you say that?
- What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?

3. Seek clarity and check for inconsistencies. For example:

- Can you explain what you mean by....?
- Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines: INTRODUCTION

Suggested time: 10 minutes

- Thank the participants for coming.
- Explain the purpose of the group discussion:

- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is said in the discussion should not be talked about outside of the group.
- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.
- Ask everyone to speak one at a time.
- Read out the consent script.
- Read the participant instructions.
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

Hello, my name is \_\_\_\_\_. We are here on behalf of GH PRO to evaluate the BIPAI program for testing, care and treatment of pediatric HIV/AIDS. The purpose of this FGD is to better understand how the caregivers of families affected with HIV/AIDS feel about the clinical and community-based services they receive. The FGD should last 30 minutes.

**ACTIVITY I: Expert/Peer program**

Suggested time: 20 minutes

1. Please share with us what the Expert/Peer program does.
2. How would you describe the altitude of community members towards the Expert/Peer program today?
3. How do community member attitudes today compare to community attitudes about a year ago?  
Probe: Attitude of appreciation vs. stigmatization
4. How do community member behaviors related to HIV testing/treatment today compared to about a year ago?
5. Describe the attitudes and behaviors of those who seem to favor HIV testing/treatment community members.
  - a. Describe those who do not seem to favor testing and treatment activities.
6. Is HIV testing among infants/children/adolescents a priority for people living in this community? Why? Why not?
7. What makes it easy to promote HIV activities in this community? What makes it difficult?  
Probe: How did community members respond to your role promoting HIV testing and treatment? Were you accepted in this role? If not, why do you think that was so? How did you overcome this?
8. Tell me about some of the things you have done to promote HIV testing and treatment in this community in the past year?  
Probe: How have community members responded to these activities? How involved are community members?
9. Which community members are more involved than others? Why do you think makes this so?
10. Tell me a story about one of the successes of your community program to promote HIV testing and treatment

Probe: Describe how a pregnant woman and her family have benefited from HIV testing and treatment activities?

11. What does the community think about HIV testing? Who should be tested? Why? What do they know about pediatric testing for HIV? Where can they get tested? When can they get tested? How eager are they to be tested? Why? What is their source of information for pediatric HIV testing?

12. Please describe a challenge you experienced while promoting HIV testing and treatment activities in the community.

Probe: How did you overcome the challenge?

13. What should be done to encourage community participation in HIV testing and counseling?

a. What activities are most effective? What messages are most effective? Which people should be involved?

b. Probe: For reasoning behind the answers

14. Would you say that your involvement in the program has helped improve the way you care for your HIV-infected child?

15. What training have you received from Baylor and others if any to help you perform the role as an Expert/Peer Mother?

<b>ACTIVITY 2: CLOSING</b>
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Suggested time: 5 minutes
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- Thank people for their participation. Remind them that the discussion will be kept confidential.
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## PREGNANT WOMEN FOCUS GROUP DISCUSSION

Date: \_\_\_\_\_

Start time: \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility name: \_\_\_\_\_

Facility type/level: *(circle the appropriate option)*

COE

Regional hospital

Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions. In particular, there are 3 main approaches to eliciting more information from the respondents:

1. Seek more detail or explanation of a response. For example:

- Tell me more about \_\_\_\_\_
- Can you give an example of \_\_\_\_\_?
- What happened next?

2. Explore the reasons behind a response. For example:

- What makes you say that?
- What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?

3. Seek clarity and check for inconsistencies. For example:

- Can you explain what you mean by....?
- Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines: INTRODUCTION

Suggested time: 10 minutes

- Thank the participants for coming.
- Explain the purpose of the group discussion.
- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is said in the discussion should not be talked about outside of the group.
- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.

- Ask everyone to speak one at a time.
- Read out the consent script.
- Read the participant instructions.
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

Hello, my name is \_\_\_\_\_. We are here on behalf of GH PRO to evaluate the BIPAI program for testing, care and treatment of pediatric HIV/AIDS. The purpose of this FGD is to better understand how pregnant women in communities affected with HIV/AIDS feel about the clinical and community-based services they receive. The FGD should last \_\_\_\_\_.

### **ACTIVITY 1: HIV Testing and Treatment**

Suggested time: 60 minutes

12. Please tell us what you know about HIV testing in pregnancy and how it affects the baby.  
Probe: Negative results / positive results.
13. Could you please tell us ways in which a mother can prevent her baby from getting infected with HIV?  
Probe: PMTCT methods – testing and counseling, medical treatment, use of condoms
14. When you go to the health center, what does the nurse discuss with you in relation to HIV testing and treatment?
15. Where do most pregnant women in this community go for HIV testing? Where else might they go? What motivates pregnant women to go to these various locations for testing? How do they choose?
16. What do you think are the benefits of HIV testing and treatment behaviors?
17. What do you think they would say are disadvantages of HIV testing and treatment behaviors?
18. How available and accessible are HIV, testing and counseling services? Probe: How involved are community members? How involved are men in HIV testing and treatment activities?
19. Do male partners encourage or discourage women to access HIV testing and treatment? Why?
- Do other family members encourage pregnant women to access HIV testing? Which family members encourage pregnant women to HIV testing and treatment? Why do they encourage this behavior?
  - Which family members discourage pregnant women from accessing HIV testing and treatment? Why do they discourage?
20. Will [husband] accompany his wife for HIV testing and treatment? Why or why not?
21. How would you describe your attitude towards scheduled clinic visit today? Probe:
- How do your attitudes today compare to your attitudes about a year ago?
  - How do your behaviors related to scheduled clinic visits today compare to about a year ago?
22. Besides the health center, where else would you get information about pregnancy and HIV?

### **ACTIVITY 2: CLOSING**

Suggested time: 5 minutes

- Thank people for their participation. Remind them that the discussion will be kept confidential.
- Anything said in the discussion should not be talked about outside of the group.

## FOCUS GROUP DISCUSSION GUIDE FOR ADOLESCENTS

Date: \_\_\_\_\_

Start time: \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility name: \_\_\_\_\_

Facility type/level: (circle the appropriate option)

COE

Regional hospital

Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions.

In particular, there are 3 main approaches to eliciting more information from the respondents:

1. Seek more detail or explanation of a response. For example:

- Tell me more about \_\_\_\_\_
- Can you give an example of \_\_\_\_\_?
- What happened next?

2. Explore the reasons behind a response. For example:

- What makes you say that?
- What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?

3. Seek clarity and check for inconsistencies. For example:

- Can you explain what you mean by....?
- Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines: INTRODUCTION

Suggested time: 10 minutes

- Thank the participants for coming.
- Explain the purpose of the group discussion:
- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is said in the discussion should not be talked about outside of the group.
- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.
- Ask everyone to speak one at a time.
- Read out the consent script.

- Read the participant instructions.
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

Hello, my name is\_\_\_\_\_. We are here on behalf of GH PRO to evaluate the BIPAI program for testing, care and treatment of pediatric HIV/AIDS. The purpose of this FGD is to better understand how teens affected with HIV/AIDS feel about the clinical and community-based services they receive. The FGD should last 30 minutes.

**ACTIVITY 1 Adolescents living with HIV/AIDS**

Suggested time: 20 minutes

1. Could you please tell us about the teen program and what it means to you?  
Probe: how did they know about the program?
2. How has participating in the teen group changed your lives and ability to care for yourselves?
  - a. Probe: Prevention to transmission to others
  - b. Adherence to medication, managing side effects
3. In which areas do you feel confident to care for yourself?
4. Please can you share with us what it means to live positively while being HIV positive?
5. What are the community perceptions towards your HIV status? Do they treat you differently? If so in what ways?
6. How do attitudes about your HIV status today compare to a year ago? Can you give me an example?
7. To what extent are your caregivers willing and able to seek care or treatment for you? Why? Why not?
8. Please describe to us your coping skills and tell us if there are any different in comparison to the time before you joined the program?
  - a. Probe: Improvement in coping skills (need to explain coping skills)
  - b. Difficulties in coping skills before
9. What other skills would you like to acquire that are not part of the Teen program?
10. Could you please describe a challenge you experienced while promoting HIV testing and treatment activities in the community.
  - a. Probe: How did you overcome the challenge?
11. What should be done to encourage community participation in supporting the teen program?
12. What should be done to encourage community participation in overcoming stigma and discrimination?

**ACTIVITY 2: CLOSING**

Suggested time: 5 minutes

- Thank people for their participation. Remind them that the discussion will be kept confidential.
- Anything said in the discussion should not be talked about outside of the group.

## VILLAGE LEADER CHANGE AGENTS FOCUS GROUP DISCUSSION

Date: \_\_\_\_\_

Start time: \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility name: \_\_\_\_\_

Facility type/level: (circle the appropriate option)

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Position/designation</u>

### General guidelines:

The topics and questions below should be used to guide the focus group. Keep in mind when conducting the focus group to respond to the answers provided by the respondents by asking additional questions or adapting to more appropriate questions. In particular, there are 3 main approaches to eliciting more information from the respondents:

1. Seek more detail or explanation of a response. For example:

- Tell me more about \_\_\_\_\_
- Can you give an example of \_\_\_\_\_?
- What happened next?

2. Explore the reasons behind a response. For example:

- What makes you say that?
- What was it about \_\_\_\_\_ that made you decide to \_\_\_\_\_?

3. Seek clarity and check for inconsistencies. For example:

- Can you explain what you mean by....?
- Earlier you said \_\_\_\_\_ but it also seems like \_\_\_\_\_. Can you explain?

### Focus Group Discussion Guidelines: INTRODUCTION

Suggested time: 10 minutes

- Thank the participants for coming.
- Explain the purpose of the group discussion:

- Tell the amount of time the discussion is expected to last – about 1 hour.
- Introduce the facilitator, the note taker and explain what each one will be doing.
- Explain that a tape recorder will be used since the note taker can't write down everything.
- Assure that the discussion will be kept confidential. Remind the participants that anything that is said in the discussion should not be talked about outside of the group.
- Explain that there are no right answers and it is okay to disagree. It is important to respect others' opinions.
- Ask everyone to speak one at a time.
- Read out the consent script.
- Read the participant instructions.
- Ask if there are any questions.
- Have participants introduce themselves. If they want they can choose a nickname or fictional name to use during the group discussion instead of their real name.

Hello, my name is \_\_\_\_\_. We are here on behalf of GH PRO to evaluate the BIPAI program for testing, care and treatment of pediatric HIV/AIDS. The purpose of this FGD is to better understand how communities affected by HIV/AIDS feel about the clinical and community-based services they receive. The FGD should last 1 hour and 1/2.

**ACTIVITY 1: Attitudes and Behaviors Toward HIV/AIDS**

Suggested Time: 15 minutes

- 1) How would you describe community member attitudes towards your involvement as a change agent?
  - a) Is HIV testing and treatment an issue of importance to this community? Why? Why not?
  - b) Probe: How do attitudes about HIV testing today compare to a year ago? Can you give me an example?
- 2) Are you aware of HIV activities in this community? If yes, describe some of these activities to me.
- 3) Probe: What has this community done in the past year to support more pregnant women and families affected by HIV to go for HIV testing and treatment?
- 4) How have community members responded to the implementation of HIV testing and treatment activities in the community?
- 5) Probe: How involved are community members?
  - a) How involved are men? How could men support these activities for their families?
  - b) What are the characteristics of community members?
  - c) Who favors HIV testing and treatment programs?
  - d) Who does not favor HIV treatment and testing activities?
- 6) What are some of the ways information about HIV testing and treatment has been provided to community members in the past year?
- 7) In your opinion, has this information been effective in increasing the number of people in the community accessing HIV testing and treatment?

**ACTIVITY 2: Prevention practices HIV testing and treatment**

Suggested time: 15 minutes

- 1) What does the community think about HIV testing? Who should be tested? Why? What do they know about pediatric HIV testing? When can they test? Where can they test? How eager are they to test? Why? Where can they access HIV testing services?
- 2) What would you say about attitudes towards testing in the community have they changed over time? If so can you explain how?
- 3) Do male partners encourage or discourage women to access HIV testing and treatment?
  - a) If so could you please state some of the reasons?
- 4) Do other family members encourage pregnant women to access HIV testing? Which family members encourage pregnant women to HIV testing and treatment Why do they encourage this behavior? Which family members discourage pregnant women from accessing HIV testing and treatment? Why do they discourage?
- 5) Will [husband] accompany his wife for HIV testing and treatment? Why or why not?
- 6) How has been community response to mobilization and education on pediatric HIV and related TB?
- 7) What are some of prevention practices that the community is engaged in to support infant/ children/adolescents with HIV infection (people living with HIV)?
- 8) How best can the community be mobilized to create demand for prevention services? In which focus areas do they need the most sensitization? What activities? What should be done to encourage community participation?
- 9) Describe some of the activities which you as village leaders have implemented in this community in the past year meant to support people living with HIV:
  - a) Probe: Receive treatment and care support
  - b) Promote nutrition support
- 10) How have caregivers / pregnant women in this community responded to your outreach activities to promote HIV testing/treatment?
- 11) What factors motivate caregivers in this community to practice these behaviors? What factors prevent them from practicing these behaviors?
  - a) What activities? What messages? Which people should be involved?

<b>ACTIVITY 3: Know Your Child's Status</b>
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Suggested time: 15 minutes
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- 1) Have you ever heard of the “know your child’s status” outreach program? Please tell us what you know about this program:
  - a) Probe: How active is the program in this community? What topics do they discuss?
  - b) In your opinion, how effective is this program at promoting infant HIV testing / and HIV testing in general in your community?
  - c) What, if any, effect has the program had on you and your lives?
- 2) Has the program engaged with you as village leaders? If so how?
- 3) In your opinion, how effective is this program at promoting infant HIV testing / and HIV testing in general in your community?
- 4) What, if any, effect has the program had on you and your community?

- 5) What is the most significant change that has occurred in the community as a result of “know your child’s status” outreach program?
- 6) How would you describe the attitudes of community members towards HIV testing?
  - a) Probe: How do community members attitudes about HIV testing today compare to community attitudes about a year ago?
- 7) How do community members behavior related to infant and children HIV testing today compared to a year ago?
- 8) Is infant/children HIV testing a priority for people living in this community? Why? Why not? What makes it easy to promote infant / children testing in this community? What makes it difficulty?
  - a) Probe: How did community members respond to your role as a village leader promoting infant HIV testing? Were you accepted in this role? If not why do you think that was so? How did you overcome lack of acceptance from the community?
- 9) Please tell me about some of the things you have done to promote infant HIV testing in the past year:
  - a) Probe: How has community members responded to these activities? How involved are community members?
  - b) Which community members are more involved than others?
  - c) What factors motivate people in this community to practice these behaviors? What factors prevent them from practicing these behaviors?
- 10) How do you (could you) collaborate/coordinate/engage with health care providers in you village to encourage your community especially pregnant women to seek HIV testing and counseling?
- 11) What did the health providers discuss with you in relation to HIV testing and treatment?
  - a) Probe: Where do most pregnant women in this community go for HIV testing? Where else might they go? What motivates pregnant women to go to these various locations for testing?

<b>ACTIVITY 4: Peer Mothers</b>
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Suggested time: 15 minutes
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- 1) Have you ever heard of the ‘Peer Mothers Program’? Please tell me what you know about Peer Mothers Program:
  - (a) Probe: What do Peer Mothers do in your community?
  - (b) What topics do they sensitize/inform the community on?
- 2) What do you think about the work Peer Mothers do? What are some of the ways through which the Peer Mothers have provided information about HIV treatment and care information has been provided to community members in the past year?

<b>ACTIVITY 5: Community Drama</b>
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Suggested time: 15 minutes
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- 1) Are you aware of any community drama activities on HIV testing, treatment?
  - a) Have you ever watched one of these dramas?
  - b) If yes tell me what you know about the drama activities.
  - c) Probe: the topic of the drama at the time of watching

- d) What did you learn from the drama?
- e) What did you do with this information?
- 2) Do you have other information about drama, “know your child’s status” activities and behaviors in this community that you would like to share?

<b>ACTIVITY 6: Vijana Super Group (VSG)</b>
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Suggested time: 10 minutes
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- 1) Have you ever heard of a youth group called Vijana Super Group (VSG)? If so, what do you know about it?
  - a) Probe: Have you ever watched them perform? If so, how many times? If not why not?
  - b) What topics have you learned about from watching VSG or listening to them on the Radio?
  - c) Probe for: HIV, nutrition
  - d) How useful was the information you heard?
- 2) What actions did you take after hearing this information? Did you discuss it with someone? Who?
- 3) What role have you played in relation to the VSG to encourage the community listen/watch?

<b>ACTIVITY 7: CLOSING</b>
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Suggested time: 5 minutes
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- Thank people for their participation. Remind them that the discussion will be kept confidential.
- Anything said in the discussion should not be talked about outside of the group.

## HEALTH CARE WORKER KEY INFORMANT INTERVIEW

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility: \_\_\_\_\_

Facility type/level: (*circle the appropriate option*)

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

- Doctor
- Pediatric Specialist
- In-charge of Health Center
- Midwife
- H/C Nurse
- PMTCT
- Laboratory
- Pharmacy
- Program Manager
- Other: \_\_\_\_\_

(SPECIFY)

SEX OF RESPONDENT: Male      Female      (CIRCLE ONE)

### Approach

1. Please tell me what you know about how the family-centered approach to pediatric HIV/AIDS care and treatment works.

### BIPAI

2. Are you aware of the BIPAI program?
3. What is your overall impression of how effective the program has been in regards to:
  - a. Identification of children who are exposed to and infected with HIV
  - b. Testing of children who are exposed to and infected with HIV
  - c. HIV treatment of children who are exposed to and infected with HIV

PROBE: Can you provide some examples?

### Training

4. Are you aware of the BIPAI training on HIV for health care workers? What do you think of the methods that they use (didactic, mentorship and clinical attachment)?
5. Have you been through the BIPAI training? If yes,

- a. What topics were you trained in?
  - b. How do you feel about the training you received?
  - c. How did it change your clinical practice?
  - d. How can it be improved?
6. Have you been through the mentorship program with BIPAI? If yes,
    - a. How were you mentored?
    - b. How do you feel about the mentoring you received?
    - c. How did it change your clinical practice?
    - d. How can it be improved?
  7. Have you been involved in a clinical attachment with BIPAI? If yes,
    - a. What was the clinical service to which you were attached?
    - b. How do you feel about the attachment?
    - c. How did it change your clinical practice?
    - d. How can it be improved?
  8. Can you comment on how your involvement with BIPAI training/mentorship/clinical attachment has improved your clinical practice, if yes, how?
  9. I am interested in learning about the clinical Standard Operating Procedures (SOPs) in your facility.
    - a. What SOPs are available in this facility?
    - b. Have you been trained on them?
    - c. Where you can find them in the facility?

#### Confidence

10. Can you tell me about how competent you feel in your practice to:
  - a. provide family-centered HIV/AIDS care and treatment?
  - b. provide early infant diagnosis (EID)?
  - c. mobilize and educate the community on pediatric HIV and HIV-related TB?
11. In what areas do you feel you need more training?

#### Clinical Supervision

12. How do you feel about the support you receive from your supervisor?
13. Do you have any suggestions to improve the quality of supervision?

#### Testing

14. What do you think are the weaknesses or barriers in providing family-centered pediatric testing and counseling services?
15. To what extent has it been possible to identify infants according to the recommended time frame?
16. What is the appropriate time to test infants for HIV?
  - a. What have been the barriers for testing in this time frame?
  - b. What have been the facilitators for testing in this time frame?
17. What would you say are factors inhibiting clients coming back to get their results?
18. How effective has the BIPAI program been in identification of HIV-exposed infants in the local communities?
  - a. What have been the facilitators?

- b. What have been the barriers?
- c. How can the program be improved in this regard?

#### Laboratory

19. Please tell me about how the coordination is between the laboratory and clinical staff.
- a. How reachable/responsive is the laboratory staff when you have follow on questions?
  - b. Is there is a standard time frame for lab results to be returned?

#### Referrals

20. How are referrals to this facility made for newly identified HIV-positive clients?
- a. How do you think the system can be improved?
  - b. **At COE only:** Why do you think clients come to this site?

#### Lost to Follow-up

21. How does your facility define “lost to follow up”?
- a. In the past year, what percentage of clients are lost to follow up?
  - b. What are the most common reasons why clients are lost to follow up?
22. Can you describe the system to re-enroll clients who are lost follow up?
- a. How well is the system working?
  - b. How do you think the system can be improved?

#### Quality of Services/Retention

23. How do you feel about the quality of services that are provided here?
- a. What can be done to improve the quality of services?
24. How satisfied are you in your current position?
- a. If you are not satisfied, what would improve your satisfaction?

#### Community

25. Please describe the methods outreach activities that you aware of at the facility and those at the community?
- a. What has been the most effective tool for community outreach and why?
  - b. Which of these activities have been most effective and why?
  - c. How satisfied is the community with the services provided and why?
  - d. How can the community be mobilized to create demand for these services?
  - e. In which areas do they need the most sensitization?
  - f. What should be done to encourage community participation?
  - g. What people should be involved?

## NATIONAL LEVEL KEY INFORMANT INTERVIEW (BIPAI, CHRISTIAN SOCIAL SERVICES COMMISSION, WALTER REED PROGRAM)

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Position of the respondent:

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

Clinician (Specialist, MD, AMO, CO, CA)

Pediatric Specialist

In-charge of Health Center

Midwife

Nurse

PMTCT

Laboratory

Pharmacy

M&E Specialist

Program Manager

WHO

CDC

Type of Stakeholder \_\_\_\_\_

(SPECIFY)

SEX OF RESPONDENT: Male    Female    (CIRCLE ONE)

### A: PROGRAM MANAGEMENT

1. What are the major challenges in delivery of pediatric HIV care and treatment/PMTCT services in Tanzania?

**(Probes)** How has the BIPAI program uniquely confronted those challenges? How has the BIPAI program coordinated, cooperated and/or collaborated with you to address these challenges?

2. What are the major strengths of the BIPAI program? What are the major shortcomings of the BIPAI program?

3. How satisfied have you been with the BIPAI program in each of the 5 aims of BIPAI?

(Probe for) AIMS:

- *Provide family-centered pediatric HIV prevention, care and treatment*
- *Expand case finding of HIV-positive kids through strengthened care and treatment using family-centered approach*
- *Strengthen human resources and health system capacity to provide family-centered HIV care*
- *Sensitize and mobilize PLHWA to support services*

- *Help reduce HIV infection in kids and reduce deaths of mothers and children by increased postpartum care in Mbeya City*

## **B: PROGRAM ACCOMPLISHMENTS AND RESULTS**

4. Is there evidence that BIPAI have improved the **identification, testing, treating** and caring of HIV-infected children in the geographical areas you are working and other areas? (*Probe for improvement of the quality of services at the community level*)
5. How effective is the family-centered counseling and testing model in reaching the target population and why? Why not? If the effectiveness of this model is limited, please explain the limitations.
6. How is BIPAI project strengthening the local human resource and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services?
7. In your opinion, has the BIPAI project established constructive working relationship with you and other key stakeholders such as government, like-minded partners? (***Probe on how regular meetings for update are held and if the government provides guidance and feedback***)

## **C: LESSONS LEARNED and APPLICABLE, FUTURE PROGRAMMING AND SUSTAINABILITY**

8. How has BIPAI built capacity (human resources, institutions, and systems/policies) to ensure that HIV pediatric services are provided beyond project phase-out? (*Probe on type of services, target population groups, institutions, implementing partners, collaborators*)
9. What good practices (what works well) and lessons have been learned in the BIPAI project in that you think can be replicated in the country and elsewhere?
10. What would you advise the Government of Tanzania, USAID and BIPAI are the current and future funding priorities with regard to strengthening comprehensive HIV/AIDS services for children in Tanzania?
11. What recommendations (in regard to strengthening pediatric HIV services) would you make for future programming?

## DISTRICT KEY INFORMANT INTERVIEW (DACCO / DRHCO)

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Position of the respondent:

Facility type/level: (*circle the appropriate option*)

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

- Clinician (Specialist, MD, AMO, CO, CA)
- Pediatric Specialist
- In-charge of Health Center
- Midwife
- Nurse
- PMTCT
- Laboratory
- Pharmacy
- Program Manager
- Other: \_\_\_\_\_

(SPECIFY)

SEX OF RESPONDENT: Male    Female    (CIRCLE ONE)

### A: PROGRAM MANAGEMENT

1. What are the major challenges in delivery of pediatric HIV care and treatment/PMTCT?

**(Probe) How has BIPAI uniquely confronted those challenges?**

2. What are the major strengths of the BIPAI program? What are the major shortcomings of the BIPAI program?

3. How satisfied have you been with the BIPAI program in each of 5 aims?

**(Probe for) AIMS:**

- *Provide family-centered pediatric HIV prevention, care and treatment*
- *Expand case finding of HIV-positive kids through strengthened care and treatment using family-centered approach*
- *Strengthen human resources and health system capacity to provide family-centered HIV care*
- *Sensitize and mobilize PLHWA to support services*

- *Help reduce HIV infection in kids and reduce deaths of mothers and children by increased postpartum care in Mbeya City*

## **B: PROGRAM ACCOMPLISHMENTS AND RESULTS**

4. Is there evidence that BIPAI has improved the quality in
  - ***Identification of the exposed/infected children***
  - ***Testing of identified children***
  - ***Treating of identified children (probe for the quality of service)***
5. Tell me your understanding of family-centered counseling and testing?
  - How effective is family-centered counseling and testing model in reaching the target population. ***(Probe: why do they think that BIPAI has been effective?)***
6. How BIPAI has strengthened the local human resources and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services?
7. In your opinion, how has BIPAI established constructive working relationships with key stakeholders such as government and like-minded partners? ***(Probe on how regular meetings for update are held and if the government provides guidance and feedback)***

## **C: LESSON LEARNED AND SUSTAINABILITY**

8. How has BIPAI built capacity and/or institutionalized to ensure that HIV pediatric services are provided beyond project phase-out? ***(Probe on type of services, target population groups, implementing partners, training institutions)***
9. What are the good practices (what works well) in this project that can be replicated (sustained) in your district?
10. What improvements would you make to the program going forward?
11. Has the BIPAI project helped integrated HIV prevention services into the reproductive health and family planning program? (please give examples: PMTCT)

## KEY INFORMANT INTERVIEW (GOVERNMENT OFFICIALS AT NATIONAL LEVEL: (MOHSW-NACP/RCH SECTION))

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

Position of respondent:

RESPONDENT TYPE: (CIRCLE ONE)

MOHSW

Clinician (Specialist, MD, AMO, CO, CA)

In-charge of Health Center

Midwife

Nurse

PMTCT

Laboratory

Pharmacy

M&E Specialist

Program Manager

WHO

CDC

Type of Stakeholder \_\_\_\_\_  
(SPECIFY)

SEX OF RESPONDENT: Male      Female      (CIRCLE ONE)

### A: PROGRAM MANAGEMENT

1. What are the major challenges in delivery of pediatric HIV care and treatment/PMTCT services in Tanzania?

**(Probe)** How has the BIPAI program uniquely confronted those challenges? How has the BIPAI program coordinated, cooperated and/or collaborated with you to address these challenges?

2. What are the major strengths of the BIPAI program? What are the major shortcomings of the BIPAI program?

3. How satisfied have you been with the BIPAI program in each of the 5 aims of BIPAI?

**(Probe)** AIMS:

- *Provide family-centered pediatric HIV prevention, care and treatment*
- *Expand case finding of HIV-positive kids through strengthened care and treatment using family-centered approach*
- *Strengthen human resources and health system capacity to provide family-centered HIV care*
- *Sensitize and mobilize PLHWA to support services*

- *Help reduce HIV infection in kids and reduce deaths of mothers and children by increased post-partum care in Mbeya City*

## **B: PROGRAM ACCOMPLISHMENTS AND RESULTS**

**4.** Is there evidence that BIPAI has improved the **identification, testing, treating** and caring of HIV-infected children in the geographical areas you are working and other areas? **(Probe for Improvement of the quality of services at the community level)**

**5.** How effective is the family-centered counseling and testing model in reaching the target population and why? Why not? If the effectiveness of this model is limited, please explain the limitations.

**6.** How is BIPAI project strengthening the local human resource and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services?

**7.** In your opinion, has the BIPAI project established constructive working relationships with you and other key stakeholders such as government and like-minded partners? **(Probe on how regular meetings for update are held and if the government provides guidance and feedback)**

## **C: LESSONS LEARNED AND APPLICABLE FUTURE PROGRAMMING AND SUSTAINABILITY**

**8.** How has BIPAI built capacity (human resources, institutions, and systems/policies) to ensure that HIV pediatric services are provided beyond project phase out? **(Probe on type of services, target population groups, institutions, implementing partners, collaborators)**

**9.** What good practices (what works well) and lessons have been learned in the BIPAI project in that you think can be replicated in the country and elsewhere?

**10.** What would you advise the Government of Tanzania, USAID and BIPAI are the current and future funding priorities with regard to strengthening comprehensive HIV/AIDS services for children in Tanzania?

**11.** What recommendations (in regard to strengthening pediatric HIV services) would you make for future programming?

## KEY INFORMANT INTERVIEW GOVERNMENT OFFICIALS AT REGIONAL LEVEL: (RACCO / RRCHCO / RPMTCT COORDINATORS)

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Position of respondent:

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

Clinician (Specialist, MD, AMO, CO, CA)

Pediatric Specialist

In-charge of Health Center

Midwife

H/C Nurse

PMTCT

Laboratory

Pharmacy

M&E Specialist

Program Manager

WHO

CDC

Type of Stakeholder \_\_\_\_\_  
(SPECIFY)

SEX OF RESPONDENT: Male      Female      (CIRCLE ONE)

### A: PROGRAM MANAGEMENT

1. What are the major challenges in delivery of pediatric HIV care and treatment/PMTCT services in this region?

**(Probe)** How has the BIPAI program uniquely confronted those challenges? How has the BIPAI program coordinated, cooperated and/or collaborated with you to address these challenges?

2. What are the major strengths of the BIPAI program? What are the major shortcomings of the BIPAI program?

3. How has been support to improve the skills and capacity of local human resource **(Probe for supervision, assessment and feedback)**

4. How satisfied have you been with the BIPAI program in each of the 5 aims of BIPAI?

**(Probe for AIMS):**

- *Provide family-centered pediatric HIV prevention, care and treatment*
- *Expand case finding of HIV-positive kids through strengthened care and treatment using family-centered approach*
- *Strengthen human resources and health system capacity to provide family-centered HIV care*

- Sensitize and mobilize PLHWA to support services
- Help reduce HIV infection in kids and reduce deaths of mothers and children by increased postpartum care in Mbeya City

## **B: PROGRAM ACCOMPLISHMENTS AND RESULTS**

**5.** Is there evidence that BIPAI have improved the *identification, testing, treating* and caring of HIV-infected children in the geographical areas you are working and other areas? (**Probe for improvement of the quality of services at the community level**)

**6.** How effective is the family-centered counseling and testing model in reaching the target population and why? Why not? If the effectiveness of this model is limited, please explain the limitations.

**7.** How is BIPAI project strengthening the local human resource and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services?

**8.** In your opinion, has the BIPAI project established constructive working relationship with you and other key stakeholders such as government and like-minded partners? (**Probe on how regular meetings for update are held and if the government provides guidance and feedback**)

## **C: LESSONS LEARNED AND APPLICABLE FUTURE PROGRAMMING AND SUSTAINABILITY**

**9.** How has BIPAI built capacity (human resources, institutions, and systems/policies) to ensure that HIV pediatric services are provided beyond project phase out? (**Probe on type of services, target population groups, institutions, implementing partners, collaborators**)

**10.** What good practices (what works well) and lessons have been learned in the BIPAI project in that you think can be replicated in other regions and elsewhere?

**11.** What would you advise the Government of Tanzania, USAID and BIPAI are the current and future funding priorities with regard to strengthening comprehensive HIV/AIDS services for children in this region and elsewhere?

**12.** What recommendations (in regard to strengthening pediatric HIV services) would you make for future programming?

## NATIONAL LEVEL KEY INFORMANT INTERVIEW (USAID, CDC, UNAIDS, WHO, UNICEF)

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Position of respondent:

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

Clinician (Specialist, MD, AMO, CO, CA)

Pediatric Specialist

In-charge of Health Center

Midwife

H/C Nurse

PMTCT

Laboratory

Pharmacy

M&E Specialist

Program Manager

WHO

CDC

Type of Stakeholder \_\_\_\_\_  
(SPECIFY)

SEX OF RESPONDENT: Male                      Female                      (CIRCLE ONE)

### A: PROGRAM MANAGEMENT

1. What are the major challenges in delivery of pediatric HIV care and treatment/PMTCT services in Tanzania?

**(Probes)** How has the BIPAI program uniquely confronted those challenges? How has the BIPAI program coordinated, cooperated and/or collaborated with you to address these challenges?

2. What are the major strengths of the BIPAI program? What are the major shortcomings of the BIPAI program?

3. How satisfied have you been with the BIPAI program in each of the 5 aims of BIPAI?

**(Probe for)** AIMS:

- *Provide family-centered pediatric HIV prevention, care and treatment*
- *Expand case finding of HIV-positive kids through strengthened care and treatment using family-centered approach*
- *Strengthen human resources and health system capacity to provide family-centered HIV care*
- *Sensitize and mobilize PLHWA to support services*

- *Help reduce HIV infection in kids and reduce deaths of mothers and children by increased postpartum care in Mbeya City*

## **B: PROGRAM ACCOMPLISHMENTS AND RESULTS**

- 4.** Is there evidence that BIPAI have improved the **identification, testing, treating** and caring of HIV-infected children in the geographical areas you are working/ other areas? **(Probe for improvement of the quality of services at the community level)**
- 5.** How effective is the family-centered counseling and testing model in reaching the target population and why? Why not? If the effectiveness of this model is limited, please explain the limitations.
- 6.** How is BIPAI project strengthening the local human resources and health system capacity to provide comprehensive, family-centered, pediatric HIV/AIDS prevention, care and treatment services?
- 7.** In your opinion, has the BIPAI project established constructive working relationship with you and other key stakeholders such as government and like-minded partners? **(Probe on how regular meetings for update are held and if the government provides guidance and feedback)**

## **C: LESSONS LEARNED AND APPLICABLE FUTURE PROGRAMMING AND SUSTAINABILITY**

- 8.** How has BIPAI built capacity (human resources, institutions, and systems/policies) to ensure that HIV pediatric services are provided beyond project phase out? **(Probe on type of services, target population groups, institutions, implementing partners, collaborators)**
- 9.** What good practices (what works well) and lessons have been learned in the BIPAI project that you think can be replicated in the country and elsewhere?
- 10.** What would you advise the Government of Tanzania, USAID and BIPAI are the current and future funding priorities with regard to strengthening comprehensive HIV/AIDS services for children in Tanzania?
- 11.** What recommendations (in regard to strengthening pediatric HIV services) would you make for future programming?

## FACILITY-LEVEL KEY INFORMANT INTERVIEW (IN CHARGE)

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility: \_\_\_\_\_

Facility type/level: (circle the appropriate option)

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

- Doctor
- Pediatric Specialist
- In-charge of Health Center
- Midwife
- H/C Nurse
- PMTCT
- Laboratory
- Pharmacy
- Program Manager
- Other: \_\_\_\_\_

(SPECIFY)

SEX OF RESPONDENT: Male                      Female                      (CIRCLE ONE)

1. In your opinion, what are the major challenges in delivery of Early Infant Diagnosis/Pediatric HIV care and treatment in your facility?
2. How has the BIPAI program addressed these challenges?
3. How has BIPAI training/support changed the identification, testing or treatment of HIV-infected children in your facility?
4. In your opinion, what are the major strengths of the BIPAI program?
5. In your opinion, what are the major shortcomings of the BIPAI program?
6. Please provide some examples of how the BIPAI program has satisfied you.
7. Please provide some examples of how the BIPAI program has dissatisfied you.
8. What changes (additions or expansions) would you suggest for the program going forward?
9. In your opinion, how has the BIPAI project established constructive working relationships with key stakeholders such as government and like-minded partners? (**Probe on how regular meetings for update are held and if the government provides guidance and feedback**)

10. What do you think about the extent to which BIPAI is building the capacity of the government staff to improve identification of children who are exposed to and infected with HIV?
11. What do you think about the extent to which BIPAI is building the capacity of the government staff to improve testing of are children exposed to and infected with HIV?
12. What do you think about the extent to which BIPAI is building the capacity of the government staff to improve treatment of children who are exposed to and infected with HIV?
13. To what extent has participation in the BIPAI program affected the retention and/or career development of trained staff?
14. What has been done to increase the community service demand and utilization?

## FACILITY-LEVEL SURVEY

Date: \_\_\_\_\_

Start time \_\_\_\_\_ End time: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Facility: \_\_\_\_\_

Facility type/level: *(circle the appropriate option)*

- COE
- Regional hospital
- Health Center

Community: \_\_\_\_\_

Interviewer code: \_\_\_\_\_

RESPONDENT TYPE: (CIRCLE ONE)

In-charge of Health Center

Other: \_\_\_\_\_  
(SPECIFY)

SEX OF RESPONDENT: Male      Female      (CIRCLE ONE)

1. Please indicate whether the following services are provided in this facility: ***(Circle all appropriate options)***

1. Collection of DBS samples
2. Initiation of ART treatment for children
3. Other HIV treatment for children (OI diagnosis, OI treatment)
4. Initiation of ART treatment for adults
5. Other HIV treatment for adults (OI diagnosis, OI treatment, cervical cancer screening)
6. Prevention of mother-to-child-transmission (PMTCT) of HIV
7. TB screening
8. TB treatment
9. Maternity/delivery
10. CD4 testing
11. PCR Testing
12. Nutrition assessment and counseling
13. Nutrition support, e.g. therapeutic/supplements food
14. Infant feeding counseling
15. Immunization
16. TB meetings

2. Does your facility participate in or support? ***(Circle all appropriate options)***

1. Peer mothers program
2. Teen club

## PEDIATRIC HIV/AIDS

3. Number of service providers/service providers participating in BIPAI activities

	Number on staff	
	Full time	Part time
a) Pediatricians		
b) Medical Officers		
c) Assistant Medical Officers		
d) Clinical Officers		
e) Clinical Assistants		
f) Enrolled Nurses		
g) Registered Nurses		
h) Auxiliary Nurses		
i) Laboratory Staff		
j) Pharmacy		
k) Other		

4. When did this facility start to initiate pediatric ART treatment (month/year): \_\_\_\_\_

5. a) Does this facility have pediatric specific ART clinic days?

1. Yes
2. No

b) If yes, how frequently? \_\_\_\_\_

6. a) Does this facility supervise satellite clinics for ARV refills or other HIV care?

1. Yes
2. No

b) If yes, how many clinics? \_\_\_\_\_

7 a). Did this facility receive support supervision from the district/region in the past 3 months? (**Circle the appropriate option**)

1. Yes
2. No

b) **If YES, request and verify using supervision report** \_\_\_\_\_

8. How many staff been trained on the following SOP's? (*fill in all appropriate options*)

	I. Pediatric Early Infant Diagnosis	2. Pediatric HIV Care and Treatment
a) Pediatricians		
b) Medical Officers		
c) Assistant Medical Officers		
d) Clinical Officers		
e) Clinical Assistants		
f) Enrolled Nurses		
g) Registered Nurses		
h) Auxiliary Nurses		
i) Laboratory Staff		
j) Pharmacy		
k) Other		

9. Are clinical SOP's for pediatric HIV/AIDS care and treatment posted?

1. Yes
2. No

b) *If YES, request & verify* \_\_\_\_\_

10. Are clinical SOP's for EID posted?

1. Yes
2. No

b) *If YES, request & verify* \_\_\_\_\_

11. Do nurses initiate pediatric ART in this facility?

1. Yes
2. No

12. Has this facility experienced stock-outs of any ARV for children in the past 3 months? (**Circle all appropriate options**)

1. AZT, 3TC, NVP
2. AZT, 3TC, EFV
3. Stavudine, 3TC, NVP

13. Has this facility experienced stock-outs of HIV test kits in the past 3 months? (**Circle the appropriate option**)

1. Yes
2. No

14. Has this facility experienced stock-outs of DBS kits in the past 3 months? (**Circle the appropriate option**)

1. Yes
2. No

15. Has this facility experienced stock-outs of Cotrimoxazole for children in the past 3 months? (**Circle the appropriate option**)

1. Yes

2. No

16. Does the facility ensure privacy for clients being tested and treated?

1. Yes, visual only
2. Yes, auditory only
3. Yes, visual and auditory
4. No, neither one

17. Is the facility linked to any community programs or workers that support PMTCT or pediatric care of HIV in the community? (**Circle the appropriate option**)

1. Yes
2. No

18. Does the facility supervise any community programs or workers that support PMTCT or pediatric care of HIV in the community? (**Circle the appropriate option**)

1. Yes
2. No

19. If yes, what types of community pediatric HIV support are being offered?

1. HIV testing
2. Referral
3. Adherence
4. Peer support
5. Others (specify): \_\_\_\_\_

## **EARLY INFANT DIAGNOSIS**

20. Are any of the following tests performed at the point of care (POC) in this facility? (**Circle all appropriate options**)

1. CD4 count
2. Rapid HIV Antibody Test
3. PCR
4. Hematology
5. Viral load
6. Others (specify): \_\_\_\_\_

21. Where do you send DBS specimens after collection? (**Circle one relevant option**)

1. District
2. Direct to PCR laboratory
3. Region
4. Other (specify): \_\_\_\_\_

22. How frequently are the DBS samples sent to the above location? (**Circle one appropriate option**)

1. Daily
2. Weekly
3. Monthly
4. No specific schedule, depends on the availability of transport or a courier
5. No specific schedule, depends on the quantity

23. How are DBS results returned to the facility?

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24. Have there been any delays (more than 4 weeks after sending samples) in receiving results from laboratory in the past 3 months?

1. Yes
2. No

25. If yes, what are the reasons for the delay?

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26. How are DBS results returned to the mother/caretaker?

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27. Can mothers receive results directly from the laboratory? (**Circle one relevant option**)

1. Yes
2. No

28. On average how long does it take for mothers to receive results?

\_\_\_\_\_ Days

29. Based on your experience what are the common problems facing EID service in your facility?

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### **ART INITIATION AND RETENTION**

30. If results are positive, how long does it take to initiate treatment for children aged less than 2 years? (**Circle one appropriate option**)

1. Less than one week
2. Less than two weeks
3. Less than one month
4. More than one month

31. Who normally initiates treatment for children aged less than 2 years in this facility? (**Circle all relevant options**)

1. Clinicians (Pediatrician, MD, AMO, CO, CA)
2. Nurses (NO, NM, EN)
3. Others (Specify): \_\_\_\_\_

32. What are some reasons for delay in initiating children on ART in your facility?

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33. Where do ARV refills done? (**More than one option may apply**)

1. In this facility
2. Referred to Refill sites

34. How does this facility assist families in adherence to ART medication for children? \_\_\_\_\_

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35. What are the common factors affecting retention of children on ART once initiated in your facility:

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### **BIPAI PROGRAM**

36 Are you aware of the BIPAI training for pediatric HIV/AIDS family-centered care?

1. Yes
2. No

37. Has staff in your facility been trained by BIPAI for pediatric HIV care?

1. Yes
2. No

38. How many of each staff participated in training on Pediatric HIV/AIDS care from BIPAI?

	Participated in BIPAI Pediatric HIV		
	1. Training	2. Mentoring	3. Attachment
Pediatricians			
Medical Officers			
Assistant Medical Officers			
Clinical Officers			
Clinical Assistants			
Enrolled Nurses			
Registered Nurses			
Auxiliary Nurses			
Laboratory Staff			
Pharmacy			
Other			

## PROGRAM EVALUATION TEMPLATE

Specific Aim 1: To provide comprehensive, family-centered, pediatric HIV/AIDS care and treatment services							
S/No	Activity/Indicator	Facility (COE/ CTC/ Community)	Frequency	Results (Total, M/F) 2011	Results (Total, M/F) 2012	Results (Total, M/F) 2013	Results (Total, M/F) 2014
Continue to provide comprehensive family-centered pediatric HIV/AIDS care and treatment through the Children's Clinical Centers of Excellence (COEs) in the Lake and Southern Highlands Zones							
	Children and caregivers receiving counseling and testing						
	Children enrolled into HIV care and treatment						
	HIV infected, clinically malnourished children received therapeutic or supplementary food						
	Eligible clients receiving nutrition services						
	HIV-positive patients screened for TB						
	Children initiated on ART						
	Eligible HIV positive children receiving CPT						
	Number of Educational Sessions conducted to Teen Club members						
	Pediatric-focused support groups (including Teen Club) established and maintained						
	Income generating activities for adolescents						
	Number of adolescent receiving RCH (family planning) services and education						
	Number of children receiving TB diagnostic services						
	Number of children receiving TB treatment						
	Tracking of missed appointment and Lost to Follow Up (LTFU) of patients						
Continue to support comprehensive, family-centered pediatric and adolescent HIV/AIDS care and treatment in regional and district level facilities in the Southern Highlands zones. Baylor Tanzania supports 6 regions in Southern Highlands Zones.							
	Child and caregiver HIV testing and counseling						
	Children enrolled into HIV care						
	Children initiated onto ART						
	HIV+ children screened for TB						

<b>Specific Aim #2: To expand case finding for children who are HIV-positive through strengthened pediatric HIV/AIDS counseling and testing using a family-centered testing model</b>								
<b>S/No</b>	<b>Activity/Indicator</b>	<b>Facility (COE/ CTC/ Community)</b>	<b>Frequency</b>	<b>Results (Total, M/F) 2011</b>	<b>Results (Total, M/F) 2012</b>	<b>Results (Total, M/F) 2013</b>	<b>Results (Total, M/F) 2014</b>	
	Support facility-based HIV Provider Initiated Testing and Counseling (PITC) and Voluntary Counseling and Testing (VCT)							
	Number of health facilities supported to conduct pediatric-focused PITC through technical support and mentorship							
	Pediatric patients hospitalized receiving counseling and testing services (PITC)							
	Support and strengthen EID of HIV and care services in RCH of each mentoring site							
	Number of PNCs providing early infant diagnosis							
	Conduct pediatric-focused testing event, including "Know Your Child's Status" days, targeting children of known HIV positive adults or other high risk groups							
<b>Specific Aim 3: To strengthen the local human resource and health system capacity to provide comprehensive, family-centered HIV/AIDS care and treatment services</b>								
<b>S/No</b>	<b>Activity/Indicator</b>	<b>Facility (COE/ CTC/ Community)</b>	<b>Frequency</b>	<b>Results (Total, M/F) 2011</b>	<b>Results (Total, M/F) 2012</b>	<b>Results (Total, M/F) 2013</b>	<b>Results (Total, M/F) 2014</b>	
	Facilitate Practical Clinical Attachments Training							
	Conduct-on site clinical mentoring/facilitative supervision							
	# of trainees receiving on-site clinical mentoring and facilitative supervision							
	Conduct Continuing Professional Development sessions							
	Provide pediatric HIV training to pre-service AMO and medical doctors students at BMC and MRH							
	Number of HCW trained and supported on EID and exposed infant care							
	Didactic teaching/lectures to HCWs							

Specific Aim 4: To sensitize and mobilize people living with HIV/AIDS (PHAs) and the general community to support pediatric HIV prevention, care and treatment services							
S/No	Activity/Indicator	Facility (COE/ CTC/ Community)	Frequency	Results (Total, M/F) 2011	Results (Total, M/F) 2012	Results (Total, M/F) 2013	Results (Total, M/F) 2014
	Provided HIV preventive, care and treatment services to OVC clients and identify and link with OVC institutions						
	Hold community level sensitization meetings and outreach events to mobilize children for testing and integration into care						
	Partnering with OVC/MVC committees						
	Home visits for lost to follow up clients, social difficulties and adherence difficulties						
	"Peer Mothers" program						
	Radio broadcast						
	World AIDS Day events						
	Partnerships with local authorities including ward executive officer, village/street chair persons, street executive officers, Balozito share strategies and initiate programs						
	Partnerships with local CBOs/NGOs, and working together with them on community level case finding and referrals						

## ANNEX 3. PERSONS INTERVIEWED AND SITES VISITED

Evaluation team members visited a total of 26 sites and met with 66 people, listed in the table below.

Date	Location & Site	Purpose	Persons Met
01/16/2015	Sea Cliff Hotel, Dar es Salaam	KII	Dr. Lumumba Mwita (BIPAI Country Director)
01/22/2015	CDC Office, Dar es Salaam	KII	Dr. Sajida Kimambo (Pediatric AIDS Program Officer) and Mr. Gongo Ramadhani (M&E Officer)
01/26/2015	CSSC Office, Dar es Salaam	KII	Dr. Josephine Balati (Country Director) and Dr. Pastory Sekule (Program Manager)
01/27/2015	MoHSW NACP Office, Dar es Salaam	KII	Dr. Annette Rwebemero (NACP Pediatric Specialist)
01/28/2015	Office of Regional Medical Officer (RMO), Mwanza	KII	(RMO Dr. James was not available.) Ms. Cecelia (RCH Coordinator) and Ms. Makuza (PMTCT Assistant)
01/28/2015	Bugando Referral/Consultant Hospital, Mwanza	KII	Prof. Dr. Kien (Director-General)
01/29/2015	Care and Treatment Clinic (CTC), Nyamagana District	KII	Dr. Abigail (Clinical Officer) and Dr. Nzahi Tabera (Acting In-Charge)
01/29/2015	Care and Treatment Clinic (CTC), Nyamagana District	KII	Ms. Agnes (CTC/RCH Nurse)
01/30/2015	Center of Excellence (CoE), Mwanza	Briefing and KII	Dr. Mercy Minde, Dr. Shannon Shea, Ms. Elgiva Batungi (Matron-in-Charge), Ms. Ester Kanga (Nurse HCW), Mr. Thomas Roche (HCW Counsellor)
01/30/2015	Nyamagana District Hospital, Mwanza	KII	Ms. Betha (Nurse)
01/30/2015	Center of Excellence (CoE), Mwanza	KII	Dr. Judith (Pediatrician)
01/30/2015	Center of Excellence (CoE), Mwanza	KII	Dr. Chiweka (Medical Officer)
01/31/2015	Ryan's Bay Hotel, Mwanza	Courtesy	Dr. Fatma Mrisho, (Executive Chair, Tanzania AIDS Commission)
01/31/2015	Office of the Regional AIDS Control Coordinator (RACCO), Mwanza	KII	Dr. Pius Maselle (RACCO)
02/03/2015	Office of the District Executive Director (DED), Mwanza	KII	Mr. Halifa Hida (DED and member of the City Council AIDS Committee)
02/03/2015	Health Center (HC), Igoma District, Mwanza	KII	Dr. David Rwezaula (HC In-Charge)
02/03/2015	Igoma Health Center (HC), Mwanza	KII	Mr. Wanchori Wambura (CTC Clinician)

Date	Location & Site	Purpose	Persons Met
02/03/2015	Igoma Health Center (HC), Mwanza	KII	Ms. Glory Majaliwa (CTC/RCH Nurse)
02/04/2015	CoE, Mwanza	Debrief and KII	Dr. Mercy Minde (CoE Director), Dr. Shannon Shea (Pediatric Specialist) and Ms. Selifina (Outreach Coordinator)
02/04/2015	Ryan's Bay Hotel, Mwanza	KII	DRCHCo Nyamagana District
02/06/2015	Offices of Mbeya City and Mbeya District Directors, Mbeya	CC	Unavailable for meeting: Ms. Miriam Mtunguja (RAS) and Mr. Mussa Zungiza (City Executive Director)
02/06/2015	Mbeya Referral Hospital, Mbeya	KII	Dr. Mpoki Ulisubisya (Director-General)
02/06/2015	Office of RMO, Mbeya	KII	Dr. Sceif Mhina (RMO)
02/06/2015	Office of District Medical Officer (DMO), Mbeya	KII	Dr. Louis Chemboko (DMO)
02/06/2015	Office of RMO, Mbeya	KII	Ms. Pauline Mbezi (PMTCT Coordinator)
02/06/2015	Center of Excellence, Mbeya	KII	Ms. Victoria Lunanilo (DACC Mbeya City)
02/06/2015	Center of Excellence, Mbeya	KII	Ms. Nginaeli Ngowo (DRCHCo Mbeya City)
02/06/2015	Center of Excellence, Mbeya	KII	Ms. Upendo Sanga (DACC Mbeya DC)
02/06/2015	Center of Excellence, Mbeya	KII	Ms. Niiitike Kyejo (DACC Mbeya DC)
02/06/2015	Walter Reed Program, Mbeya	KII	Dr. Klaus Sturbeck (Country Director), Joseph Chintowa (Senior Technical Director), Dr. Alexander Christopher (Pediatric HIV Manager), David Maganga (Program Pharmacy Advisor) and others
02/06/2015	Office of the Regional AIDS Control Coordinator (RACC), Mbeya	KII	Dr. Sewangi (RACC)
02/06/2015	Center of Excellence, Mbeya	KII	Dr. Fadhili (CoE Pediatrician)
02/09/2015	Mbeya Regional Hospital, Mbeya	KII	Dr. Paul Mwanyika (RMH In-Charge)
02/09/2015	Southern Highlands Regional Hospital, Mbeya	KII	Ms. Rosasa Msaki (Nurse)
02/09/2015	Center of Excellence, Mbeya	Briefing and KII	Dr. Bertha Kasambala (CoE Director), Dr. Jason Bacha (Pediatrician), Dr. Liane Bacha (Pediatrician) and Dr. Moses Chodota (M&E Coordinator)

<b>Date</b>	<b>Location &amp; Site</b>	<b>Purpose</b>	<b>Persons Met</b>
02/09/2015	Center of Excellence, Mbeya	KII	Ms. Veronica Mng'ong'o (Nurse Matron and Outreach Coordinator) and Dr. Theopista Jacob (PMTCT-PHFS Coordinator)
02/09/2015	Center of Excellence, Mbeya	KII	Mr. Ibrahim Mgaya (Counsellor)
02/10/2015	Center of Excellence, Mbeya	KII	Dr. Theopista Jacob (PMTCT-PHFS Coordinator)
02/10/2015	Igawilo City Hospital	KII	Dr. Richard Uria (In-Charge of the Hospital)
02/10/2015	Igawilo City Hospital	KII	Ms. Lumwesa (RCH Nurse)
02/11/2015	Mbeya Regional Hospital, Pediatric HIV Ward, Mbeya	KII	Dr. Fausta (HIV Ward Primary Pediatrician) and Dr. Adili (General Ward Secondary Pediatrician)
02/11/2015	Ifisi District Designated Hospital	KII	Dr. Chambo (In-Charge of Pediatric Ward)
02/11/2015	Ifisi District Designated Hospital	KII	Dr. Khamis Ally (CTC In-Charge)
02/11/2015	Ifisi District Designated Hospital	KII	Ms. Elianora Otto Kigahe (RCH Nurse)
02/16/2015	UNICEF Office, Dar es Salaam	KII	UNICEF's Pediatric AIDS, PMTCT and Malnutrition Teams (Ms. Victoria Chuwa, Ms. Hafsa Khalfani, Mr. Birem Ndiaye, Ms. Leila Coppens and Ms. Winfred Mutsotso)
02/18/2015	CDC	Follow-up KII	Dr. Sajida Kimambo (Pediatric AIDS Program Officer)



## **ANNEX 4. EVALUATION TEAM MEMBERS**

### **TEAM LEADER: ROBERT S. BERNSTEIN, MD, MPH, PHD, FACPM**

Dr. Bernstein is a medical epidemiologist, public health and preventive medicine thought leader and a seasoned team leader with more than 30 years of experience leading health services research, evaluating and improving public health policy and practices and providing training for USAID and U.S. health agencies, U.N. agencies and developing country ministries of health in numerous countries in Africa and Asia. He has excellent management, leadership, decision-making and interpersonal skills, with successful team leader or senior advisor experience on 13 health projects for USAID, WHO, UNICEF, CDC, the World Bank, and the Asian Development Bank. Dr. Bernstein brings more than eight years of direct practice in HIV/AIDS-related epidemiology and policy with USAID globally, as well as extensive health program M&E experience throughout Asia and Africa. He has experience in performance management, monitoring and evaluation applied to the design of start-up activities on the PEPFAR HIV/AIDS Prevention, Care, and Treatment project in Vietnam. Highly capable of mentoring developing country health officials on health systems research methodologies and use of research results, he served as CDC Resident Advisor for the Indonesia and KSA Field Epidemiology Training Programs and led teams of medical experts building capacity within their Ministries of Health, assessing and improving public health services and investigating complicated public health issues such as HIV transmission in hemodialysis centers. As an Adjunct Associate Professor of Global Health at Emory University since 1987, and an Adjunct Professor of Global Health at the University of South Florida, he has published more than 20 peer-reviewed articles in books and well respected scholarly journals. Topics include epidemiology education and training, health systems research methodology, prevention, surveillance and control of HIV/AIDS, and other health-related issues.

### **M&E EXPERT: SYLVESTER BERNARD NANDI, MD, MSc, INT DIP, MPH**

Dr. Nandi, a public health informatics specialist, medical doctor and trainer, has more than nine years of experience in developing, managing, implementing and advising on comprehensive HIV/AIDS programs in Tanzania. As the Senior Program Advisor for Maternal, Newborn and Child Health at the Aga Khan Development Network, Program Advisor for Comprehensive HIV Care and Treatment with HJF-MRI, Strategic Information Advisor with MSH-Tanzania and former Interagency Technical Team Lead for TB and TB/HIV within the PEPFAR program in Tanzania, Dr. Nandi coordinated all HIV, TB and TB/HIV technical and leadership issues within the U.S. Government agencies operating under PEPFAR (CDC, USAID and U.S. Department of Defense). His outstanding technical and leadership services in public health were recognized with Superior Honor Awards from the U.S. State Department in July 2008, May 2009 and August 2009 and Franklin Awards in August 2010 and February 2011. Dr. Nandi's main duties include providing technical oversight, leadership and managerial direction for the successful project design, implementation and M&E of projects to enhance high quality program results. He worked in close collaboration with PEPFAR and U.S. Government agencies, the Tanzania National Tuberculosis Program, the National AIDS Control Program and partners that

implement HIV/AIDS, TB and TB/HIV collaborative services. He has also worked as HIV/AIDS Care and Treatment Officer for AIDSRelief (Tanzania) and Project Leader of Nutrition and HIV/AIDS for the Tanzania Food and Nutrition Centre in the Tanzania Ministry of Health and Social Welfare.

#### **PEDIATRIC HIV SPECIALIST: JUDITH BILETNIKOFF HARKINS, MPH, MSN, RN**

Judith Harkins has experience in global health, non-profit management and clinical nursing based in the US and abroad. Her key qualifications include technical guidance and writing, program design and evaluation, curriculum development and training, research and data collection, grant writing and evaluation and non-profit management. She has 10 years of independent consulting experience which has included writing technical guidance for post-PMTCT referrals in developing countries, creating training curriculum and materials for adherence counsellors as Adherence Specialist for a pre-exposure prophylaxis of HIV clinical trial, writing a 10-country review of best practices in PMTCT and pediatric treatment of HIV, creating comprehensive training curricula for nurses and community health volunteers on HIV and antiretroviral therapy, adherence and referral networks, reviewing national guidelines for care and treatment of HIV and creating baseline assessment tools for clinical facilities providing antiretroviral treatment. She also brings experience in non-profit management, community health and research and clinical nursing expertise.

#### **BEHAVIOR CHANGE COMMUNICATION/DEMAND CREATION EXPERT: MPUNDU MWANZA, MPH**

Mpundu Mwanza is a highly trained public health and behavioral health professional, with both domestic and international experience in strategically designing communication programs, project management, research, budgeting and performance monitoring. Ms. Mwanza has more than 15 years of experience in designing and implementing behavior and social change communication strategies and campaigns as well as advocacy in HIV, MCH, malaria and reproductive health. She has demonstrated superb organization, strategic leadership, analytical and problem-solving skills. Ms. Mwanza has supervised professional and support staff in a multicultural, multi-linguistic environment and led start-up operations in low-income communities. She is skilled in building communication networks and communities that extend beyond organized boundaries.

#### **RESEARCH ASSISTANT AND LOGISTICS: NEEMA FRITZ MATEE, BA**

Neema Matee is a trained sociologist with experience in community development programs in Tanzania. She has been involved in social impact assessments and community health programs and participated in a number of health (mainly HIV/AIDS, malaria and family planning) research projects in East Africa. She is also experienced in M&E, research tool preparation, data collection and analysis for qualitative and quantitative methods, socioeconomic and environment assessments and participatory approaches for community projects. She works with MS Office programs, email and internet advanced application tools. She is conversant with N6 for qualitative analysis and SPSS for quantitative data analysis.

**RESEARCH ASSISTANT: ROSE ERNEST, BA**

Rose Ernest is a sociologist with experience in rural development and specialized in community development programs in Tanzania. She has been involved in a number of research activities aimed at developing communities, including socioeconomic, cultural and health research projects. She has demonstrated experience in both qualitative and quantitative methodologies and computer programs such as NVivo 8 and SPSS. Similarly she is conversant in working with MS Office programs, email and internet. Rose can express herself well in English, Swahili and her native language.

**RESEARCH ASSISTANT: VICENT TEMBA, BA**

Vicent Temba has a degree in sociology and research experience on agriculture, economic development and health projects in Tanzania. His experience includes qualitative and quantitative data collection, cleaning, management and analysis; questionnaire design; quality control; development of stakeholder relationships; and training and supervision of field data collection.



# ANNEX 5. CONFLICT OF INTEREST STATEMENTS

## USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

### USAID Non-Disclosure and Conflicts Agreement-Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form,

"sensitive but unclassified information," procurement sensitive and source selection information, and

information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1 I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2 Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.

3 I agree to abide in all respects by 41, U.S.C. 2101 -2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4 I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5 Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6 I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7 Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or

both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8 All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

(continued on the following signature pages for each consultant)

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data. 9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE** The undersigned accepts the terms and conditions of this Agreement.

\_\_\_\_ Signature & Date



5 December 2014

\_\_\_\_ Name Title

**Dr. Robert Bernstein, MPH, MD, PhD, FACPM  
Adjunct Associate Professor,  
Department of Global Health,  
Rollins School of Public Health, Emory University**

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

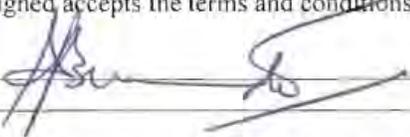
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT  
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

Signature		Date	Dec 5 <sup>th</sup> , 2014
Name	SYLVESTER B. NANDI	Title	DR.

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT  
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Signature

*Judith B Hawkins*

Date

12/06/2014

Name

Judith Biletnikoff Hawkins

Title

Consultant

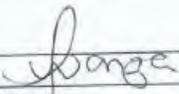
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\_\_\_\_\_  
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Date 12/5/14

Name Mpundu F. Mwanza

Title SBCC Expert

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT  
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 _____ Signature	Date  13/12/2014
_____ Name	_____ Title RESEARCH ASSISTANT

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