



## CASE STUDY

# Improving Linkages between Health Facilities and Communities in Muheza, Tanzania

In the Muheza Region of Tanzania, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project applied the Community Health System Strengthening (CHSS) model to improve linkages between health facilities and communities in order to increase HIV testing and retention in care. Working in five communities, community teams were created from existing community groups to work with the local home-based care (HBC) volunteer. Teams in each of the communities relayed information from the facility to the community through their community groups and vice-versa. Over the course of seven months, they were able to trace 39 of 44 patients who were lost to follow-up; of these, 23 went back to treatment, five had moved to a different health facility, 11 had died, and five were still unaccounted for. This case study describes the process undertaken and perspectives of the community members and health facility personnel who were involved.

### Background

In early 2014, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, with support from the President’s Emergency Plan for AIDS Relief (PEPFAR), began the Community Linkages activity in five villages of the Muheza District of the Tanga Region in Tanzania, building on existing work to increase retention in the HIV continuum of care. The Community Linkages component was added by employing the Community Health System Strengthening (CHSS) model to increase linkages between health facilities and communities. Prior to the introduction of this model, government home-based care (HBC) volunteers who live in the communities were the only link between the facility and the community.

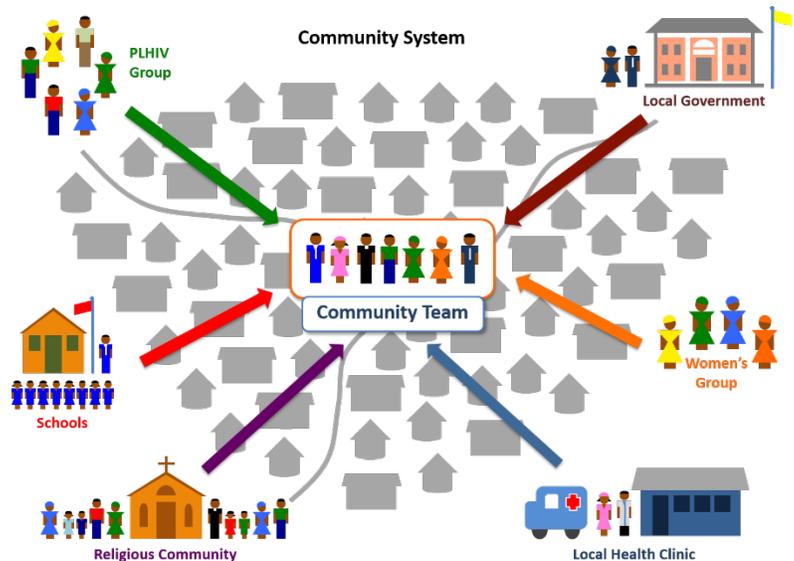


Figure 1: The Community Health System Strengthening model

HBC providers in Tanzania offer education on testing and treatment of HIV, support people living with HIV, and share information about the community’s health with the facility. At the district level, there is an HBC Coordinator who supports the HBC volunteers and typically interacts with HBC volunteers when they come to health facilities. The HBC volunteers are responsible for covering 20-25 households in their community as well as relaying information to and from the health facility. Yet the HBC volunteers

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reported that they often felt overwhelmed and that they could not reach all of the households with the information they were supposed to be providing. Health facilities' only interaction with communities was through the HBC volunteers. To get patients to come back to treatment, the facilities had tried calling them on the phone, but it had not worked. The CHSS model brings together formal and informal pre-existing structures and networks to create an integrated care system. Most communities in low-resource settings possess their own informal support and social welfare systems where community members make decisions and work together to improve the health of community members and the general welfare of the community. This system may consist of formal community groups, such as village government, schools, religious groups, agricultural groups, 'savings and credit' groups, etc. In the CHSS model, the improvement work is managed by representatives from each community group, representatives from the facilities, and delegates from the local government, who all come together to serve as the community improvement team for the purposes of identifying local gaps in health care and developing and testing strategies to overcome those gaps. This team applies improvement principles to strengthen the performance of the community health system by identifying and strengthening the processes by which participating groups and structures function and interact with each other to provide integrated, seamless care.

When all elements of the community health system are harmonized and functioning well and coordinated with the efforts of community health workers, including community-based care providers, health services become more accessible to community members, and accurate information exchange between health facilities and households occurs more rapidly and effectively.

### **Implementing the CHSS model in Muheza**

ASSIST identified the groups and committees that were active in five communities in Muheza District. ASSIST then identified the existing group in each community that had the most representation from all community groups and engaged that group to serve as the community team. When needed, members were added to ensure full representation from all community committees in this community team. Each team also included the local HBC volunteer. Group members were invited to trainings held by ASSIST in which they discussed HIV content, including adherence to treatment, educating others, advantages and disadvantages of HIV testing, etc., and looked at ways to improve support for HIV care in the community.

ASSIST also trained coaches at the district and health facility to support the community teams. While the focus of the activity was on improving retention of patients in care, the community teams first looked at improving HIV testing in their communities as a way to familiarize themselves with the process and obtain some early success before addressing retention.

During their first community team meetings in January 2014, the HBC volunteer and community team members discussed low levels of HIV testing uptake. According to facility data brought to the meetings by the HBC volunteers, just 106 people went for testing in January (42 men and 64 women, shown in Figure 2). The main reason given for this low number was that the HBC providers assigned in each village were not able to reach all households to sensitize people to go to the health facility for an HIV test.

When the community team members approached other members of the groups they are part of, they asked their group members to talk to their families about things such as HIV testing uptake and the importance of staying on ART treatment. Group members then talked to their family members, urging them to go for HIV testing, highlighting the importance of knowing their status for their own health and for the health of the family and community.

### **Increasing HIV testing**

After the community group members spoke to their family members about the importance of getting tested for HIV, 319 people went for testing in February (122 men and 147 women). Not only did the number of people tested for HIV increase, but the number of male partners who came for testing HIV also increased. A few of the communities had such interest in HIV testing that they requested the facility

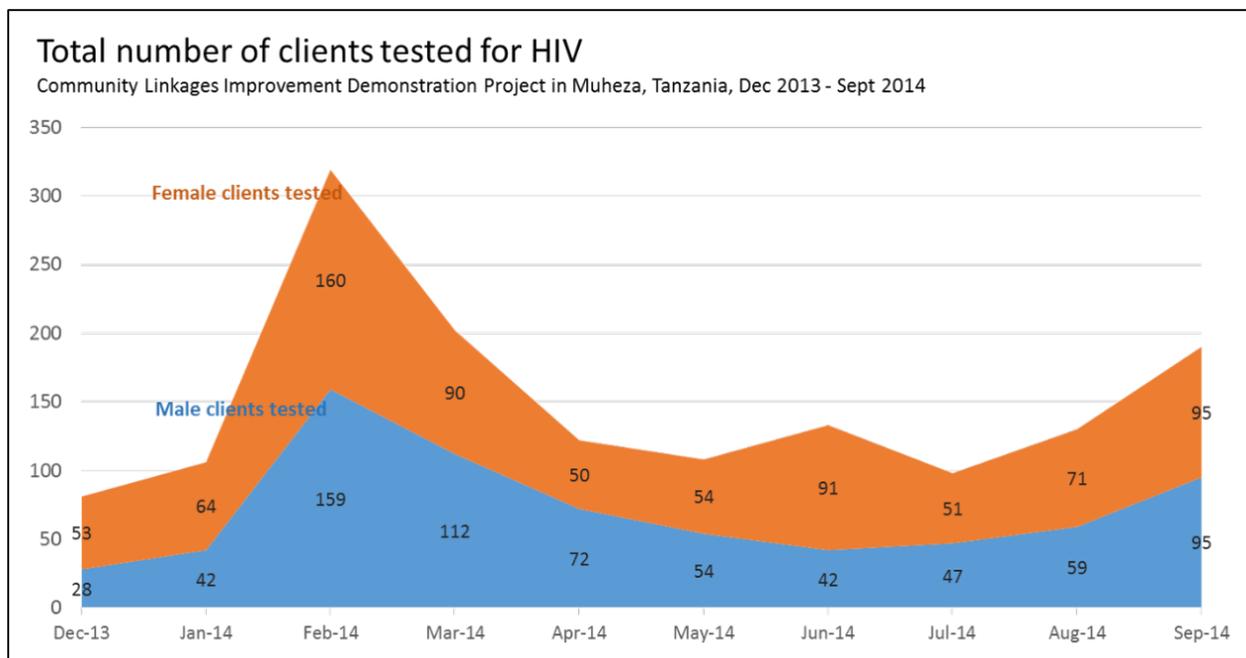


Figure 2: HIV testing in five communities, Muheza District, Tanzania

provide testing in the village itself in February, making it even easier to access and causing even higher uptake. In June 2014, the number of individuals being tested was 133 as the community teams continued to share messages on HIV testing and re-testing.

The HBC volunteers also noticed improved understanding of HIV and health in the communities. They noted that before this work, pregnant women and people who were feeling ill were the most likely to go for HIV testing, but they saw an increase in both men and women going regardless of their current health status. A representative from the Matumaini B PLHIV group in Enzi noted that more people being tested were returning to the facility to receive their results than before; that stigma was reducing; and people understood better that they could live well with HIV.

#### **Reducing loss to follow-up**

To address retention of HIV-positive patients in treatment, the HBC volunteer would receive data from the facility on the number of patients lost to follow-up that month. Using the same approach as for HIV testing, the HBC volunteer would work with the community team to spread messages to their respective networks and families on the importance of adhering to antiretroviral therapy and remaining in care.

At the start of March 2014, according to facility data, 31 patients were lost-to-follow-up. Between March and September an additional 13 were lost. By the end of September, 23 of these 44 patients were on treatment again. Of the remaining, five had moved to a different health facility, 11 had died, and five were still unaccounted for (see Figure 3).

At the community level, the community teams feel proud of what they are doing. They said that when they see people going to test for HIV, they feel that they are having a positive impact on the health of their families and community. The HBC volunteers have felt relieved through this collaboration. They are no longer working in isolation and instead have a whole community network to work with through their participation in the community team. According to one

*"It was difficult for HBC volunteers to track the clients who are lost to follow up because they are few and the villages are big, it was not easy for them to reach everyone... we are thankful because the community groups have been very helpful.*

- Health Care Provider, Mkuzi Health Center

## Getting Lost-To-Follow-Up (LTFU) Patients Back in Care

Community Linkages Improvement Demonstration Project in Muheza, Tanzania, March-May 2014

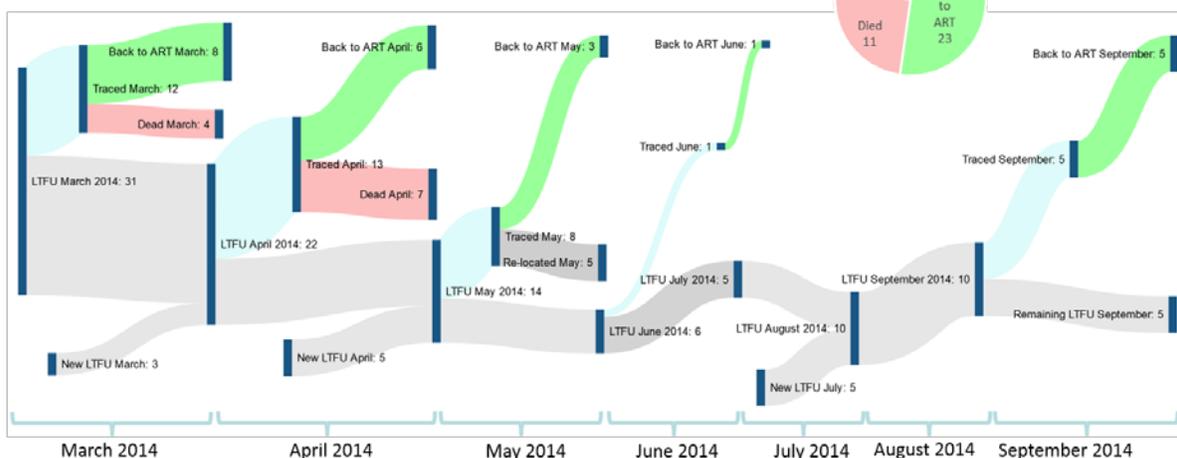


Figure 3: Reduction of loss to follow-up in five communities, Muheza District, Tanzania

HBC volunteer, “Information doesn’t stop now, it flows. The community used to be far from the facility, now it is close.”

The facility providers noticed the same improvements, saying that they see coordination and community involvement that was not there before. They have seen increases in service utilization and achievements they were unable to obtain on their own. One facility nurse said that information spreads easily because “the team touches everywhere.”

The District HBC Coordinator commented that now she knows when the community teams meet, so she joins them, while before she only went to the facilities and talked primarily to just the health staff. She sees motivation in the communities that she had not seen before. She added that she “used to hear about community participation and engagement, but this is the real way they can be involved in the health of their communities.”

### **Conclusion**

The application of the CHSS model in the five communities in Muheza District demonstrated its utility in increasing uptake of HIV testing and, more importantly, reduction in loss to follow-up and improved retention in HIV care. It is a promising approach to strengthen linkages between health facilities and the communities they serve. Opportunities to implement the CHSS model in new communities in Tanzania are currently being explored.