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USAID ASSIST Project

Applying Science to Strengthen and Improve Systems

USAID ASSIST Project

Tanzania Country Report FY13

Cooperative Agreement Number:

AID-OAA-A-12-00101

Performance Period:

October 1, 2012 – September 30, 2013

DECEMBER 2013

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DISCLAIMER

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CHMT	Council Health Management Team
CTC	Care and treatment centers
DSW	Department of Social Welfare
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
HBC	Home-based care
HCI	USAID Health Care Improvement Project
HIV	Human immunodeficiency virus
IF	Infant feeding
IP	Implementing partners
MDG	Millennium Development Goals
M&E	Monitoring and evaluation
MOHSW	Ministry of Health and Social Welfare
MVC	Most vulnerable children
MVCC	Most Vulnerable Children Committees
NACP	National AIDS Control Program
PCR	Polymerase chain reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
PQI	Partnership for Quality Improvement
QI	Quality improvement
QIT	Quality improvement team
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
SOP	Standard operating procedures
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development
WI-HER	Women Influencing Health Education and Rule of Law, LLC

1 Introduction

University Research Co., LLC (URC) began working in Tanzania in 2003 through the USAID-funded Quality Assurance Project and subsequently through the USAID Health Care Improvement Project (HCI). With funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), HCI supported the Ministry of Health and Social Welfare (MOHSW), USAID implementing partners (IPs), and Regional and Council Health Management Teams (RHMTs and CHMTs) to: scale up quality improvement of prevention of mother-to-child transmission of HIV (PMTCT) services; improve the quality of infant feeding (IF) in the context of PMTCT; and to design and manage a national quality improvement program for antiretroviral therapy (ART). In addition, HCI provided support to the Department of Social Welfare (DSW) serving most vulnerable children (MVC) to improve the quality of MVC services; started an improvement collaborative in the Bagamoyo district to improve the welfare of MVC and caregivers; and supported the MOHSW and IPs to develop standard operating procedures (SOP) for the home-based care (HBC) program.

Starting in October 2012, through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, URC began building on the gains from HCI to support the MOHSW and implementing partners to scale up activities to additional regions not covered under HCI.

2 Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Support MOHSW and PMTCT implementing partners to scale up programs providing women and their families improved access to HIV prevention, testing, care, treatment and support through quality improvement approaches along the PMTCT cascade	• % pregnant women who book ANC at 14th week of pregnancy • % HIV positive pregnant women who receive ARVs • % HIV+ screened for TB at Reproductive and Child Health centers (RCH) • % non-pregnant women accessing FP tested for HIV	12/26 regions: Iringa (66 sites), Kilimanjaro (14 sites), Tanga (9 sites), Mtwara (20 sites), Lindi (10 sites), Morogoro (42 sites), Manyara (8 sites), Dodoma (9 sites), Shinyanga (10 sites), Tabora (14 sites), Arusha (16 sites) and Njombe (10 sites). 73/80 districts of the focus regions and 227 facilities/1830 PMTCT sites in these districts
2. Support MOHSW and HIV-Free Survival Partners towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers through nutritional services for mothers, infants, and young children and health system strengthening of the postnatal continuum of PMTCT care	• % mother-infant pair retention rate to postnatal care • % mother-infant pair adherence to package of postnatal care services	Improvement collaboratives started in 10 sites in Nzega district (Tabora region), 10 sites in Mbeya Urban (Mbeya region) and 10 sites in Mufindi district (Iringa region).
3. Support MOHSW and IPs to scale up sustainable improvements in coverage, retention and outcomes for patients on ART	• % eligible people living with HIV (PLHIV) attending care and treatment centers (CTC) receiving FP methods • % PLHIV (pre ART or ART) diagnosed with TB treated with anti TB drugs • % patients with follow-up CD4 at six months	205 health facilities in 12/26 regions with 400 facilities offering CTC services

What are we trying to accomplish?	How will we know?	At what scale?
	• % patients alive and on treatment 12 months after ART treatment initiation • % ART patients keeping appointments	
4. Support MOHSW, MVC IPs and local structures to strengthen quality of care, support and protection to vulnerable children	• # of vulnerable children referred and linked with different community, health and other services	All 22 wards in Bagamoyo District have been covered with 125 QITs; community QI teams established in 11 wards in Kigoma and integration of OVC and HBC in three wards in Muheza District Training: Dar es Salaam, Kigoma, Pwani and Tanga regions.
5. Work with MOHSW and stakeholders to improve the quality of community-level home-based care (HBC)	• # of clients accessing a broader range of HBC services as guided by the SOP • # of regions and implementing partners applying SOP	HBC SOPs piloted in 16 out of 24 wards in Tanga City HBC SOP field tested in six wards in Dodoma. HBC QI training conducted in 13 out of 26 regions

3 Key Activities, Accomplishments, and Results

Activity 1. Improve access to HIV prevention, testing, care, treatment, and support through QI approaches along the PMTCT cascade

Background

In FY12, HCI supported the MOHSW, HIV/AIDS implementing partners, regional health management teams (RHMTs), and council health management teams (CHMTs) in Tanzania to develop, implement, and scale up PMTCT quality improvement efforts to 10 regions. During this period, the project also supported the National AIDS Control Program (NACP) to revise the national PMTCT and infant feeding guidelines, and corresponding job aids. The main interventions included: PMTCT systems redesign; process analysis to define and close implementation and practice gaps in all sites; and the establishment of a national Partnership for Quality Improvement (PQI) to coordinate approaches and efforts of RHMTs, CHMTs, and implementing partners. These efforts resulted in positive changes in access, retention and wellbeing of PMTCT clients. However, despite these changes, the PMTCT program in Tanzania remains wanting. The key challenges now facing the program are related to the need to strengthen aspects of the health care system, including: leadership at the regional and district levels; management of health resources; performance measurement and management; community involvement and accountability for PMTCT; as well as increasing investments for PMTCT.

In FY13, the USAID ASSIST Project began activities in Tanzania to continue supporting the MOHSW to sustain the improvement gains from the HCI Project and to scale up activities to additional regions. ASSIST supports the MOHSW, RHMTs, CHMTs, and implementing partners to reach the national targets to increase access and improve the quality of PMTCT services through strengthening of organizations and effectiveness of PMTCT processes as well as improving providers' performance and productivity. Efforts are being made to ensure the project contributes to the objectives of the US Government/Tanzania HIV Partnership Framework; the National Response to HIV/AIDS (2009 - 2013); the Health Sector Strategic Framework (2009 - 2015); the National Plan for Elimination of Mother to Child Transmission of HIV (2012-2015); and towards the attainment of Millennium Development Goals (MDG) 4, 5 & 6. As the MOHSW is in process of adopting the new PMTCT strategy Option B+, the project is supporting prototyping the new approach.

PMTCT

Improvement Strategy

This work is being implemented using the collaborative improvement approach including learning sessions and mentoring and coaching visits to facility teams. Government officials from MOHSW, RHMTs, and CHMTs are fully involved in carrying out these QI activities to build their competencies. In each region, ASSIST works with the RHMT, CHMTs and regionalized implementing partners to use assessment tools that capture gaps in health systems and linkages. Periodic review of health systems gaps is also done through learning sessions and coaching visits, when processes of service delivery are redesigned for improved systems and linkages.

Spread Strategy

Districts and regional IPs were urged to work on supporting spreading of best practices to other facilities.

Accomplishments and Results

- **Conducted situational analyses:**
  - *Tabora and Arusha regions:* In the second quarter of FY13, USAID ASSIST conducted a situational analysis in the new regions of Tabora and Arusha in partnership with R/CHMTs and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). Planning meetings were conducted with members of the RHMT by introducing them to the activities supported by ASSIST and to QI methodologies. Joint site visits by ASSIST, EGPAF and R/CHMT staff were conducted to carry out the situational analysis in seven hospitals, four health centers, and three dispensaries in the six districts in the Tabora Region and in nine hospitals and six health centres in the Arusha Region. To identify implementation gaps, baseline data were collected from November 2012 to January 2013 for 12 PMTCT and four ART indicators.
  - Most of the sites visited during this assessment did not have QI teams or activities. Some health facilities did not have any data on family planning for HIV-positive clients, caretakers receiving DNA polymerase chain reaction (PCR) results for HIV-exposed infants, and six-month follow-up for CD4 tests. The plan to initiate collaborative improvement activities was implemented jointly with EGPAF so as to mainstream QI activities and strengthen services for ART and PMTCT in these regions.
  - *Iringa Region:* Using district funds, CHMTs conducted baseline assessments of the quality of care for PMTCT services in their four districts between April and May 2013 covering 66 out of the 176 facilities offering such services. Among the service gaps identified were: inadequate documentation; poor access to CTCs; inadequate CD4 monitoring; inadequate family and community support for PMTCT; as well as various organizational bottlenecks such as inadequate supplies and commodities.
- **Conducted stakeholder meeting for scaling up ART/PMTCT QI efforts*:***

  Iringa Region: In April 2013*,* USAID ASSIST supported the MOHSW, TUNAJALI Deloitte, the ART/PMTCT IPs, RHMTs and CHMTs to conduct a stakeholders' meeting for scaling up ART/PMTCT QI efforts in the region. The meeting brought together 51 representatives from the MOHSW, the Tanzania Food and Nutrition Centre, NACP PMTCT, IPs, RHMTs, CHMTs from the four districts and representatives from the regional referral hospital. The status of QI implementation in the 11 demonstration sites was shared. Gaps reported by participants were: inadequate knowledge on early infant diagnosis and QI content; frequent stock-outs of reagents and test kits; inadequacies in patient follow-up, especially CD4 follow-up tests; and late response to maintenance and repair of the CD4 machine. Sixty-six (66) health facilities (seven hospitals, 22 health centres, 35 dispensaries and two stand-alone CTCs) were identified for scale up.
- **Formed QI teams and conducted learning sessions, coaching and mentoring visits:**
  - *Tabora, Arusha, Dodoma:* Following the baseline assessment, learning sessions were held in Tabora, Arusha, and Dodoma between April and July 2013. Participants were introduced to QI principles, dimensions of quality, clients' rights and providers' needs, steps in QI and application of the QI model to strengthen ART-PMTCT services, and the use of Standard Evaluation System (SES) team journals for documentation of QI work. QI teams were formed at facility, district and regional levels. Teams developed improvement changes, tested them and will share their experiences during subsequent learning sessions for internal spread of best practices.

- *Iringa:* In June 2013 ASSIST held an orientation and preparatory meeting with nine R/CHMTs and one Zonal Reproductive and Child Health Coordinator to build their skills in conducting the learning session. The learning session was conducted for two out of the four districts that finalized the baseline assessment. The first learning session brought together 83 service providers from 34 sites (four hospitals, 14 health centers, 16 dispensaries and two stand-alone CTC sites). Two RHMT and six CHMT members took the lead in facilitating the learning session assisted by four QI mentors selected among service providers. The Zonal Reproductive and Child Health Coordinator also participated to learn more about QI. Baseline assessment results were shared and participants were introduced to QI terminologies, dimensions of quality, principles of quality, steps in QI, and the QI model. QI teams were strengthened for the eight demonstration sites and formed for the 26 new facilities. Participants developed work plans to address the identified performance gaps and agreed on necessary metrics to monitor progress. In April 2013, coaching was conducted for three demonstration sites working with community groups to improve: ANC booking by 14 weeks; exclusive breastfeeding for 6 months; men escorting their female partners; testing for HIV; and follow-up for children under age five. A sharing meeting for the six community coaches from these sites was held where coaches reported improved communication between facility and community members when attending the facilities. Subsequently, community coaches were supported to lead a QI meeting for Community QI teams, where a total of 108 participants attended. Community QI teams agreed to put up communication posters at worship houses, market places, and local government offices. At facilities, client tracking cards were introduced to facilitate identification and counting of pregnant women and male partners who were referred from the community groups. A total of 51 service providers from 11 Assuring Infants and Mothers Get All PMTCT Services (AIMGAPS) sites were supported to identify and document tested changes and their outcomes as recorded in their team journals. Among the tested changes were: same day enrollment to PMTCT care; on-the-job training on documentation in PMTCT registers; CD4 sample collection through Reproductive and Child Health (RCH) services; prioritizing HIV-positive pregnant women for CD4 testing; on-the-job and peer mentoring on Dried Blood Sample (DBS) collection; daily enrollment of HIV-positive pregnant women to CTC irrespective of CTC clinic day; documentation of ANC number in CTC register for easier identification of pregnant women enrolled in CTC; and cross checking of undocumented ANC visits by verification from PMTCT dispensing register and mother's ANC card.

A health worker explaining to ASSIST QI Senior Advisor Dr. Elizabeth Hizza, the changes the facility implemented during the AIMGAPS pre harvest meeting at Ilula Lutheran Hospital in Iringa region.

Addressing gender-related issues

In Shinyanga and Morogoro opinions from participants of QI training and coaching were solicited on how to best encourage males to participate in RCH services. From the responses a key strategy that was developed was to educate men and the community at large about the importance of being involved in RCH services. Proposed interventions included:

- Community social groups and influential leaders provide messages about the importance of participating in RCH services to men and communities.
- Service providers at facility levels were identified to provide messages at the facility levels and RCH services on the importance of testing both men and women.

These ideas are being implemented in Shinyanga, Morogoro, Arusha, Kilimanjaro and Iringa.

- *Arusha:* In the fourth quarter ASSIST – in collaboration with EGPAF, RHMT and CHMTs – conducted coaching and mentoring visits to 16 QI sites in the Arusha Region and mentored 89 QI

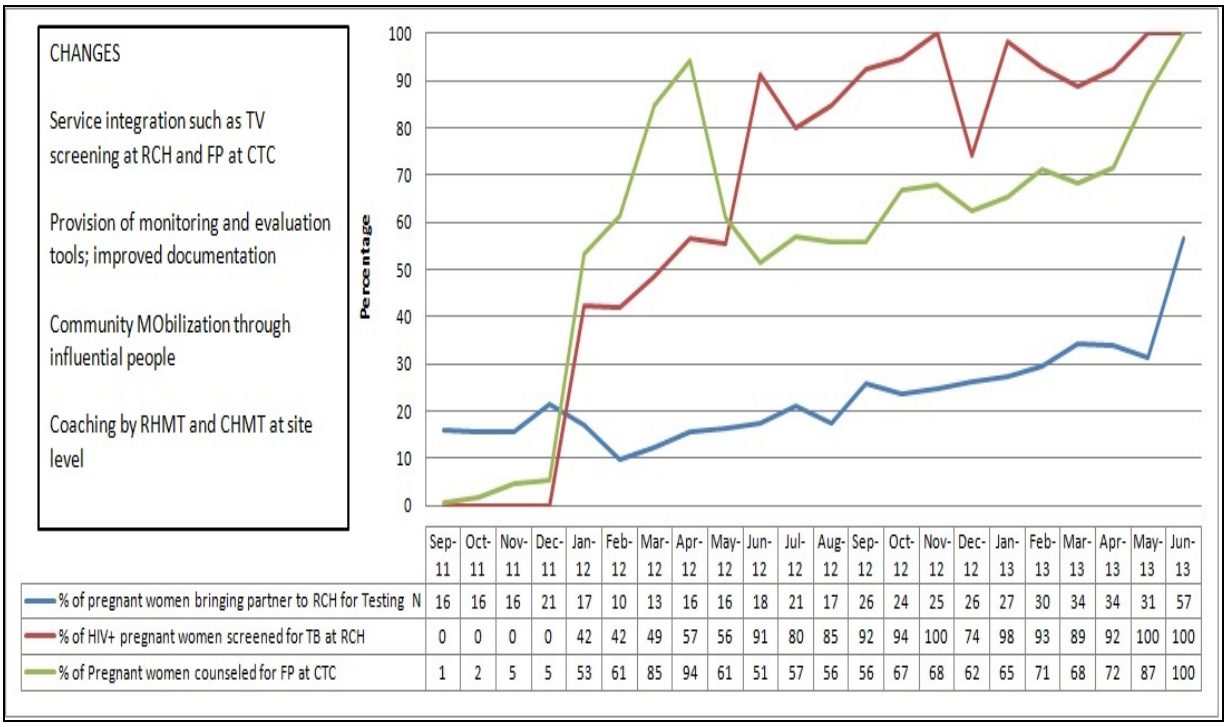
team members. During the coaching visits it was found that in some facilities, some of the staff trained in improvement had been transferred. Therefore, intense coaching was conducted to revive the improvement teams and begin testing planned changes.

- *Manyara:* During FY13, two learning sessions were held in collaboration with CHMTs and RHMTs. Participation of CHMTs and RHMTs improved their coordination and supervisory competencies. Participants were trained on QI principles and improvement models and they shared experiences on how to use QI approaches to improve integration of PMTCT and RCH services.
- *Kilimanjaro:* ASSIST supported the 14 collaborative sites to integrate PMTCT and RCH in Kilimanjaro Region in July 2013. Learning sessions were held in 12 out of 13 hospitals in Kilimanjaro implementing PMTCT QI activities. A total of 65 participants attended the training, including doctors, nursing officers, laboratory technicians, pharmacists, nurse midwives and enrolled nurses from RCH, CTC and labor wards. Coaching and mentoring visits were held with 14 QI sites and 79 QI team members. Regional IPs, RHMTs and CHMTs continue to lead the coaching visits.
- *Morogoro:* In FY 13 ASSIST provided support to CHMTs and RHMTs in scaling up QI trainings into four districts with coverage of 30 new PMTCT sites. QI teams were formed and members developed facility QI work plans to address priority PMTCT quality gaps such as male partner testing, follow-up of exposed children to ensure timely uptake of Cotrimoxazole, and receiving DNA PCR results.
- *Shinyanga:* In February 2013, ASSIST led joint QI coaching and mentoring visits to 10 sites testing changes to address PMTCT challenges. Through a request from the CHMTs and IPs, an additional 14 sites were added where ASSIST facilitated QI trainings to service providers from these health facilities. Priority PMTCT areas were identified and QI teams developed plans to narrow the existing gaps in implementation. These areas include enrollment of HIV-positive pregnant mothers into CTC and male partner participation in RCH.
- *Mtwara:* Sixty-five (65) health care workers from eight collaborative sites in five districts attended a second learning session on use of QI approaches to improve human resource (HR) performance in March 2013. The session was co-facilitated by RHMTs and ASSIST. Two program officers from EGPAF also attended this learning session. Participants shared their experiences on improvement changes that improved HR productivity and ART and PMTCT service outcomes. Participants revised their job descriptions to better align their tasks and roles with program goals. They also identified competency gaps and developed action plan to address them. Teams developed work plans for the next action plan and developed a system to ensure that there is regular performance feedback within team members and their supervisors.

- **Substantial improvement in key PMTCT indicators was achieved** in select elements of PMTCT (Figure 1). In the Kilimanjaro region, the proportion of pregnant women booking for ANC by 14 weeks increased from 9% in September 2011 to 35% in May 2013. The proportion of pregnant women 15-49 years counselled on FP at CTC rose from 1% in September 2011 to 100% in June 2013. Furthermore, the percentage of pregnant women who were accompanied by their male partners to participate in RCH services increased from 16% in September 2011 to 64% by August 2013. While in September 2011 0% of HIV+ pregnant women were screened for TB during RCH in facilities participating in the improvement collaborative, by August 2013 all (99%) HIV-positive pregnant women were (Figure 1, Table 1). In the Iringa region, in sites that have previously participated in the infant feeding demonstration collaborative, there was an increase in proportion of HIV-positive lactating women practicing exclusive breast feeding (Figure 2). Integration of HIV testing services in FP clinics also increased dramatically in Tumani Hospital, with the percentage of family planning clients who were tested for HIV increasing from 0% in January 2012 to 100% in April 2013 (see Figure 3).
- **Changes that resulted in improvement of FP uptake among PLHIV were documented, and some health care workers were interviewed for a success story that was written about this topic.**[1]

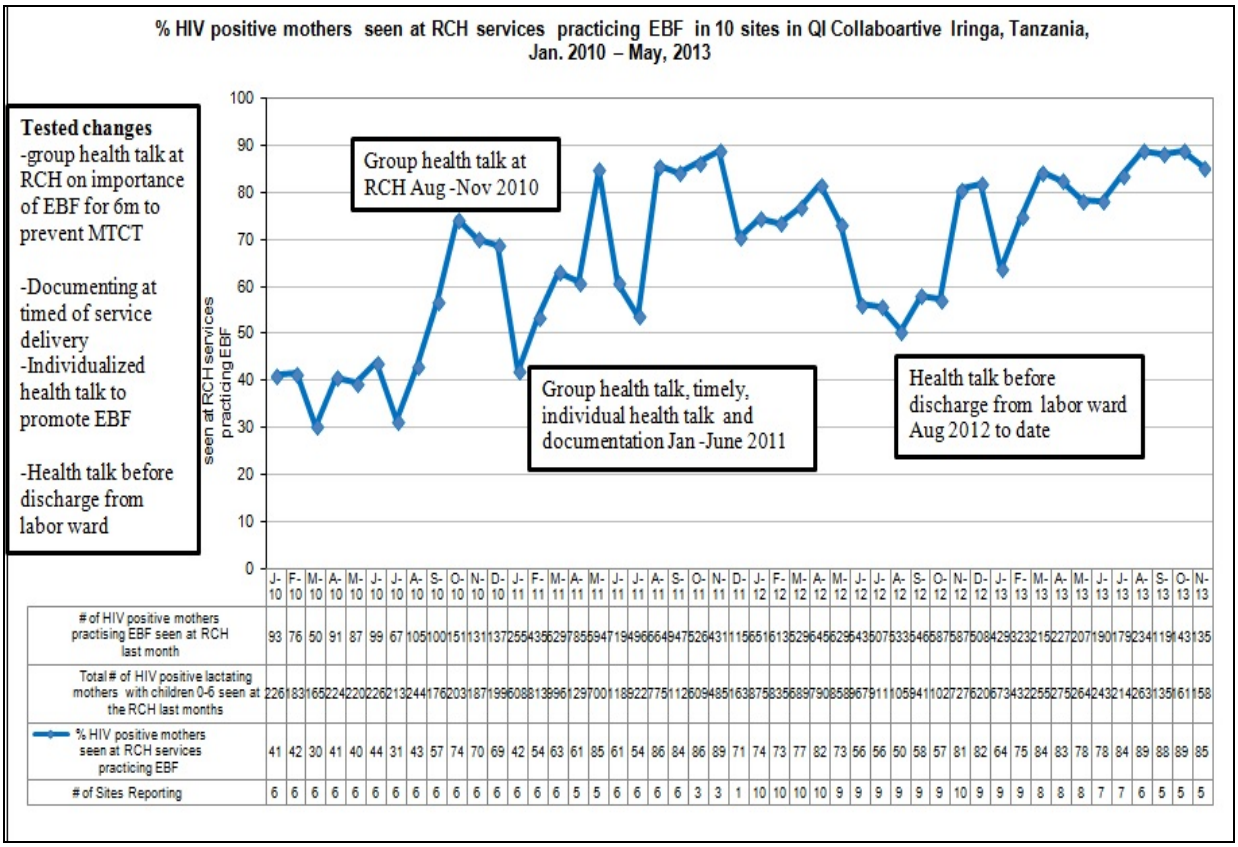
[1] **Success Story**: Making Family Planning More Convenient to Clients, Improves Service Uptake in Manyara Region, Tanzania.

Figure 1: Sustained improvement in select elements of PMTCT care, Kilimanjaro Region (September 2011- June 2013)



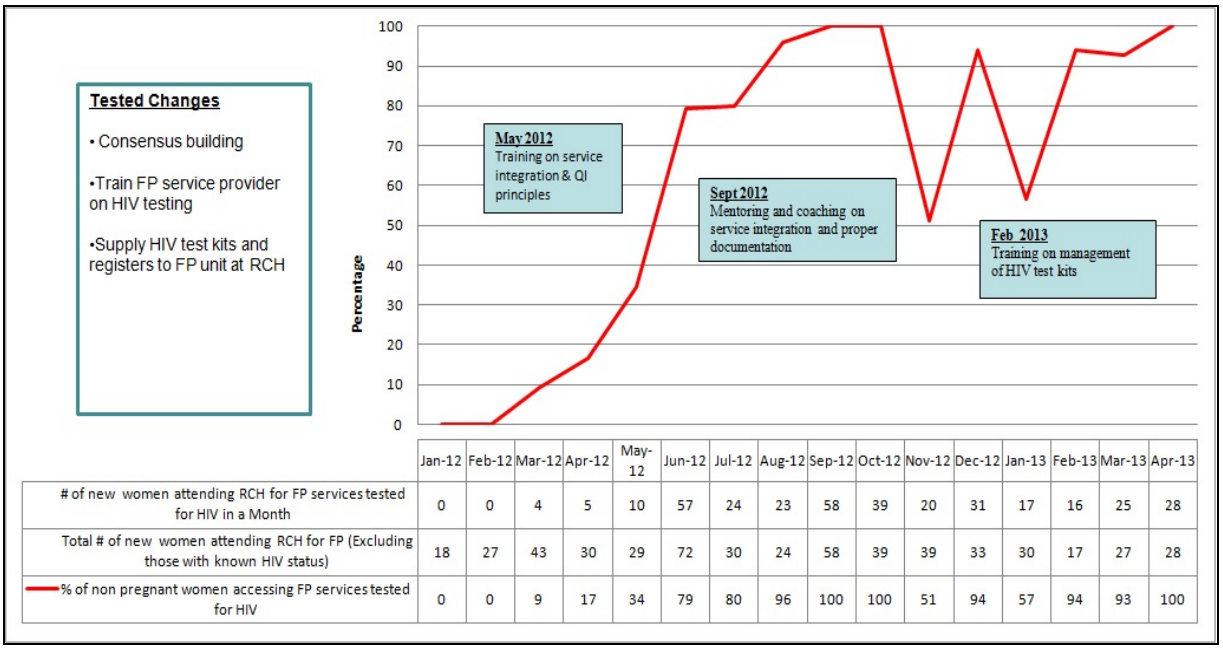
	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
% of pregnant women bringing partner to RCH for Testing N	16	16	16	21	17	10	13	16	16	18	21	17	26	24	25	26	27	30	34	34	31	57
% of HIV+ pregnant women screened for TB at RCH	0	0	0	0	42	42	49	57	56	91	80	85	92	94	100	74	98	93	89	92	100	100
% of Pregnant women counseled for FP at CTC	1	2	5	5	53	61	85	94	61	51	57	56	56	67	68	62	65	71	68	72	87	100

Figure 2: Percentage of HIV-positive mothers seen at RHC services who are practicing exclusive breastfeeding at 10 sites, Iringa Region (January-May 2013)



	J-10	F-10	M-10	A-10	M-10	J-10	J-10	A-10	S-10	O-10	N-10	D-10	J-11	F-11	M-11	A-11	M-11	J-11	J-11	A-11	S-11	O-11	N-11	D-11	J-12	F-12	M-12	A-12	M-12	J-12	J-12	A-12	S-12	O-12	N-12	D-12	J-13	F-13	M-13	A-13	M-13	J-13	J-13	A-13	S-13	O-13	N-13
# of HIV positive mothers practising EBF seen at RCH last month	93	76	50	91	87	99	67	105	100	151	131	137	255	435	629	785	594	719	496	664	947	526	431	115	651	613	529	645	629	543	507	533	546	587	587	508	429	323	215	227	207	190	179	234	119	143	135
Total # of HIV positive lactating mothers with children 0-6 seen at the RCH last months	226	183	165	224	220	226	213	244	176	203	187	199	608	813	896	1297	001	1189	2275	1126	094	85	163	875	835	689	790	858	967	911	1059	411	102	727	620	673	432	255	275	264	243	214	263	135	161	158
% HIV positive mothers seen at RCH services practicing EBF	41	42	30	41	40	44	31	43	57	74	70	69	42	54	63	61	85	61	54	86	84	86	89	71	74	73	77	82	73	56	56	50	58	57	81	82	64	75	84	83	78	78	84	89	88	89	85
# of Sites Reporting	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	5	5	6	6	6	6	3	3	1	10	10	10	10	9	9	9	9	9	9	10	9	9	9	8	8	8	7	7	6	5	5	5

Figure 3: Percentage of women accessing FP services at RCHs who are tested for HIV, Tumani Hospital, Manyara (January 2012-April 2013)



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
# of new women attending RCH for FP services tested for HIV in a Month	0	0	4	5	10	57	24	23	58	39	20	31	17	16	25	28
Total # of new women attending RCH for FP (Excluding those with known HIV status)	18	27	43	30	29	72	30	24	58	39	39	33	30	17	27	28
% of non pregnant women accessing FP services tested for HIV	0	0	9	17	34	79	80	96	100	100	51	94	57	94	93	100

Table 1: Improvement in key PMTCT indicators in FY13

Activity	Indicators	Baseline	Last value in FY13
To support MOHSW and PMTCT IPs to scale up programs providing women and their families improved access to quality care along the PMTCT cascade	• % pregnant women who book ANC at 14th week of pregnancy	9% (Sept. 2011, Kilimanjaro)	35% (May 2013, Kilimanjaro)
	• % HIV-positive screened for TB at RCH	0% (Sept. 2011, Kilimanjaro)	99% (Aug. 2013, Kilimanjaro)
	• % of male tested at RCH	16% (Sept. 2011, Kilimanjaro)	64% (Aug. 2013, Kilimanjaro)
	• % of women counseled for FP at CTC	1% (Sept. 2011, Kilimanjaro)	100% (June 2013, Kilimanjaro)
	• % Exposed infants practicing exclusive breastfeeding	48% (Sept. 2011, Kilimanjaro)	84% (May 2013, Kilimanjaro)
	• % HIV-positive pregnant women counseled for FP at ANC	13% (Sept. 2011, Kilimanjaro)	100% (May 2013, Kilimanjaro)
	• % HIV-positive pregnant women who receive ARVs	43% (Jan. 2010, Iringa)	85% (May 2013, Iringa)
	• % Exposed infants practicing exclusive breastfeeding	41% (Jan. 2010, Manyara)	78% (May 2013, Manyara)
	• % Non-pregnant women accessing FP tested for HIV	8% (Jan. 2012, Manyara)	100% (May 2013, Manyara)

What Are We Learning?

- Engagement of local community and influential leaders promotes service uptake as observed in increased male partner testing for HIV in Kilimanjaro QI efforts.
- Service integration improves uptake and addresses missed opportunities which were there for a long time but were not addressed, as is seen in the case of improved FP uptake among CTC clients in Manyara.
- Public - Private collaboration improves accessibility and quality of health services – Sabasaba dispensary in Iringa increased access to CD4 through transfer of samples to the private sector.

Activity 2. Eliminate HIV infection in children and reduce deaths among HIV-infected mothers through nutritional services and health systems strengthening of the postnatal continuum of PMTCT care

Background

Under HCI, URC supported the MOHSW, IPs, RHMTs and CHMTs to improve the quality of infant feeding in the context of PMTCT. An infant feeding demonstration improvement collaborative was implemented in six sites in Iringa promoting early initiation of breastfeeding, counselling of mothers on breast-feeding practices, counselling for improved and exclusive breast-feeding, and community follow-up by peer groups.

In FY13, USAID ASSIST followed up on the work conducted under HCI to strengthen the post-natal continuum of PMTCT care through application of quality improvement initiatives. Tanzania is one of the six countries in Africa which was selected to carry out a pilot program of the Partnership for HIV-Free Survival (PHFS). The aim of the project is to support country efforts to eliminate maternal to child transmission of HIV (MTCT) though additional focus on the postnatal cascade of the PMTCT pathway. This will be done through QI approaches to develop scalable and sustainable district-wide programs to prevent postnatal transmission of HIV and to promote breastfeeding in high HIV prevalence communities. In FY13, USAID ASSIST collaborated with the MOHSW and PMTCT IPs to provide technical support to service providers at the district level to: maximize postnatal care for mother-baby pairs with follow-up during the postnatal period for up to two years; conduct nutritional assessments; conduct counselling and management for all HIV-positive and HIV-negative mothers; provide encouragement of breastfeeding during the first 12 months of age; provide ARVs to HIV-infected mothers or HIV-exposed infants during the breastfeeding period; link mothers and infants to routine maternal and pediatric services in facilities and communities; establish health and nutrition surveillance; improve referral and tracking systems to facilitate early infant diagnosis (EID) and address maternal and infant malnutrition and health problems. A quality improvement framework was developed to support this implementation and to monitor progress of the expected outcomes, starting with baseline assessments, initial quality improvement introduction to the members of the RHMTs and CHMTs in the respective districts as well as follow-up coaching and learning sessions.

In addition, in FY13 USAID ASSIST worked with the MOHSW, PMTCT IPs and technical partners– EGPAF, Delloitte Tunajali, Baylor Paediatric AIDS Initiative, FANTA (FHI 360) and Jhpiego – to start activities for PHFS in 10 selected sites in each of the three districts of Tanzania (Nzega, Mufindi and Mbeya Urban). The three demonstration districts were, and will be, involved in a quality improvement demonstration program (during the PMTCT B+ changes that are ongoing in Tanzania) to improve post-natal care and well-being for both mothers and their infants.

Partnership for HIV-Free Survival

Improvement Strategy

The PHFS strategy is led by the MOHSW and Tanzania Food and Nutrition Centre and incorporates three regional IPs (EGPAF, Baylor, and Deloitte Tunajali) and four technical partners (FHI 360/FANTA, Jhpiego, and ASSIST). These national partners are working with the district and regional teams to support health care workers at the selected health facilities. Learning platforms are planned at health facility, district, and national levels and between countries to ensure that lessons learned are shared for improvement.

Spread Strategy

The activity plans to use improvement methods to ensure that health care workers at health facilities have clear objectives for improvement that will be achieved through a change package of interventions and PHFS being led by the MOHSW. These interventions will inform that national scale-up of PMTCT Option B+.

Accomplishments and Results

- **Completed national protocol for PHFS:** Worked with IPs to develop national PHFS protocol.
- **Developed monitoring and evaluation (M&E) framework for project:** Developed the M&E framework of the project and the related QI framework.
- **Conducted baseline assessment in three demonstration districts of PHFS:** Worked with

MOHSW, IPs and health workers in Nzega, Mbeya Urban and Mufindi districts to collect baseline data.

- **Conducted learning sessions:** Worked with IPs (Delloitte-Tunajali in Mufindi district of Iringa, EGPAF in Nzega district in Tabora and Baylor in Mbeya Urban district) to provide technical assistance for conducting learning sessions in 30 sites in these districts. During the learning sessions participants were trained on QI principles, dimensions of quality, clients' rights and providers' needs, steps in QI and application of the QI Model to strengthen ART/PMTCT services. Participants were also trained on the use of the QI team journal for documentation of improvement work. Findings from the baseline assessment were presented, areas that needed improvement were discussed and consensus was reached on selection of priority improvement areas. Indicators for monitoring the priority areas were also selected and agreed upon.
- **Participated in all national and regional steering committee and M&E sub-group meetings and PHFS webinar calls:** Monthly national progress meetings, multicounty webinars and sharing meetings coordinated the partnership and harmonized implementation. Two meetings were held in Uganda and one in South Africa.
- **Improvements in several key PHFS indicators.** Table 2 shows improvements for several key indicators from baseline to October 2013 from Nzega (sample site), including: percentage of HIV-positive post-natal care women initiated on ART, percentage of HIV-positive women on ART, percentage of infants being exclusively breastfed, percentage of mother-baby-pairs attending post-natal clinic, and percentage of infants tested by DNA/PCR and receive results.

Table 2: Improvement in key PHFS indicators in FY13

Activity	Indicators	Baseline (April-June 2013) Nzega District	Last FY13 value (Oct 2013) Nzega District
To support MOHSW and HIV Free Survival Partners towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers through nutritional services for mothers, infants and young children and health systems strengthening of the postnatal continuum of PMTCT care	• % infants who are malnourished	0%	0%
	• % women in ppostnatal care (PNC) and pregnant women who are malnourished	0%	0%
	• % mothers who attend post-natal care	43%	A
	• % HIV-positive post-natal care women initiated on ART	22%	38%
	• % infants who are EBF	41%	87%
	• % infants tested by DNA/PCR and receive results	62%	67%
	• % mother-baby pairs attending post-natal clinic	0%	12%
	• % HIV-infected infants <2yrs initiated on ART	50%	50%
	• % HIV-positive pregnant women currently on ART	0%	74%

NA=Not available

What Are We Learning?

- Use of 'Knowledge Cafes' in learning sessions allows participants to explore solutions to health system challenges (Mbeya).
- Developing knowledge nuggets can be useful to share experiences with other ASSIST countries and implementing partners.

Activity 3. Achieve sustainable improvements in ART patients' coverage, retention and clinical outcomes

Background

Prior to the implementation of USAID ASSIST, HCI supported the MOHSW and IPs in designing and managing a national QI program for antiretroviral therapy (ART) for individual health and PMTCT. For over four years (2008-2012), QI programs in demonstration regions (Tanga, Morogoro, Lindi and Mtwara) produced evidence-based strategies and best practices on how to improve several aspects of ART services. Remarkable achievements in patient-level outcomes were achieved. Regional, council, health facility leaders, and implementing partner stakeholders were actively engaged and their capacities for designing and implementing QI activities were strengthened.

Despite these achievements, the ART program still faces several quality problems. About 57% of the estimated 1,300,000 HIV+ clients in the country were enrolled in HIV care by December 2010. Only 20% of these were on ART, of which about 63% were retained on treatment 36 months after initiation of ART (NACP National database).

USAID ASSIST in FY13 worked to strengthen the MOHSW managerial capacity and adoption of integrated QI approaches and best practices at all levels to address prevailing system gaps contributing to low coverage, retention, and well-being of patients on ART. Most of these activities were done jointly with the PMTCT activities.

ART

Improvement Strategy

Supported MOHSW at various levels and IPs to use the collaborative improvement approach in addressing common practice gaps across different sites.

Applied ART and QI guidelines to improve the quality of ART services in intervention regions. Experiences gained from patient self-management aspect of the Chronic Care Model was used to actively engage in care, in terms of improving understanding and active participation in care by provision of HIV education, adherence support counseling and empowering them collaborate with other patients to find solution for their problems.

Established QI teams at all levels and capacitate them to apply QI methods to address implementation gaps. Enable teams to use Standard Evaluation Systems to plan, test and document changes and monitor improvement on priority technical areas while site-level databases will be used to monitor progress.

Supported these structures to apply known best practices in improving ART care whilst packaging emerging best practices from ongoing work. To facilitate sharing of innovations and scale up, quarterly experience sharing meetings between various teams were organized.

Spread Strategy

The RHMTs, CHMTs and IPs in respective regions where ASSIST supports improvement have managed to spread best practices and foster establishment of QI activities to lower level facilities through meetings with health facilities.

Oriented CHMT, RHMT and health care workers on QI

- *Dodoma:* ASSIST supported the MOHSW, RHMTs, CHMTs, and IPs in the Dodoma region to initiate QI activities in six district hospitals, three high-volume health centers, and one referral hospital. A total of 60 health care workers, 48 CHMTs and nine RHMTs were oriented on the improvement model that was used in implementing QI activities in the region to identify performance gaps in ART and PMTCT services. Teams were taught how to analyze systems and redesign process performance to increase client outcomes in CTC and RCH. As the country is proceeding to implementation of PMTCT Option B+, USAID ASSIST advocated for integration of RCH and CTC in facilities with CTC to eliminate mother to child transmission of HIV to all mothers and children in the region. In addition, ASSIST supported teams to select indicators for baseline data collection and continuous monitoring performance in implementation of QI activities in the region. To improve human performance, ASSIST empowered Dodoma R/CHMTs on QI methods

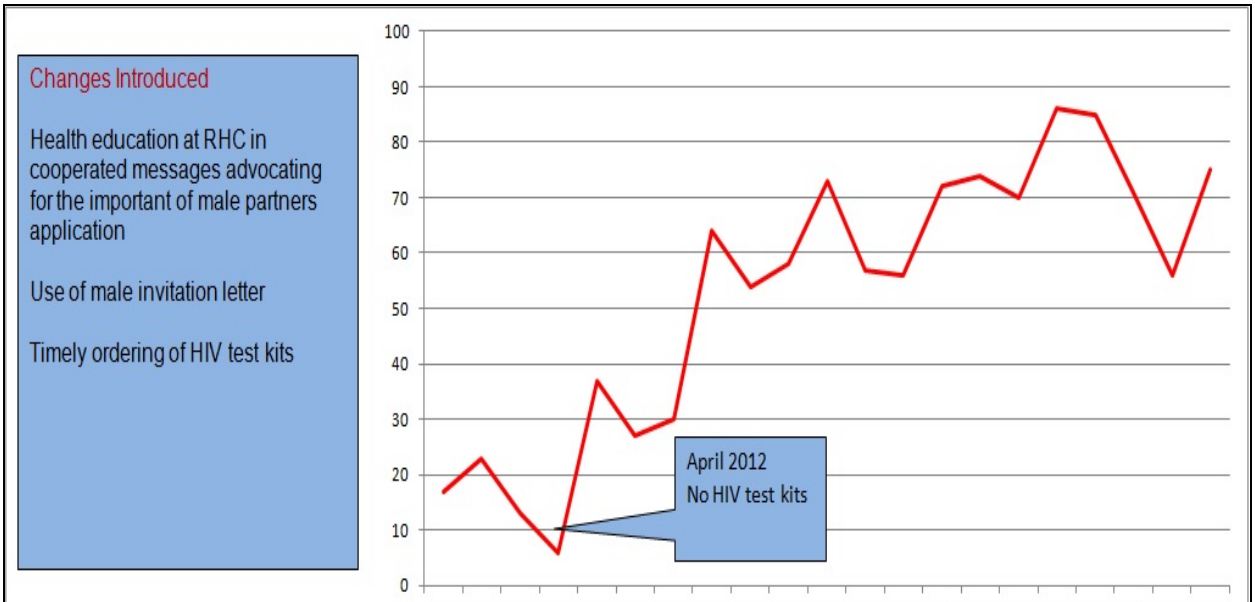
and techniques to support teams during supervision to build competencies in meeting both clients' health care workers expectations. ASSIST also supported CHMTs to reform QI teams in all participating health facilities, roles and responsibilities for team members and a focal person were clearly defined.

  - *Tabora:* A one day orientation meeting was conducted for five RHMTs and EGPAF whereby a brief overview of QI methodologies and selection of initial health facilities for QI implementation was done.

- **Conducted baseline assessments:**
  - *Lindi:* CHMTs in Lindi's districts conducted a baseline assessment of 14 new sites and prepared improvement work plans for the priority areas.
  - *Morogoro:* Thirty (30) new sites were engaged in improvement activities. The old sites had baseline assessments conducted during HCI.
  - *Tabora:* All six districts were involved and collection of baseline data was done in 14 sites to prepare them for implementation of QI.
  - *Arusha:* ASSIST and EGPAF conducted a baseline assessment of 14 facilities in Arusha. The assessment revealed late ANC booking, low male partner testing for HIV at ANC, low FP uptake among HIV+ women, and low rates of treatment for co-infection of TB. In addition, very few HIV exposed infants (HEI) received ARV prophylaxis and ART initiation for HIV-infected children below two years was low. Improvement work was initiated with 16 improvement teams in six districts across the region. The main technical areas of focus were: improving access, retention and wellbeing for PLHIV.
- **Conducted learning sessions:** Supported ART IPs, the RHMTs and CHMTs to conduct the first learning session in Shinyanga, Morogoro and Dodoma regions.
  - *Shinyanga:* Twenty-four (24) health care workers from 14 improvement teams and four staff from regional IPs participated.
  - *Morogoro region:* Thirty (30) new sites were reached with involvement of 85 health care workers.
  - *Dodoma region:* A learning session with 70 participants was conducted for nine improvement teams providing CTC and RCH services. Team leaders were selected and they developed plans according to priority indicators to monitor Improvement and record performance in the first action period.
  - *Tabora:* A total of 63 health care providers from 14 health facilities were trained on QI principles and improvement models and QI teams were formed accordingly. Health facilities were provided with QI files for record keeping, including tools such as the SES journal, a framework of writing meeting minutes and a QI training package for reference.
  - *Arusha:* The first learning session was conducted for 56 health care workers from 16 high-volume facilities, 4 RHMT members, 14 CHMT members and 7 program officers from EGPAF.
- **Provided support to CHMTs and RHMTs in conducting coaching and mentoring visits:**
  - *Shinyanga:* In six out of 10 initial collaborative sites in the six districts where QI teams are implementing changes to address ART quality gaps, preliminary results indicate improvement among PLHIV who are keeping appointment for CTC services and adherence counseling for ART patients. Several meetings were conducted by ASSIST coaches in collaboration with the IPs and R/CHMTs in an effort to increase availability of ARV and test kits at the site level (this scarcity is a result of distance between sites and transport issues). The regional IPs will be taking supplies whenever they go the sites.
  - *Morogoro:* In five sites in two districts, the USAID ASSIST team, in collaboration with RHMTs and IPs in the Morogoro region, supported QI teams to develop change ideas for improving comprehensive follow-up of HIV-exposed children, PCR testing, and HIV testing and counselling (HTC) for male partners at RHC services. Teams were also supported to improve their knowledge on numerators, denominators, and their data sources for focus indicators. Changes have been tested such as: data auditing to identify lost to follow-up clients and conducted physical/phone contact to bring them back to care; family planning for CTC clients focusing on HIV-positive women age 15-49 and timely HIV testing among HIV-exposed Children (HEI).

- **Supported RHMTs, CHMTs, and health facility staff to analyze processes of ART and PMTCT care** to address health system gaps and linkages such as challenges in managing commodities, data quality, HR and service delivery processes in CTC and RCH services in the region Morogoro, Lindi, Tabora and Arusha regions.
- **Supported QI teams to ensure proper reporting:** In Morogoro, Arusha and Dodoma the ASSIST team in collaboration with R/CHMT supported QI teams to ensure proper reporting and to request of the PMTCT program commodities using requesting and reporting forms and validating the number of dispensed drugs with total number of drugs given to PLHIV during the reporting period. This was in response to a data quality assessment that revealed inconsistency in numbers of clients and ARVs dispensed from some of the facilities. Teams were encouraged to perform interfaculty mapping of LTFU patients and tracking of missed appointments to reduce patients being lost.
- **Addressed gender gaps:** *Morogoro:* ASSIST has been following up integration of essential services and sustaining male participation. Strategies to increase male participation in PMTCT were tested in five sites in Morogoro with significant improvement especially in Ngerengere Health Center, the percentage of male partners tested during RCH services every month increased from 17% in January 2012 to 75% in September 2013 (Figure 4).
- **Coverage with CD4 monitoring every six months improved** from 47% in July 2010 to 100% in August 2013 in Tandahimba Hospital in Mtwara (see Figure 5).

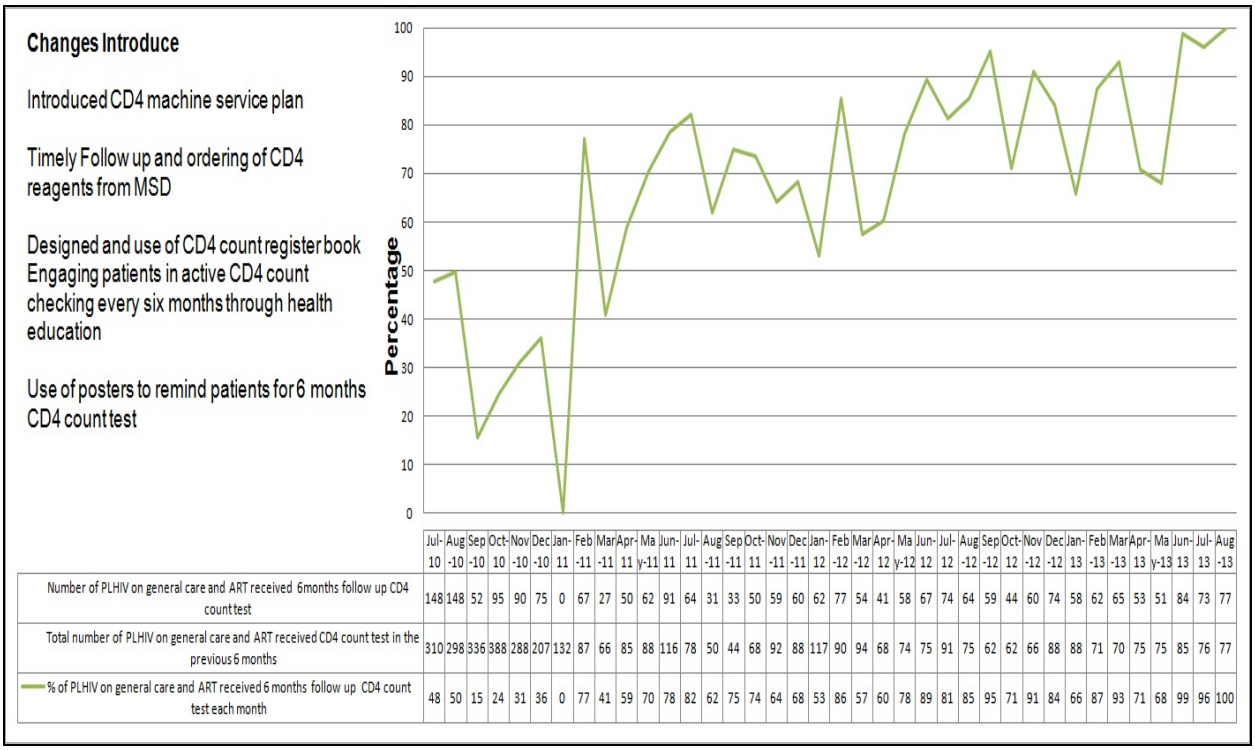
Figure 4: Percentage of partners tested for HIV at RCH, Ngerengere Health Center, Morogoro Region (January 2012-September 2013)



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
% of Male partner tested at RCH every month	17	23	13	6	37	27	30	64	54	58	73	57	56	72	74	70	86	85	71	56	75
# of male partners tested for HIV at ANC each month	5	7	3	6	16	7	10	21	19	18	19	16	17	29	20	16	18	17	25	14	22
Total number of woman booked for ANC every Month	29	31	24	32	38	26	33	33	35	31	26	28	30	40	27	23	21	20	35	25	29

Data Sources: National ANC PMTCT register

Figure 5: Percent of PLHIV on general care and ART receiving CD4 count every six months, Tandahimba District Hospital, Mtwara Region (July 2010-August 2013)



	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Number of PLHIV on general care and ART received 6months follow up CD4 count test	148	148	52	95	90	75	0	67	27	50	62	91	64	31	33	50	59	60	62	77	54	41	58	67	74	64	59	44	60	74	58	62	65	53	51	84	73	77
Total number of PLHIV on general care and ART received CD4 count test in the previous 6 months	310	298	336	388	288	207	132	87	66	85	88	116	78	50	44	68	92	88	117	90	94	68	74	75	91	75	62	62	66	88	88	71	70	75	75	85	76	77
% of PLHIV on general care and ART received 6 months follow up CD4 count test each month	48	50	15	24	31	36	0	77	41	59	70	78	82	62	75	74	64	68	53	86	57	60	78	89	81	85	95	71	91	84	66	87	93	71	68	99	96	100

Table 3: Improvement in key ART indicators in FY13

Activity	Indicators	Baseline	Last FY13 value
To support the MOHSW and IPs to scale up QI activities for ART services to achieve sustainable improvements in patients' coverage, retention and clinical outcomes	• % of patients on ART who are lost to follow-up	15% (Oct 2012, Morogoro)	7% (Sept 2013,Morogoro)
	• % of HIV patients receiving CD4 test every 6 months	70% (Oct 2012, Tandahimba Mtwara)	100 % (Sept 2013, Tandahimba Mtwara)
	• % of HIV patients assessed for active TB	71% (Oct 2008, Morogoro)	85% (Apr 2013, Morogoro)
	• % of male partners tested for HIV	7% (Morogoro), Jan 2012)	76% (Sept 2013, Morogoro)

What Are We Learning?

- Service integration improves uptake and addresses long-standing missed opportunities during service delivery (the case of improved FP uptake among CTC clients).
- After scaling up trainings to lower level facilities, we learned that council level QI teams can facilitate QI trainings with minimal support from ASSST and RHMT staff.
- As changes are implemented, management of the efforts (change management) is imperative for achieving sustained results.

Activity 4. Strengthen quality of care, support and protection to Most Vulnerable Children

Background

In the past, through HCI, we provided technical support to the DSW and IPs serving Tanzania's most vulnerable children to improve the quality of MVC services through compliance to national guidelines for the care, support, and protection of vulnerable children. Critical interventions included provider training, and communicating and implementing the MVC guidelines at the point of service delivery. In addition, HCI supported the implementation of an improvement collaborative in the Bagamoyo District to improve

the welfare of most vulnerable children and caregivers. During the initial nine-month implementation of the collaborative (May 2011 to February 2012) through HCI, there were notable improvements in access to adequate shelter, access and use of insecticide-treated nets, the percentage of vulnerable children who get two or more meals a day, and the percentage of children with birth certificates. Familiarization and accessibility of MVC QI guidelines increased but did vary from the national to the primary levels.

MVCC member presenting his teams progress during a coaching visit at Kiwangwa ward in Bagamoyo district, Pwani region.

In FY13 USAID ASSIST continued to support the DSW and MVC IPs to build on the existing systems and structures for the care, support and protection of MVCs in order to provide quality services and address implementation gaps. USAID ASSIST worked with stakeholders to help achieve the implementation of goals and objectives of the USG/URT Five-Year Partnership Framework in Support of Tanzanian National Response to HIV and AIDS (2009-2013) and of the new Tanzania National Costed Plan of Action for MVC (2013-2017). We applied improvement science to strengthen child protection systems; provide household economic strengthening; integrate community and health services; and worked to sustain the gains made under HCI as well as USAID ASSIST.

Most Vulnerable Children

Improvement Strategy

During implementation of this activity, the district authority, specifically those involved with MVC services, the Social Welfare Office and Community Development have been effectively involved to ensure ownership and sustainability. Furthermore ward and village authorities have been engaged to ensure they provide support to QI teams/MVCC, vulnerable children and caregivers.

Accomplishments and Results

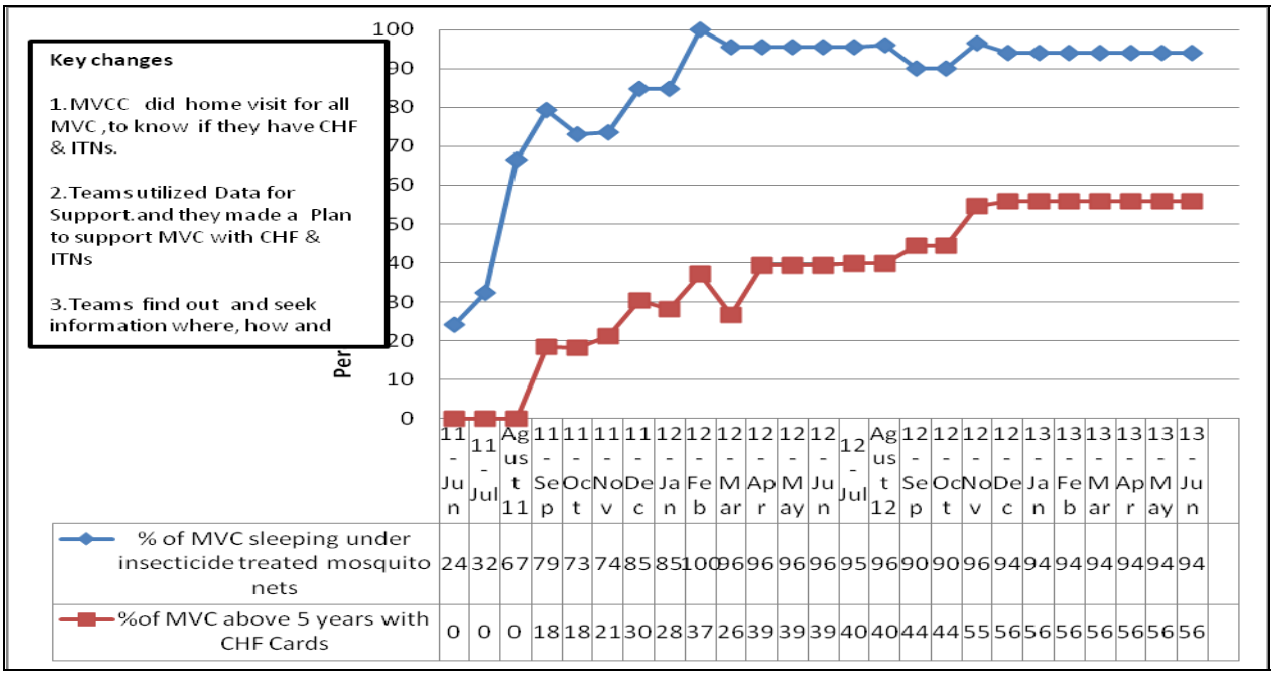
- **Continued to support Most Vulnerable Children Committees (MVCCs)/QI teams through learning and coaching sessions:** ASSIST, in collaboration with DSW, conducted a three-day refresher OVC QI training which was held in the Morogoro region April 10–12, 2013**,** aimed at equipping Social Welfare Officers from Dar es Salaam, Pwani, Tanga and Kigoma regions with MVC QI knowledge and skills based on the National MVC QI guidelines to be able to facilitate MVC QI in their respective districts. A total of 36 district social welfare officers participated. During this training, participants were able to share what their districts are doing in order to improve the quality of services that are provided to vulnerable children and identified QI gaps. In addition, they developed QI plans to address the gaps based on the knowledge and skills they acquired from the training.
- **In May 2013, ASSIST, in collaboration with Tanzania Interfaith Partnership, conducted a one-day QI advocacy meeting with MVC stakeholders in Kigoma Ujiji Municipality and Kigoma Rural districts.** A total of 47 MVC stakeholders participated during this advocacy meeting. In addition, a learning session was conducted in Kigoma Ujiji Municipality and Kigoma Rural districts to strengthen the knowledge, skills and conduct of the professionals, frontline workers and volunteers responsible for protecting children from violence, abuse, neglect and exploitation. A total of 39 participants participated during the learning sessions.
- **ASSIST, in collaboration with Bagamoyo District Council, continued to support MVCCs/QI teams through a coaching session which was organized in three wards of Kiwangwa, Dunda, and Fukayosi.** A total of 118 QI teams/MVCC members participated. Coaches from the district were able to provide guidance on different challenges raised by teams such as processes of acquiring birth certificates and Community Health Fund (CHF) cards.

  QI teams continued to sustain and mobilized local available resources and opportunities to support vulnerable children and caregivers. With ASSIST support, MVCC from Masugulu village managed to raise funds from local resources to support five vulnerable children through secondary education. In addition, the team saved approximately TSH500,000 ($312) that was also locally raised and can be used to fund any vulnerable children's pressing needs.

- **Teams have been given skills to update MVC registers and use the documents to reference the actual number of vulnerable children and as a record of their specific needs.** With this knowledge they have engaged various actors in planning support for the vulnerable children.

MVCC/QI teams in Bagamoyo working in collaboration with village leadership managed to improve and sustain access to basic health care services for vulnerable children (Figure 6).

Figure 6: Percentage of most vulnerable children sleeping under insecticide treated nets (ITNs) and percentage with CHF cards, Bagamoyo District (June 2011-June 2013)



USAID ASSIST also advocated for MVC improvement activities and support for MVC services to be across sectors and departments in the council such as education, Tanzania Commission for AIDS (TACAIDS), and health.

Table 4: Improvement in key MVC indicators in FY13

Activity	Indicators	Baseline	Last value
1. To support MOHSW, MVC IPs and local structures to strengthen quality of care, support and protection to Most Vulnerable Children through QI approaches	• % of MVCs sleeping under ITNs	24% (June 2011, Bagamoyo)	94% (June 2013, Bagamoyo)
	• % of MVC above 5 years with CHF cards	0% (June 2011, Bagamoyo)	56% (June 2013, Bagamoyo)

What Are We Learning?

- The MVCC/QIT members, if they are capacitated, can improve the lives of children and care givers.
- A committed leadership from both ward and village levels is crucial in guiding QI teams and in mobilizing local resources to support MVC and caregivers.
- Regular coaching to teams help teams to stay updated on issues related to care, support and protection of MVC; and therefore is an essential practice to sustain results.

Activity 5: Community home-based care

Background

In FY12, HCI supported the MOHSW and IPs to develop national Standard Operating Procedures for the HBC program and started its dissemination. HCI also started prototyping the HBC SOP in Tanga and Dodoma regions to demonstrate proper usage of SOP and to document how utilization of the SOP by HBC providers facilitates access to broad range of HBC services to clients. The prototyping of HBC SOP demonstrated improved referrals as well as improved documentation and reporting. In the same fiscal year, HCI started to pilot an integration of HBC and MVC services in Muheza district, Tanga region using the process improvement model.

However, HBC providers' understanding of clients' needs and the services offered still reflect the pre-ART era while standards to guide and benchmark their practice in the current context are lacking. In FY13, USAID ASSIST therefore supported the MOHSW and HBC IPs to disseminate and introduce HBC SOPs in service delivery sites across all levels of care, as well as to strengthen the collection, recording and reporting system and use of an HBC database.

Community Home-based Care

Improvement Strategy

In FY13 USAID ASSIST supported the MOHSW, NGO/CBOs and other IPs in Tanga and Dodoma regions to use the process improvement model and principles such as Smart Integration, Sustainability and Ownership to engage CHBC and MVC actors at all levels in designing and implementation of improvement efforts. ASSIST continues to support the MOHSW and IPs at national level in their efforts to spread application of the HBC SOP countrywide.

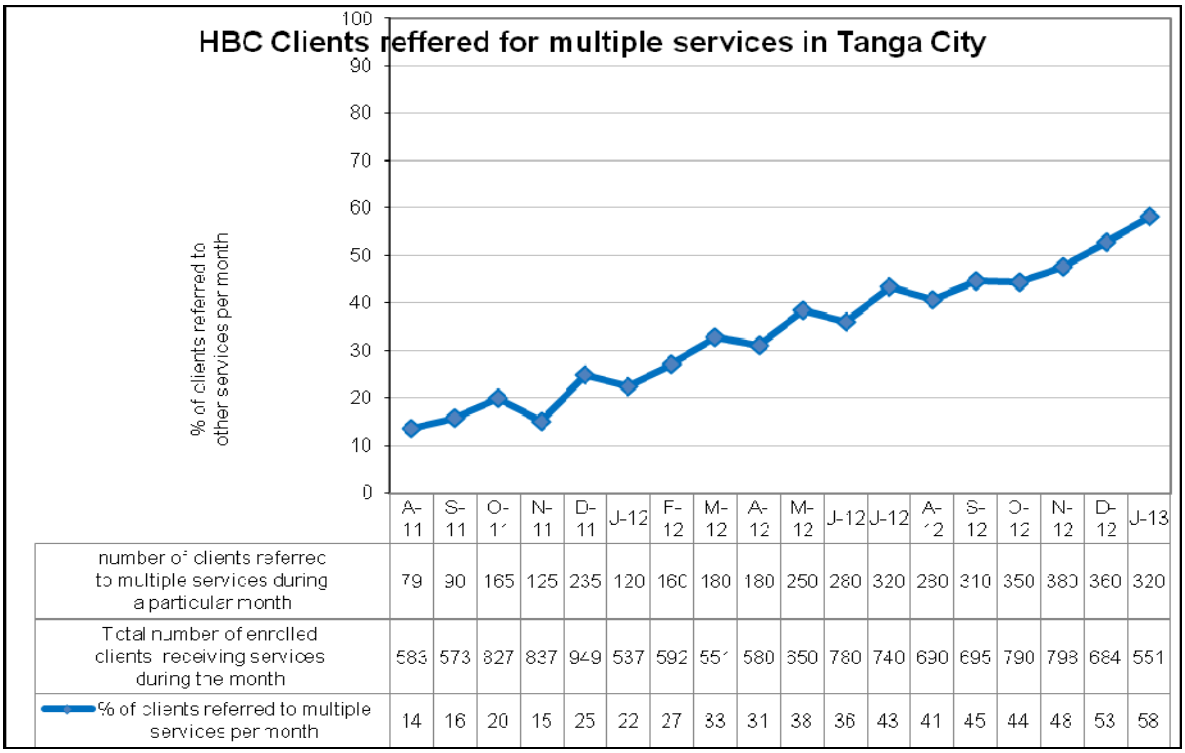
Spread Strategy

In FY13, ASSIST supported the MOHSW-led effort to scale up HBC SOP use nationwide. The scale-up first covered Eastern, North and Central zones using a group of national HBC TOTs concurrent with scale-up of training of HBC providers on revised HBC curriculum.

Accomplishments and Results

- **Built capacity to apply SOPs for HBC:**
  - *Tanga City:* Supported the RHMTs, CHMTs, HBC supervisors and providers in Tanga City on how to properly apply SOPs for HBC in routine service delivery in 14 wards and proactively link clients to various community-based services available in the city. Positive results have been noted through the application of SOPs and QI techniques such as: improved linkages among community-based service providers; increased frequency of clients' referrals; and improved access to service (Figure 7).
  - *Muheza District:* Supported the CHMT in Muheza district to review and translate from English into Swahili the monitoring and evaluation tools for HBC and MVC.
  - *Kilulu, Kicheba and Genge wards of Muheza district:* Provided capacity building to RHMTs and CHMTs on M&E and QI functions including compilation of providers' reports, extraction of indicator data as well as equipping teams with QI concepts and how to overcome implementation bottlenecks. In these sessions, two RHMT members, three CHMT members, three designated District hospital staff, 19 HBC supervisors, and 117 HBC providers and MVCC members were involved.
- **Conducted coaching through telephones and e-mails:** *Tanga City and Muheza:* ASSIST staff conducted telephone and e-mail communications to support teams on challenges encountered during implementation of HBC SOPs and job aids in Tanga and Muheza districts. A total of 14 supervisors and three CHMT members were involved in this coaching.
- **Supported national wide scaling up of SOPs:** ASSIST supported MOHSW to conduct zonal training/orientation of RHMTs from 13 regions on the SOPs and empowering region to conduct local step-down training/orientation to CHMTs and community teams.

Figure 7: Application of HBC SOPs improved access to multiple services among HBC clients, Tanga City (August 2012-December 2013)



	A-11	S-11	O-11	N-11	D-11	J-12	F-12	M-12	A-12	M-12	J-12	J-12	A-12	S-12	O-12	N-12	D-12	J-13
number of clients referred to multiple services during a particular month	79	90	165	125	235	120	160	180	180	250	280	320	280	310	350	380	360	320
Total number of enrolled clients receiving services during the month	583	573	827	837	949	537	592	55[illegible]	580	350	780	740	690	695	790	798	684	551
% of clients referred to multiple services per month	14	16	20	15	25	22	27	33	31	38	36	43	41	45	44	48	53	58

What Are We Learning?

- Conducting individual need assessment among HBC clients improves referral to various HBC-linked services.
- Focused counseling for men during home visits by HBC providers improved number of referrals for male clients to other services.

Cross-cutting Activities

- **Conducted Data Quality Assessment (DQA):** *Morogoro region:* Conducted DQA in five health facilities in Morogoro region (two from District Council and three from the Municipal Council) to verify data quality as per ASSIST project goals to determine whether findings observed by the health facility during QI activities truly represent what is being measured by those health facilities in the region. The DQA consisted of document finding and comparing actual to reported indicators, security of the rooms where data was stored, and determining areas of improvement in data collection, documentation, analysis and reporting by the QI teams. Most of the information provided by the QI team members was correct. All facilities had secure rooms for data storage and they had a clear flow of patients' files. However, it was found that there were several blanks in the CTC cards which needed to be filled in. The areas which were commonly left out were the demographic part, the eligibility criteria and different tests to be conducted to patients (e.g., liver function or renal function tests). The gaps identified were then discussed with the QI teams and action plan to work on them was developed.
- **Conducted training on integrating gender into QI programming:** ASSIST held a two-day gender training during the third quarter of FY13 in Dar es Salaam that brought together 28 participants from USAID ASSIST, Tibu Homa Project and TACAIDS to learn how to integrate gender into QI programming. The two-day training was facilitated by Dr. Taroub Faramand from ASSIST partner Women Influencing Health Education and Rule of Law (WI-HER, LLC).

4 Sustainability and Institutionalization

The design and implementation of improvement efforts under ASSIST have contributed to sustaining the improvement gains. Generally, policy guidelines, implementation tools and appropriate competences were developed prior to implementation. For the facility-based improvement work in ART and PMTCT, staff within the programs constituted the improvement teams and were trained and supported as they tested changes to narrow or close implementation gaps. ASSIST also supported RHMTs and CHMTs to function as coaches and mentors to the site teams. The practice has increased local ownership of the improvement gains and also introduced an element of accountability for sustaining the results. Some districts in Morogoro, Iringa, and Tanga included improvement activities in their Annual Plan, and during FY13, ASSIST staff were invited to facilitate learning sessions funded by Local Councils in Iringa and Morogoro. During the year, ASSIST also supported the MOHSW to develop a National Improvement Strategy covering all technical areas. This document constitutes the national agenda for improvement and also provides direction for the future.

In community programs (i.e., MVC and HBC), efforts were made to increase participation of all stakeholders in the improvement work. In this context, PLHIV, most vulnerable children or caregivers were encouraged to join the improvement teams. Together with care providers, they tested changes, reviewed results, and decided on the way forward. Implementation of improvement work was conducted along the existing structures using volunteers as the main providers. Learning sessions for these groups provided a forum for building solidarity around the results and motivation to continue.

5 Knowledge Management Products and Activities

USAID ASSIST Tanzania carried out the following knowledge management activities during FY13:

- Two USAID ASSIST Tanzania staff participated in the ASSIST PHFS meeting in Uganda in June. The meeting brought together HCI and ASSIST staff from four countries and was aimed at having participants share and to learn about activities to improve PMTCT services.
- Six USAID ASSIST Tanzania staff participated in the PMTCT Option B+ training of trainers since the MOHSW is preparing for the country's roll-out of PMTCT Option B +. During the training, they were provided technical support on revision of M&E tools and monitoring indicators emphasizing timing for initiation of ARTs and logistics and supplies. ASSIST has taken a leading role to develop QI indicators for PMTCT Option B+ in Tanzania.
- ASSIST was represented at a regional health forum in Lindi region, the "Joint Partnership Strategy towards Improved Health Status in Lindi." ASSIST and other IPs were invited to share their experiences in implementing QI activities in the region. They also discussed and presented achievements and challenges faced when working with the region and its districts.
- Documented a success story on integration of FP into CTC in Manyara Region. The story can be accessed at http://www.urc-chs.com/news?newsItemID=376
- Documented a success story on how HIV care improvement work affects lives of children in Iringa Region. The story can be accessed at http://www.urc-chs.com/news?newsItemID=377
- Five abstracts were submitted and accepted for the International Society for Quality Assurance in Health Care (ISQua) conference in Edinburgh in October 2013 and one for the Tanzania National FP conference in October 2013.
- Developed a knowledge nugget and shared it with other countries implementing PHFS on the URC Intranet.

6 Directions for FY14

- Develop National PMTCT Improvement Framework in the context of Option B+.
- Prototype the new improvement framework for Option B+ in one model district in Mwanza Region.
- Establish a model district in child protection focusing on vulnerable children (Mkuranga in Pwani Region).
- Develop an improvement framework for infant and childhood ART services and support the MOHSW and IPs in its implementation.

USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS PROJECT

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