PARTNERSHIP FOR HIV-FREE SURVIVAL (PHFS) SCALE-UP PLAN FOR TANZANIA

2015 – 2016
<table>
<thead>
<tr>
<th>S/No</th>
<th>Item</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Acronyms</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>What are we trying to scale-up from the initial implementation</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Compilation of the tested changes that were used during the initial phase of the demonstration</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Summary results of the first phase of implementation of PHFS in the 3 districts</td>
<td>7</td>
</tr>
<tr>
<td>6.</td>
<td>Examples of results obtained from PHFS implementation in the 3 districts</td>
<td>7</td>
</tr>
<tr>
<td>7.</td>
<td>Phase II of the project implementation – The scale-up phase</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>i) What to scale-up and how</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>ii) Improvement objectives and indicators</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>iii) Key activities related to scale-up</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>iv) How will we measure success of the scale-up</td>
<td>9</td>
</tr>
<tr>
<td>8.</td>
<td>Description of the 3 PHFS districts and the model used</td>
<td>10</td>
</tr>
<tr>
<td>9.</td>
<td>Funding and other resources planned for the scale-up</td>
<td>10</td>
</tr>
<tr>
<td>10.</td>
<td>Who are the PHFS partners</td>
<td>10</td>
</tr>
<tr>
<td>11.</td>
<td>Implementation schedule</td>
<td>11</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>ANC</td>
<td>Ante-Natal Care</td>
<td></td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
<td></td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
<td></td>
</tr>
<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
<td></td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
<td></td>
</tr>
<tr>
<td>CTC</td>
<td>Care and Treatment Clinic</td>
<td></td>
</tr>
<tr>
<td>DBS</td>
<td>Dried Blood Spot</td>
<td></td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breast Feeding</td>
<td></td>
</tr>
<tr>
<td>e MTCT</td>
<td>Elimination of Mother to Child Transmission</td>
<td></td>
</tr>
<tr>
<td>HBC</td>
<td>Home-based Care</td>
<td></td>
</tr>
<tr>
<td>HEI</td>
<td>HIV Exposed Infants</td>
<td></td>
</tr>
<tr>
<td>IPs</td>
<td>Implementing Partner</td>
<td></td>
</tr>
<tr>
<td>LTFU</td>
<td>Lost to Follow up</td>
<td></td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
<td></td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
<td></td>
</tr>
<tr>
<td>MTUHA</td>
<td>HMIS system</td>
<td></td>
</tr>
<tr>
<td>NACS</td>
<td>Nutrition Assessment, Counselling and Support</td>
<td></td>
</tr>
<tr>
<td>NSC</td>
<td>National Steering Committee</td>
<td></td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Presidential Emergency Fund for AIDS Relief</td>
<td></td>
</tr>
<tr>
<td>PHFS</td>
<td>Partnership for HIV-Free Survival</td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
<td></td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
<td></td>
</tr>
<tr>
<td>RHMT</td>
<td>Regional Health Management Team</td>
<td></td>
</tr>
<tr>
<td>SES</td>
<td>Standard Evaluation System</td>
<td></td>
</tr>
<tr>
<td>TFNC</td>
<td>Tanzania Food and Nutrition Centre</td>
<td></td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Scale up is defined as ‘...an increase in the coverage of health interventions that have been tested in pilot and experimental/demonstration projects in order to benefit more people...’ (Mangham and Hanson, 2010:2)

- ‘Change agents’ such as policy champions and community opinion leaders can influence adoption, and community acceptance of an innovation

PHFS partners will support CHMTs to put a system in place for monitoring the health care providers’ work in e-MTCT through monthly coaching visits. PHFS aim to increase coverage of health intervention that have been tested in pilot and experimental projects in order to benefit more people.

The methodology which will be used in Scaling up will be “WAVE SEQUENCE SPREAD.” The wave-sequence approach is a type of spread that focuses on spreading improved care delivery to other parts of the system. Work is initiated in ‘demonstration’ sites or ‘wave 1’ and then people from the initial slices (wave agents) are capacitated to spread the intervention to the follow up areas using collaborative methods in the ‘wave 2’ spread. Wave 1 or demonstration sites were 30 in the three districts of PHFS pilot phase and will be followed up by wave 2 sites scale-up to a total of 90 sites in the three districts.

Use of improvement collaborative approach will continue, whereby there will be quarterly learning sessions and monthly coaching visits to health facilities, using the ‘scale-up package’ to ascertain improvement of the indicators.

Peer to peer support will be done by use of ‘mother sites’ which will be providing QI ‘champions’ working with the CHMTs and being supported by the implementing partners. Teams will continue to be coached on site by monthly basis using trained coaches.

A ‘change package’ of those changes which were tried and found to be successful in improving the key interventions has been compiled whereby a package of indicators aligning to the 4 areas of retention, nutrition, HIV testing and ARV coverage will continue to be used. The R/CHMT will lead the process of scale-up. Up to 4 learning sessions will be conducted for the new sites in all the 3 districts.
THE SCALE-UP OF PHFS IMPLEMENTATION IN TANZANIA 2015 – 2016;

Background
The Tanzania Ministry of Health and Social Welfare (MOHSW) through Reproductive and Child Health Section coordinates scaled up prevention of Mother to Child Transmission of HIV (PMTCT) through integration of a package of PMTCT services into the routine Maternal and Child Health Services. Tanzania is among the countries striving for elimination of MTCT (eMTCT) to limit and reverse the impact of HIV and AIDS on individuals, communities, and nations.

The Partnership for HIV-Free Survival (PHFS) implementation in Tanzania started in 2013, through national level meetings and formation of the National Steering Committee (NSC) through partners supporting HIV activities led by the MOHSW. The implementation districts are Nzega, Mufindi and Mbeya urban district. In each district, 10 sites were selected and formed an improvement collaborative whereby the health care workers were trained and coached to achieve eMTCT. All the work was done by RHMTs, CHMTs and partners.

1. What are we trying to scale – up – from the initial implementation;

Following the initial success of the project, the scale-up will involve the following;

a. QI approach

b. Changes to system that worked (details of these changes are listed in the below table)

c. Capacity building for health workers.

Using QI methods, PHFS partners have supported prototyping of the national guidelines for PMTCT option B+ and NACS in 30 selected sites with each district starting the work in 10 sites to achieve 4 essential steps of postnatal mother-infant care that have resulted in excellent nutritional and HIV care for both the HIV-exposed and non-exposed infants over the first 24 months of life.

There have been learning sessions for the RHMTs, CHMTs and health care providers of the Nzega, Mufindi and Mbeya urban districts on QI systems leadership and support for performance issues using the collaborative approach. QI teams have been formed at district and site levels which are overseeing the implementation of the QI activities for PHFS. The QI teams have worked on the selected indicators (10) to monitor mother/baby access, retention and outcome of eMTCT care.

Capacity building for priority areas has been supported that include training for PMTCT Option B+, NACS training, Infant and Young Child Feeding trainings, Community health workers and volunteers’ training. Each site developed an improvement work plan and set-up a QI recording and data analysis system called Standard Evaluation System (SES). There has been 3-4 learning sessions for each district interspersed with coaching visits. Spreading learning within health facilities and districts has been done through learning sessions at the district, national and regional level. Virtual learning within PHFS National Steering Committee (NSC) occurred through monthly meetings of the NSC and quarterly reports to the National level M&E focal person for PHFS at the MOHSW level.

![Diagram of steps of mother-infant care](image-url)
2. Compilation of the ‘tested changes’ that were used during the initial phase of demonstration

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Key Changes that were proven to work</th>
<th>Other Changes implemented</th>
</tr>
</thead>
</table>
| Percentage of all mothers attended all post-natal care standard visits (2, 7, 28, 42 days) | • Provided a list of names of all mothers and babies with missed appointments to HBCs for tracking  
  • Calling mothers, those with mobile phones, if they missed appointment  
  • Writing on their cards the specific date and day that they should come to the clinic  
  • Counseled mothers on the importance of the four visits and dangers of not coming | • Same day appointment for the 6 weeks vaccination visit for the baby and the 42 days appointment  
  • Oriented all health care staff on how to properly document in MTUHA 13 register  
  • Weekly review of MTUHA register by the in-charge  
  • Involvement of male partners to escort their spouses |
| Percentage of HIV+ mother-baby pair attending HIV services each month     | • Giving same day appointment for the mother and infant to come for services  
  • Tracked mothers with missed appointments through mobile phones or HBC  
  • Counseled mothers on the importance of coming as a pair  
  • Stapling together mother’s CTC2 cards to the HIV Exposed Infant (HEI) cards | • Allocating specific ‘family day’ for fathers, mothers and their babies  
  • Documentation of the cards immediately after the service is carried out |
| Percentage of HIV+ mother-baby pair LTF who are tracked back to care       | • Update appointment register daily to detect missed appointments  
  • Compile a list of mother-baby pair who are lost to follow up and give it to the community health workers to track  
  • Calling mothers through mobile phones  
  • Link HEI and their mothers to CHW and HBC | • Monthly meetings with community health workers, home-based care staff and mothers’ psychosocial groups and setting reminder messages to attend  
  • Formation of mother to mother groups to encourage attendance |
| Percentage of HIV+ pregnant and lactating women on ART adherence          | • Timely ordering of adequate stock of ARVs and reagents  
  • Request ARVs from other facilities in times of shortages  
  • Counseling mothers on the importance of adherence to taking ARVs and dangers of not taking them  
  • Tracking mothers with missed appointments through mobile phones or HBC  
  • Integration of PMTCT and CTC services within RCH | • Promote disclosure to their partners  
  • Health education on use of ARVs to women on ART  
  • Weekly review of data in the ART register  
  • Orientation of all RCH staff to PMTCT Option B+ and use of CTC 2 cards |
| Percentage of HIV infected infants initiated on ART | Test all infants for HIV who come for other services in order to detect them | Timely ordering of adequate stock of pediatric ARVs and reagents |
| Percentage of exposed infants who are tested for HIV through DNA/PCR and receive results | Recording contacts of the mothers whose babies have DNA/PCR results and making phone calls to track them | Mothers are counseled on the importance of the results |
| | Improved documentation in the Mother-Baby Follow Up register | Orientation of staff on proper DBS samples collection and use of recording tools |
| | One focal person allocated to track DNA-PCR results at the facility | | |
| | Oriented new staff on how to document in registers | | |
| Percentage of pregnant and post-natal women who are malnourished | Integrate NACS into RCH services through training, identification of focal persons and identification of nutritional assessments’ point within RCH services at the clinic flow of services. | Introduce NACS tools at RCH and children wards |
| Percentage of infants who are malnourished | Acquire NACS tools and Train staff on NACS | Assign specific points/health care worker at RCH for nutritional assessments |
| Percentage of HIV+ pregnant and post-natal women who attend RCH and are counselled on nutrition | Orientation of staff on NACS to conduct nutritional assessments and document in NACS registers at each visit for mothers and their babies | Document the number of malnourished infants and mothers by severity in NACS register and monitor them |
| | Insert NACS forms for assessment for the mother and child in each of the mothers’ CTC2 cards | Link community-based nutritional support initiatives to the health facility – through referral |
| | Counsel mothers on how to properly feed their infants | Improved documentation in the NACS register |
| | Oriented all staff on how to counsel mothers on nutrition | Showing mothers how to position and attach their babies after delivery. |
| | Register all mothers in the NACS register | Early management of breast conditions |
| | Appoint NACS focal person into the QI team | | |
| | Repeated individual counseling of mothers on the importance of exclusive breast feeding and the dangers of mixed feeding in the first six months of life carried out at ANC, Labour and at RCH | | |
| | Provide therapeutic food to all malnourished individuals | | |

3. **Summary of activities & results of the 1st phase of implementation of PHFS in the 3 districts**
   - Improved documentation within reproductive clinics specifically for information on HIV testing and ART, post-natal care and follow-up, and nutrition.
   - Tracking of data in the four essential steps in the SES journals to document QI work, improve performance, and for inclusion in other reports for the implementation districts.
   - Provision of ART to HIV positive pregnant and lactating women through PMTCT B+. 
- Increase proportion on postnatal mothers completing all four standard visits.
- Increased proportion of mother-baby pairs retained in care
- Community tracking of pregnant and lactating women to attend ANC and RCH services through community volunteers and support.
- Nutritional assessments conducted for mothers and their babies including nutritional counselling as these activities were not being done in most health facilities.
- Documentation of nutritional information within NACS registers for mothers and babies’ information and nutritional status.
- Creation of district ownership for the program that enables members of the CHMT or other district level health workers to capacitate more health workers and monitor the program.
- Strong partnership developed under the MOHSW leadership that has created a forum for discussion during all the phases of implementation through the NSC.
- Sharing QI forums developed at the district and national levels to share experiences between implementers of the program.

4. **Examples of results obtained from PHFS implementation in the 3 districts**

Figure 1: Increasing retention of mother-baby pairs in care, 10 sites of each of three districts in Tanzania, (Nzega, Mufindi, Mbeya)
Figure 2: Increasing HIV+ pregnant women currently on ART, (Nzega, Mufindi, Mbeya)

Figure 3: Increasing HIV+ pregnant and lactating women counselled on nutrition, 10 sites of each of three districts in Tanzania (Nzega, Mufindi, Mbeya)
5. Phase II of the project implementation – The scale up phase:
   - PHFS partners will support CHMTs to put a system in place for monitoring providers work in e-MTCT through monthly supportive

6. Phase II of the project implementation – The scale-up phase

   i) What to scale and how;
   - Use of improvement collaborative approach will continue, whereby there will be quarterly learning sessions and monthly coaching visits to all the sites implementing the changes that worked, and using the ‘scale-up package’ to track improvement of the indicators.
   - Peer to peer support will be done by use of ‘mentor sites’ which will provide QI ‘champions’ to work with the CHMTs and supported by the implementing partners.
   - The CHMTs will assign new tasks to extend access, improve services and achieve objectives specifically community outreach during pregnancy to encourage early booking and HIV testing for mothers and their partners.
   - Teams will continue to be coached on site on a monthly basis using trained coaches’. All the sites will be coached to start with at least 4 ‘tested changes’ per indicator as described in the scale-up package.
   - The NSC will conduct quarterly reviews of progress of the monitoring and evaluation indicators as per scale-up package.

   ii) Improvement Objectives and Indicators;
   - In attaining HIV Free survival, the project will continue to support follow up of nutritional status of both mothers and their children, increasing access to HIV interventions and improve the quality of post-natal PMTCT services, including activities towards elimination of MTCT and reduction of other illnesses (infections and malnutrition) in children.
   - A ‘change package’ of those changes which were tried and found to be successful in improving the key interventions has been compiled. Refining the scale up plan will continue as implementation continues whereby the results of the first phase, need to be planned for scale up to the rest of the districts.
   - A package of 10 indicators for use during the scale-up will be aligning to the 4 areas of retention, nutrition, HIV testing and ARV coverage. In addition, 4 indicators addressing integration of NACS within HIV services and confirmatory HIV tests for infants, including the rate of HIV positive infants will be added and included in the indicator list used in the new sites.

   iii) Key activities related to scale-up include;
   - Up to four learning sessions will be conducted for the new sites in all three districts. The expected number of participants will be up to three health care workers from health centres and dispensaries participating in the sessions.
   - An expected total number of approximately 45 participants will be trained in each learning session and up to five of the R/CHMT will be trained.
   - R/CHMT planning the sessions will ensure that most of the health care workers are trained on QI during the learning sessions and on the job training is conducted for the health workers who did not attend the training by those who attended the learning sessions.
 Coaching visits will be done by the partners and the R/CHMT to conduct data validation of the collected indicators by the QI teams. The validation will review the numerators and the denominators used.

 Reporting of collected indicators will continue to be done to the National level PHFS coordinator by the districts working with the partners.

 iv) How will we measure success of the scale-up?
 Partners will analyze processes leading to the outcomes and tested changes that enhanced performance in the 1st phase of implementation. Additional indicators may be used to track other aspects of the improvement efforts, especially at the service delivery level. In all cases, a clear definition of each indicator (numerator and denominator), frequency of data collection and specific data source for each new indicator (including any necessary modifications) will be established in collaboration with PHFS partners and incorporated into site plans. All the QI indicators will be portrayed using annotated time series charts and data validation, whereby the results will be incorporated into regular RHMT/CHMT and facility supervision visits using a user–friendly checklists. To strengthen each supervisory team’s capability to validate their own data, the reports will be checked against primary data sources by PHFS partners’ staff for correctness/precision, consistency, integrity, accuracy and completeness.

 7. Description of the 3 PHFS districts and the model used;
 i) The Wave Sequence Spread Model for Scale-up of PHFS in Tanzania
 The wave-sequence approach is a type of spread that focuses on spreading improved care delivery to other parts of the system.

 The sites that will be added during the scale-up will be from the 3 initial districts of Nzega, Mufindi and Mbeya Urban. Activities will be continued in the 10 initial (wave 1) sites in each district with an additional 20 health facilities in each district during the scale-up phase. This will increase the total number of facilities to 90 health facilities; PHFS partners will continue to guide the implementation of the scale–up using quality improvement methodologies and capacity building in key areas for implementation of e-MTCT.

 ii) Scale – up sites during the second year of PHFS implementation in Tanzania

<table>
<thead>
<tr>
<th>Nzega district</th>
<th>Mufindi district</th>
<th>Mbeya Urban district</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1 (Initial)</td>
<td>Wave 1 (Initial)</td>
<td>Wave 1 (Initial)</td>
</tr>
<tr>
<td>Wave 2 (New)</td>
<td>Wave 2 (New)</td>
<td>Wave 2 (New)</td>
</tr>
<tr>
<td>10 health facilities</td>
<td>10 health facilities</td>
<td>10 health facilities</td>
</tr>
<tr>
<td>20 health facilities</td>
<td>20 health facilities</td>
<td>20 health facilities</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Funding and other resources planned for the scale-up
 The main funder of the PHFS work in Tanzania is USAID through the PEPFAR program. Partners will support at least 3 learning sessions consisting of up to 45 participants, and support coaching visits through champions and R/CHMT. The coaching visits will be up to 6 depending on the timing of the activities. During this phase all IPs that receive funding through the donor USAID will continue to report through the regular agreement mechanism, whereby the PHFS progress report will be added as a separate chapter or paragraph within the existing reporting structures.
9. **Who are the PHFS Partners**

PHFS partners (MOHSW, RHMT, CHMT, implementing partners and technical assistant partners) have worked together to support the implementation of PHFS. The MOHSW is leading the implementation and includes the head of the PMTCT section, RCHS section and TFNC. The RHMT are from the 3 regions of Tabora, Iringa and Mbeya, and the CHMT are from Nzega, Mufindi and Mbeya urban districts. The implementing partners are EGPAF, Delloite-Tunajali, Baylor - Tanzania and the technical partners have been URC-ASSIST, JHPEIGO, and FHI 360/FANTA. Lead partners are USAID as well CDC and UN organizations mainly through UNICEF and WHO.

10. **Implementation Schedule**

<table>
<thead>
<tr>
<th>Activities and Milestones</th>
<th>FY2015/FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q4 Q3 Q2 Q1</td>
</tr>
<tr>
<td>National learning platform to share learning by all the PHFS partners for the 30 pilot sites and site visit in Mbeya region health facilities</td>
<td></td>
</tr>
<tr>
<td>Sharing of tested changes with all partners and development of a specific district level implementation strategy for the activities</td>
<td></td>
</tr>
<tr>
<td>First learning session for the new - wave 2 sites Coaching and Mentoring visits with RHMT and CHMT for the new (wave 2 sites) and initial sites (wave 1 sites)</td>
<td></td>
</tr>
<tr>
<td>Second Learning session for wave 2 sites and coaching visits for both wave 1 and 2 sites in Nzega, Mufindi and Mbeya Urban districts</td>
<td></td>
</tr>
<tr>
<td>Third learning sessions for the wave 1 and 2 sites Sharing of results of the scale-up process and harvesting meeting for documentation of findings in the study districts</td>
<td></td>
</tr>
<tr>
<td>Regional Learning session</td>
<td></td>
</tr>
<tr>
<td>Compilation of what have learned in wave 2</td>
<td></td>
</tr>
</tbody>
</table>