



Tanzania Ministry of Health and Social Welfare

Rapid Scale-Up of PMTCT Service Provision Using a District Approach

The Tanzania Experience



National
AIDS Control
Program
Tanzania



U.S. Agency for
International
Development



U.S. President's
Emergency Plan
for AIDS Relief



Elizabeth Glaser
Pediatric AIDS
Foundation

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Elizabeth Glaser Pediatric AIDS Foundation
Dar es Salaam, Tanzania
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Executive Summary

The scale-up of prevention of mother-to-child transmission (PMTCT) services is a public health priority, but access to these services for women living with HIV in low- and middle-income countries remains disappointingly low. To address the need for increased access to PMTCT in Tanzania, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), under the leadership of the Tanzania Ministry of Health and Social Welfare (MOHSW), supported the rapid scale-up of PMTCT services in five regions of the country between 2003 and 2007. As of September 2007, the support provided by EGPAF had helped more than 420 Tanzanian health facilities (hospitals, health centres and dispensaries) to offer PMTCT services. More than 440,000 pregnant women have received HIV counselling and testing since this programme was initiated in 2003. EGPAF Tanzania utilized a decentralized 'district approach' in accordance with Tanzania's national decentralization policy to enhance the speed and quality of the scale-up process as well as to promote the long-term sustainability of services through the integration of PMTCT activities into existing structures and systems.

This document describes the key elements and principles of the district approach, including how implementation of this approach can be supported through a series of specific steps. Key elements of the district approach include building technical capacity at the district level, ensuring financial sustainability of programme activities, and creating mechanisms for ongoing supportive supervision and monitoring. Suggestions are also provided on how to monitor the impact of such an approach and how to embark on the next steps beyond initial implementation. The information presented is based on in-depth consultations with government officials, EGPAF staff, public health specialists, and PMTCT service providers and clients in select districts, with the aim of helping others to employ a decentralized approach to the rapid scale-up of PMTCT services in Tanzania and beyond. This document is geared toward a broad audience ranging from government health officials, public health specialists and nongovernmental organization programme managers, to health services providers and community-based AIDS service organizations.

Tanzania: A country united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus.

—Vision, Health Sector HIV and AIDS Strategic Plan 2008-2012 (MOHSW 2007)

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EGPAF-Supported Regions in Tanzania



1 Introduction to the District Approach to PMTCT Service Provision

- Background
- About the District Approach

Background

Only about one-third of women in low- and middle-income countries currently access prevention of mother-to-child transmission of HIV (PMTCT) services.¹ Without access to this set of lifesaving interventions, about one in three children born to women living with HIV will contract the virus.² The need for these services is particularly acute in sub-Saharan Africa, where three-quarters of all HIV-positive women worldwide reside. PMTCT services are also the entry point to other critical prevention and care services, the benefits of which are summarized in Box 1. The scale-up of PMTCT services is therefore a top public health priority in the countries most affected by HIV and AIDS.

Tanzania has a population of 36 million and a total fertility rate of 5.6 children per woman. The estimated HIV prevalence among women of reproductive age is 7.7%. It is estimated that 70,000 to 80,000 newborn infants are at risk of acquiring HIV every year either during pregnancy, labour and delivery, or through breastfeeding.³

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), under the leadership of the Tanzania Ministry of Health and Social Welfare (MOHSW), has employed a *district approach* to support the expansion of PMTCT services in the five regions where the Foundation supports PMTCT services: Arusha, Kilimanjaro, Mtwara, Shinyanga and Tabora (see map at left and Box 2 on the following page). In accordance with Tanzania's national policies supporting greater decentralization of health services, districts have come to play a central role in the provision of these services. In 2003, EGPAF began providing support to international partners charged with establishing PMTCT services within individual health facilities. Starting in 2004, EGPAF shifted its approach and began directly supporting the districts in keeping with Tanzania's national decentralization policies and in an effort to foster local ownership and long-term sustainability of PMTCT services. The specific activities undertaken as part of this district approach from 2004 to 2007 are outlined in the following sections.

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). *2008 Report on the Global AIDS Epidemic*. Geneva, Switzerland: UNAIDS; 2008.

2. UNAIDS. *2006 Report on the Global AIDS Epidemic*. Geneva, Switzerland: UNAIDS; 2006.

3. Tanzania Ministry of Health and Social Welfare (MOHSW). *2007 HIV and Malaria Indicators Survey*. Dar es Salaam, Tanzania: MOHSW; 2007.

Box 1. The Benefits of PMTCT Services

PMTCT ideally starts with HIV testing and counselling as a routine procedure in reproductive and child health (RCH) services. The benefits of PMTCT services include:

- ✓ **Prevention of transmission of HIV from a woman living with HIV to her child** through antiretroviral therapy (ART) and antiretroviral (ARV) prophylaxis for HIV-positive women and HIV-exposed infants, strengthened antenatal care, safe delivery practices, and counselling and support for safer infant feeding practices.
- ✓ **Linkage of mothers living with HIV (and other household members) with care, treatment and support services**, thereby prolonging their lives and enhancing the survival of their children.
- ✓ **Follow-up of HIV-exposed infants** to monitor their health and HIV status, provide prophylaxis and/or treatment for opportunistic infections and link them to care, support and treatment.
- ✓ **Establishment of a non-stigmatizing entry point for HIV and AIDS information** (i.e., primary prevention), as well as counselling and testing, for women, their partners, families, and communities.
- ✓ **Establishment of an entry point for family planning services** to help women and men living with HIV make informed reproductive choices.

Source: Adapted from Tanzania Ministry of Health and Social Welfare (MOHSW). 2007 Tanzania National PMTCT Guidelines and Training Curriculum. Dar es Salaam, Tanzania: MOHSW; 2007: p. 5.

Box 2. EGPAF-Supported PMTCT Districts by Region**TABORA**

- Sikonge
- Nzega
- Urambo
- Uyui
- Tabora Municipal
- Igunga

SHINYANGA

- Shinyanga District Council
- Kahama
- Bukombe
- Maswa
- Bariadi
- Shinyanga Municipal
- Kishapu
- Meatu

ARUSHA

- Arusha District Council
- Karatu
- Monduli
- Longido
- Meru
- Arusha Municipal
- Ngorongoro

MOSHI

- Hai
- Mwanga
- Same
- Moshi Municipal
- Rombo
- Moshi Rural

MTWARA

- Newala
- Tandahimba
- Masasi

About the District Approach

There are several characteristics of the district approach that distinguish it from other more conventional methodologies for health services expansion. These include: a focus on building technical capacity at the district level to ensure sustainability and rapid service expansion; an emphasis on financial sustainability, so that activities are included in district budgets and do not indefinitely rely on support from an implementation partner; and mechanisms for ongoing supportive supervision and monitoring to ensure the quality of services and address challenges as they arise. EGPAF defines the district approach as working *through* the districts. It involves building district-level capacity to plan, implement and monitor PMTCT activities.

‘Scaling up through a district approach means train, build capacity, supervise and expand.’

—Agatha Haule, PMTCT Technical Advisor, EGPAF

This active collaboration helps to build local capacity for PMTCT service delivery, while facilitating greater local ownership and sustainability of these services. With technical and financial support from EGPAF, the district health management teams are able to assist hospitals, health centres, dispensaries, community-based and faith-based organizations (CBOs and FBOs), community leaders and other stakeholders to implement and scale up PMTCT services.

A key aim of this approach is to build technical capacity at the district level. EGPAF assists districts in conducting a baseline survey and then helps them to develop their funding proposal. A training of trainers (TOT) is conducted among service providers in the district to ensure that all providers have the essential knowledge and tools they need to support the technical sustainability of the PMTCT programme.

EGPAF works in close collaboration with the district throughout the scale-up process. For example, from the outset, the district combines their resources with those of EGPAF to provide PMTCT services. The financial contribution of EGPAF as well as that of the district is clarified in the programme budget, which is developed collaboratively by the two groups. PMTCT funds are then channelled directly to the district rather than through another nongovernmental organization (NGO) or individual health facility in order to ensure district ownership. The district is also held accountable for all expenditures made in association with the approved plan and for timely reporting. Where supplies are included in the plan and budget, the district handles procurement in accordance with local guidelines.

Another aim of this approach is to ensure that district PMTCT activities achieve financial sustainability. Therefore, EGPAF stresses the importance of including PMTCT activities in comprehensive council health plans (CCHPs) from the start so that all stakeholders are conscious of the financial implications of the programme. EGPAF, in turn, gradually decreases its financial support to the district each year. Where there is a lack of financial management capacity at the district level, EGPAF works to address these shortcomings.

The same gradual process is used to achieve technical sustainability. During the first three months of the programme, EGPAF officers accompany the district teams during their monthly supportive supervision visits to recently-trained PMTCT providers at newly-established sites. Thereafter, these accompanied visits are reduced to once quarterly, then semi-annually, and eventually only take place on an as-needed basis.

‘The PMTCT program originates from our needs. Before submitting our plans to EGPAF we consulted hospital staff, the council health management team, and the health facilities. The proposal was adjusted to our specific needs. For example, Bukene health centres had a shortage of space, so money for renovations was requested from EGPAF.’

—Nafal Kawiche, District AIDS Control Coordinator,
Nzega District, Tabora Region

The success of this approach is dependent upon the involvement and collaboration of a range of district personnel, including those serving in non-health-related capacities. This strategy evolved over time as EGPAF realized the importance of involving stakeholders from outside the local health authorities. Initially, EGPAF worked closely with the key district-level health officials responsible for administering the district, such as the District Medical Officer, the District AIDS Coordinator and officers of the Council Health Management Team (CHMT). However, it was later discovered that other top-level government officials, such as the District Executive Director and District Treasurer, also needed to be involved in planning and decision-making in accordance with local policies and procedures. As a result, the district approach now involves all programme partners (e.g., district authorities, the CHMT, service providers at facilities, and EGPAF) working together to plan, manage, and implement the scale-up of services.

Above all, the district approach makes it possible for EGPAF to provide customized support to the districts that is responsive to the needs on the ground.

2 The Value of the District Approach

- Building Local Capacity
- Enabling Rapid Scale-Up
- Facilitating Health System Strengthening

The district approach is an important mechanism for:

1. **Building local capacity for PMTCT programming while fostering greater ownership and sustainability**
2. **Enabling rapid scale-up of new PMTCT services through integration with existing structures and systems**
3. **Facilitating health system strengthening and integration and supporting quality**

Building Local Capacity, Ownership and Sustainability

PMTCT services were introduced in Tanzania in 2000 when the MOHSW established a pilot programme at five sites. The main recommendation coming out of the pilot programme evaluation was to scale up PMTCT to all regions of the country through a phased approach.

In 2003, in collaboration with MOHSW and with support from the United States Agency for International Development (USAID), EGPAF-Tanzania initiated PMTCT activities through its Call to Action (CTA) programme. EGPAF initially provided funding for these activities to three interna-

tional NGOs; when the EGPAF country office was opened in 2004, this approach was changed based on the belief that it was critical to strengthen the planning mechanisms and capacity of existing local structures in order to develop a sustainable approach to PMTCT service provision. Accordingly, EGPAF began directly supporting national sub-grantees (i.e., government entities and FBOs). This approach was in line with Tanzania's national policies supporting the ongoing process of decentralization, in which districts are to become the focal point for health service development (see Box 3).

In order to identify appropriate sub-grantees, EGPAF solicited proposals in the priority regions that had been identified by the MOHSW. Requests for application were sent to government institutions and FBOs inviting them to submit a letter of intent. Representatives from selected organizations were then invited to participate in a workshop to further develop their proposals. More selection rounds followed before the final decisions were made.

Since this first step in 2004, several advances have been made to support the strengthening of capacity and programme ownership at the district level. PMTCT is now included, with clear targets, as a component of the national HIV/AIDS response and districts in the regions receiving EGPAF support are expected to integrate PMTCT with other health

Box 3. Decentralization in Tanzania's Health Sector

Decentralization is at the core of local government reform in Tanzania, with the goal being to move resources, decision-making and programme implementation to the districts. A transition is now underway from a centralized, public-sector system to a decentralized, district-based approach that combines public, voluntary and private-sector health-care providers.

Tanzania is comprised of 21 regions subdivided into 121 districts. Each district contains several divisions which are again subdivided into 'wards', each consisting of five to seven villages. The district, or council, is the most important administrative unit for public service planning and implementation and is thus the focal point for health service development.

The Council Health Management Team (CHMT) is the body primarily responsible for the implementation, monitoring and evaluation of the health-sector-based, district-level HIV and AIDS activities.

services. Additionally, since regionalization was introduced (whereby partners are directed by the government to work in support of specific geographical regions of the country to avoid duplication), EGPAF and other partners have been expected to work together with all districts in their respective regions.

Enabling Rapid Scale-Up

As of early 2007, only 10% of health facilities in Tanzania were providing the core components of PMTCT and only 12% of HIV-positive pregnant women were receiving ARV prophylaxis.⁴ In response to the need for greater access to these services, the Government of Tanzania has included a goal in their *Health Sector HIV and AIDS Strategic Plan 2008-2012* to increase the percentage of HIV-positive pregnant women who receive ARV prophylaxis to at least 80% by 2012. Achieving this goal will require the continued rapid expansion of PMTCT services throughout the country.

To date, EGPAF has been successful in using the district approach to support the rapid expansion of PMTCT services, enabling service delivery at the lowest level health-care facilities. Effective, timely training is a key component of successful scale-up efforts. Therefore, EGPAF employs a training strategy in which both trainers and service providers are trained in tandem with the establishment of new PMTCT sites. (This allows for a 'cascade' effect in which trained service providers are in place as new sites are launched, and trainers are ready to move on and train providers at the next planned site.)

As a result of the partnership between EGPAF and the districts, PMTCT services have been scaled up at a rate that exceeded expectations. At the end of 2004 (when the EGPAF country office first opened), EGPAF was supporting 66 PMTCT sites. By September 2007, after implementing a district approach to scale-up, more than 420 Tanzanian health facilities (hospitals, health centres and dispensaries) were being supported to offer PMTCT services (see Table 1 in the following section).

4. MOHSW. *Health Sector HIV and AIDS Strategic Plan 2008-2012*. Dar es Salaam, Tanzania: MOHSW; 2007.

Facilitating Health System Strengthening and Integration and Supporting Quality

A number of strategies under the district approach are geared toward the strengthening of health systems, and include support for quality assurance and service integration. EGPAF reaches agreements for technical and financial support directly with the districts or FBOs once their proposals have been approved. This support can take the form of training, supportive supervision, knowledge-sharing meetings with other districts, technical updates, equipment, supplies and renovations, or other types of assistance as needed.

Regular updates by EGPAF, monthly supervision by districts and good follow-up of trainees have all contributed to the support of quality within the programme. By building upon existing district structures and enhancing the capacity of districts to establish PMTCT services within their network of facilities, EGPAF has facilitated the integration of PMTCT into reproductive and child health services (i.e., as a routine element of service delivery within antenatal clinics and wards, labour and delivery wards, postnatal wards, and well-baby clinics).

As a result, the programme has been successful in limiting the number of sub-grantees (by having districts rather than facilities serve as sub-grantees) while maximizing the provision of PMTCT services.

Crucial to the successful scale-up of PMTCT under this approach is EGPAF's strategy to train PMTCT district trainers and to link the training of service providers to the establishment of new PMTCT services. District trainers receive supportive supervision from EGPAF during their first training, but train service providers independently thereafter. Ongoing mentorship, both by EGPAF and experienced district trainers, is another essential ingredient. The district trainers assist newly-trained PMTCT service providers to establish services at their facilities, and then provide ongoing supervision and mentoring.

This novel approach to training has significantly strengthened local capacity. As of September 2007, 62 district-based trainers had been trained and more than 2,000 service providers had been trained and assisted in the establishment and continued provision of PMTCT services in five regions of the country: Arusha, Kilimanjaro, Mtwara, Shinyanga and Tabora.

Table 1. Pregnant Women Receiving PMTCT Services at EGPAF-Supported Health Facilities (2003–2007)

	2003	2004	2005	2006	2007	Total
Total # of health facilities	18	74	152	250	428	—
New ANC clients	6 612	21 624	74 259	128 301	223 565	454 361
Counselled	6 644	23 104	80 388	128 993	225 820	464 949
Tested	5 743	21 973	77 355	124 049	216 774	445 894
Received results	5 497	21 436	76 732	123 372	216 384	443 421
HIV-positive	378	1 347	4 149	5 943	9 165	20 982
Mothers given NVP	228	942	2 614	4 585	9 150	17 519

Source: EGPAF GLASER Database (2008)

3 How to Support Implementation of a District Approach

- Essential Ingredients for Success
- Sequential Steps for Implementation

To gain insight on the keys to successful scale-up using a district approach, several key stakeholders were asked the following questions: ‘What did rapidly scaling up PMTCT services through a decentralized approach require?’ and ‘What are the keys to success?’ Those questioned included district officials (health and non-health), PMTCT service providers (at different levels in several districts), EGPAF staff, and public health specialists in Dar es Salaam. The essential ingredients and sequential steps listed in the following sections are based on their responses as well as client perspectives and EGPAF reports.

Essential Ingredients for Success

1. **The programme must be consistent with national government policies and guidelines.** This is the foremost requirement for sustainability and ownership. Scaling up PMTCT services through a district approach implies structuring programme implementation according to existing national policies and guidelines.
2. **The support provided must be customized to the local setting.** The support provided to district partners seeking to initiate and/or scale up PMTCT interventions must always be flexible. This means that technical and financial assistance must allow districts to design and operate programmes that are customized to the local healthcare settings, according to their capacities, needs and realities.
3. **Services must be integrated.** PMTCT services must be integrated into existing reproductive and child health services at the district and facility level from the outset. Holistic programming also implies that existing linkages in the district are utilized so as to maximize access for women, children and families to the continuum of HIV and AIDS care, treatment, support, and prevention.
4. **The programme strengthens the general health system.** The prospects for a successful PMTCT programme are largely reliant on the wider health-care system, and reproductive and child health services in particular. Designing successful PMTCT strategies in low- and middle-income countries implies strengthening health-care systems and services starting from the baseline level in the district.
5. **The ‘human factor’.** ‘To make PMTCT a success you must be close to people,’ says medical attendant Febriana at Nzega District Hospital. Being ‘close to people’ is important at all levels of the PMTCT programme: talking, listening, consulting and meeting eye-to-eye. The HIV-positive mother-to-be must be counselled and encouraged. Service providers must be given the opportunity to share their disappointment and success through organized meetings with peers. High-level authorities must be motivated to buy in to

the programme through opportunities to review data and meet people at the programme site. The human factor—seeing that the work being done is having an impact and showing clients that their service providers have the clients' health and the health of their babies at heart—contributes significantly to a successful PMTCT programme.

Sequential Steps for Implementation

- 1. Conduct an initial assessment with district staff.** As in any other programme, an initial assessment must be conducted to determine the strengths and weaknesses of the district health system, particularly the reproductive and child health services into which PMTCT will be integrated. EGPAF conducts the assessment together with the district to identify district strengths and limitations in health programs and systems. Resultant data is used to convince district officials of the importance of the programme. This fosters a greater understanding of the issues and ownership of the programme from the outset.
- 2. Engage the district administration.** Programme officials should secure the endorsement of district authorities from the beginning so they feel that they have a stake in the success of the programme. The district officials also need to be kept informed about the progress of the programme and regularly engaged. Failure to involve them in this way poses considerable risks, including duplicative or conflicting activities, procedural delays, and potential obstruction. Engaging the district administration should not be limited to the health authorities; it should also include non-health professionals such as the district executive director who is in charge of all heads of departments in the district, and the district treasurer, who oversees all financial matters.
- 3. Involve community leaders to promote PMTCT services.** In order to build broader support for PMTCT services, it is important to inform and secure the support of local politicians, church leaders, traditional birth attendants and others. Intensive community sensitization
- 4. Establish PMTCT training capacity in the district.** Training of PMTCT trainers who work for the district health system is crucial. Through this activity, districts will have a pool of trainers at their disposal who will work with regional trainers and will not have to depend on the availability of national trainers. This also facilitates independent planning for a quick expansion of services and ensures sustainability of the programme.



Mother and child wait at the Reproductive and Child Health Clinic

and promotion activities will help build demand for these services. Such activities will simultaneously address stigma and discrimination concerning mother-to-child transmission of HIV and encourage male involvement in the programme.

5. **Link PMTCT training with the establishment of new sites.** Each training should result in the development of a plan on how to establish new PMTCT sites. Helping newly-trained PMTCT service providers to establish services at their facility is one of the district PMTCT trainers' responsibilities. This is the key to realizing the cascading scale-up potential of the district approach.
6. **Integrate supportive supervision into the district routine.** Supportive supervision is a major component of quality assurance in the PMTCT programme and it should be integrated into the district supervision routine. This can be achieved through a 'tapering' method, in which district trainers are supervised by the supporting organization when they conduct their initial training, but thereafter conduct their trainings independently and become mentors to new trainers. Newly-established sites are supervised jointly by the supporting organization and the district health team for the first few months, and then the district takes over. Program officers from the supporting organization participate in the supervision of health facilities up to four times per year, depending on the programme's maturity and technical capacity. Integrating the PMTCT checklist for supportive supervision into existing district checklists is critical, and will result in district health officials taking on the added role of PMTCT facilitators/supervisors.
7. **Facilitate the exchange of experiences between districts.** Knowledge transfer between the districts through exchange visits, exchange of trainers, and annual meetings where partners share best practices and lessons learned, builds awareness of successful programmatic approaches. These opportunities help districts experiencing serious challenges to understand the constraints and design approaches to address them, while helping to maintain the motivation and momentum of all involved.
8. **Involve district stakeholders in monitoring and evaluation.** A strong monitoring and evaluation (M&E) programme is critical and should be incorporated from the beginning. It is important to collect comprehensive and timely data on important programme indicators, such as the number of women counselled, tested and receiving their results; local seroprevalence; and the number of women and infants receiving antiretroviral prophylaxis for PMTCT. Additionally, district-level capacity must be developed so that district personnel can use the data collected for programme improvement and local, decentralized decision-making. This data can also be used to advocate for programme support. All service providers involved in PMTCT should be trained in M&E processes.
9. **Make cost sharing explicit.** The respective contributions of the supporting organization and the district or facility should be clarified from the outset to illustrate how the partnership operates, to prepare the district for the cost implications of PMTCT, and to help the district plan for sustainability. In addition, it should be made clear from the start that the supporting organization's contribution will be phased out over time. It is therefore critical to advocate for the inclusion of PMTCT in comprehensive council/district-level health plans.
10. **Help build district leadership.** It is also important to develop district medical officers' capacity to understand the PMTCT programme, and oversee its planning, implementation, and monitoring and evaluation. This process should foster a feeling of ownership among district leaders, who must be able to facilitate collaboration among the government departments engaged in the programme.

- 11. Ensure linkages in the district's continuum of care.** An effective referral system and linkages between the health facilities and other institutions and community organizations need to be established to meet the comprehensive care needs of mothers, children, and other family members. The cooperation and support of numerous local entities must be enlisted when PMTCT services are established. The capacity of the existing local referral network must be assessed at the outset and reinforced throughout the process as needed.
- 12. Build the district's financial management capacity.** District financial management capacity should be strengthened through staff training and regular supervisory visits by compliance officers. Districts must have the capacity to develop budgets, as well as an understanding of the importance of spending funds within contractual periods, and the ability to provide timely and accurate financial reporting. District treasurers and executive directors (i.e., decision makers) must also be sensitized regarding the importance of following designated procedures in order to minimize procedural delays and maximize required supervision.
- 13. Facilitate modification of approaches.** National guidelines leave room for modification of approaches and districts must be guided in how to use this to their advantage. For example, if facilities do not have sufficient staff and time for individual pre-test counselling, they can opt for group counselling. Similarly, in anticipation of staff turnover, they might train all nurses and midwives at the facility on PMTCT instead of only training the few staff who work at reproductive and child health services and labour and delivery.
- 14. Encourage team building.** Team building plays an important role in developing commitment to a successful PMTCT programme throughout the various district departments engaged in the programme. Willingness to re-evaluate the agencies' roles and responsibilities, and collaboration between HIV and non-HIV professionals, should be fostered.
- 15. Establish district control over the budget.** Funding for PMTCT activities should be disbursed directly to the district team instead of being channelled through another NGO. The district is accountable for all spending under the approved plans, and is responsible for timely financial reporting.
- 16. Establish district control over procurement of equipment and supplies.** District management should have control over procurement of the equipment and supplies included in the approved plan. The procurement procedures should follow existing government guidelines.

4 Determining Programme Impact and Overcoming Challenges

- Measuring Success
- Overcoming Challenges
- Conclusion

Measuring Success

One important measure of success is the rapid rate at which PMTCT services for pregnant women living with HIV in Tanzania have been scaled up in the EGPAF-supported districts. As of September 2007, the support provided by EGPAF had helped more than 420 Tanzanian health facilities (hospitals, health centres and dispensaries) to offer PMTCT services. The rapidly increasing numbers of eligible women seen and offered PMTCT services since 2003 are shown in Figures 1 and 2.

It is also important to monitor aspects of the district approach intended to promote long-term sustainability, including the tapering of financial and technical support and accompanying annual service delivery statistics.

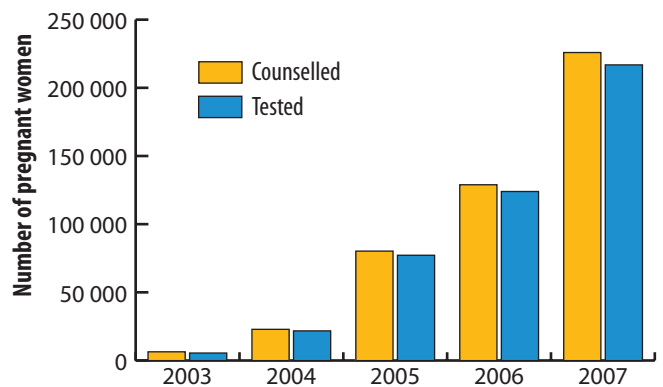


Figure 1. Scale-up of counselling and testing of pregnant women in EGPAF-supported districts

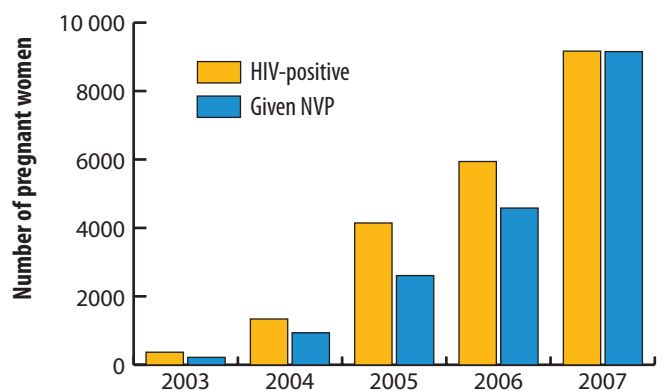


Figure 2. HIV-positive mothers receiving NVP for PMTCT prophylaxis in EGPAF-supported districts

Source: EGPAF GLASER Database (2008)

Overcoming Challenges

In spite of the successes described in this document, implementing the district approach is not without challenges. Some of the key challenges that need to be addressed throughout implementation are listed here.

- **Multiple constraints within the HIV/AIDS sector.** Common constraints include staffing shortages, limited rural coverage, service bottlenecks, low participation by males, stigma, scarcity of home-based care, and weak referral systems.^{5,6} Broad-based solutions to these challenges continue to require work by all stakeholders, including EGPAF (see Box 4). However, there are many social and cultural constraints that cannot be directly addressed by the programme (see Box 5). To tackle these issues, EGPAF assists districts in building partnerships with CBOs, traditional birth attendants and community leaders to promote women's access to follow-up services.
- **Less direct control over programme outcomes.** The district approach has demonstrated great potential for PMTCT scale-up, but it also provides less direct control over programme outcomes than traditional support strategies, such as working directly with individual facilities. Therefore, the quality and rate of expansion of PMTCT services largely depend on district leadership and the baseline level of capacity. This must be understood and accepted by EGPAF and programme donors.
- **Lack of financial management capacity.** This limitation had to be addressed in several districts, particularly early on in the programme. Although sub-grantees are expected to report monthly expenditures and request funds for the subsequent two months, many grantees only report when money is spent and then submit a new request. In some instances, little money was spent because of bureaucratic constraints. These problems delayed the implementation of planned activities. In response, EGPAF initiated training for sub-grantees to address these problems. Now when a contract is signed, EGPAF's contracts and grants officers explain to the sub-grantees what is expected of them and follow up with periodic trainings, visits by compliance officers, and updates. The district executive directors and treasurers (i.e., the decision makers) are now also being involved in this process.



Mother and child attend the Reproductive and Child Health Clinic

5. COWI. *Joint External Evaluation of the Health Sector—1996/2006*. Dar es Salaam, Tanzania: COWI; 2007.

6. Family Health International (FHI). *Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings*. Arlington, VA: FHI; 2005.

‘PMTCT is not just about finding HIV-positive women. When you have counselled pregnant women, you will have given them information about how to maintain their health. Information is power.’

—Dr. Msengi, District Medical Officer, Masasi district

■ **Rapid expansion of the programme.** With an ever-growing number of PMTCT sites in different regions, quality assurance through mentorship and supportive supervision required additional personnel at EGPAF-Tanzania. Coordination and communication between sub-recipients and EGPAF became complicated at times because of the increasing number of sub-grantees and health facilities. The establishment of field offices has relieved the pressure and improved communication and coordination.

■ **Difficulty determining when the districts are ready to operate independently.** EGPAF provides initial funding, training and mentorship, and then supportive supervision until the districts are ready to operate on their own. However, the appropriate time for ‘graduation’ is proving difficult to determine. There is a continuing need for EGPAF to guide the programmatic changes taking place within the district PMTCT programmes, including the ongoing integration of PMTCT with care and treatment. Nonetheless, an increasing independence can be observed in a number of districts. A similar challenge exists with respect to

Box 4. Perspectives on Strengthening the Health System Through the Provision of PMTCT Services

‘When addressing health system constraints, we look at the weakest components of the system. There are things that we as EGPAF can do, and things that we can’t do. What we can’t do is solve the human resource shortage. What we can do is counter or mitigate the shortage through skills transfer. We help people to acquire the skills they need to provide improved management, better counselling, and better deployment of the few available staff.

‘You can also make use of the flexibility of policy guidelines and do things a bit differently. For example, laboratory assistants were the original target group to be trained for rapid HIV testing. But there are simply not enough laboratory assistants, so we trained counsellors, midwives and nurses to do rapid HIV testing. Thus there will always be someone available in the facility to do the test.’

—Denis Tindyebwa, Technical Director, EGPAF-Tanzania.

financial sustainability. EGPAF’s goal is for districts to achieve financial sustainability by including PMTCT in their CCHPs and by looking for alternative sources of funding. However, this is another instance where the cut-off point for EGPAF support is difficult to determine. Additionally, district officials’ views regarding financial sustainability of their PMTCT programmes differ considerably among different districts, with some districts feeling this goal is well within reach while others see this as a distant reality at best (see Box 6).

Box 5. Comments on Barriers to PMTCT Uptake in the Community

The following comments were collected from participants of three focus group discussions (one for each programme site) among pregnant mothers. Discussions were held in November and December 2007 and each group had between eight and ten participants. All three groups were comprised of both HIV-positive and -negative women.

Male involvement

'Women don't tell their husband about the HIV test for fear of being divorced.'
— Focus group participant

'When I discovered I was HIV-positive, I was very shocked despite the counselling that I received from the nurse. I went home, looked at myself and started crying. For a week I cried a lot. If my husband had been caring, he would have asked me what was the problem, but he continued drinking and never cared.' — HIV-positive mother visiting a health facility with her sick child

Stigma

'I have not disclosed my HIV status to anyone. Only the nurses know about it.' — HIV-positive woman attending clinic.

'Women don't take their babies to the clinic to get nevirapine because they fear that people will be pointing fingers, saying that she and the baby are HIV-positive.' — Focus group participant

Poverty

'We are facing the problem of long distances to the clinic and we don't have money for transport.'
— Focus group participant

Breastfeeding

'Exclusive breastfeeding for six months is not possible because it is child abuse.'
— Focus group participant

Box 6. Views of District Officials on Sustainability of the PMTCT Programme

Nzega district: 'Sustainability is good. PMTCT is integrated in our CCHP. We have the trainers, and supervision is organized. In year two we sat together and discussed how we can we continue if we have no EGPAF. We decided to take from Basket Fund. Awareness and leadership support are in place. The Global Fund is already funding us, other NGOs could be involved.'

Nkinga (mission) hospital: 'We cannot sustain the PMTCT activities without EGPAF support. The number of clients is still increasing. Every year we need more test kits. Supervision in the satellites is difficult to sustain because of transport costs. Running costs cannot be fully taken over by the hospital. The government contribution to our mission hospital has a ceiling of 12% of total budget.'

Masasi district: 'We try to include PMTCT activities in the CCHP and budget. We do so little by little. But this council has little money because our revenues have declined when the cashew market collapsed. We estimate that EGPAF support will be needed for five to ten years depending on our own economic status. What we need most is capacity building, supervision, supplies, and transport.'

Conclusion

To date, the district approach has been responsible for the successful, rapid scale-up of PMTCT in Tanzania. It is expected that the strategies outlined in this document will continue to strengthen the ability of district health systems to meet the long-term health needs of women and children, towards the goals outlined in the MOHCW 2008–2012 strategic plan. This approach, however, is not without its associated challenges. As outlined in the previous section, there are a number of hurdles to overcome in pursuit

of the expanded provision of PMTCT and related services. It is especially important to ensure that barriers to long-term follow-up care for women and children are addressed through a variety of strategies, especially those that foster the active involvement of the community to address these challenges. By working toward greater collaboration of stakeholders and the decentralization and integration of services, EGPAF is supporting Tanzania in the development of strong, sustainable programmes that respond to the real needs of the population.

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