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GUIDANCE DOCUMENT

Supporting Most Vulnerable Children in Accessing HIV and Social Services in Tanzania through Community Quality Improvement Activities

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JUNE 2019

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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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ACRONYMS

ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plan
CDO	Community Development Officer
CHACC	Council HIV and AIDS Control Coordinator
CHBC	Community Home Based Care Coordinator
CHMT	Council Health Management Team
CHF	Community Health Fund
CJF	Community Justice Facilitator
CP	Child Protection
CQIT	Community Quality Improvement Team
CTC	Care and Treatment Centre
DACC	District AIDS Control Coordinator
DSW	Department of Social Welfare
FBO	Faith-based organization
HBC	Home-Based Care
HCI	USAID Health Care Improvement Project
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IP	Implementing Partner
IGA	Income Generating Activity
LTFU	Lost to follow up
M&E	Monitoring and evaluation
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committees
MTCT	Mother to Child Transmission
NCPA	National Costed Plan of Action
PDSA	Plan, Do, Study, Act
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PSS	Psychosocial Support

QI	Quality Improvement
QIT	Quality Improvement Teams
RHMT	Regional Health Management Team
SILC	Saving and internal Lending Communities
SWO	Social Welfare Officer
TA	Technical Assistance
TASAF	Tanzania Social Action Fund
TFNC	Tanzania Food and Nutrition Centre
URC	University Research Co., LLC
USAID	United States Agency for International Development
VEO	Village Executive Officers
VICOBA	Village Community Bank
WEO	Ward Executive Officer

Definition of terms

Terms	Definition
Change ideas	Specific activities or solutions which improvement teams have adopted that are expected to lead to improvement in the quality of services among target population (e.g. vulnerable children). Changes are tested by teams to see if they actually lead to improvement.
Child protection services	Activities that prevent and respond to violence, exploitation, and abuse against children. Child protection maintains children's basic rights to care, protection and justice.
MVC quality improvement (QI) Task Force	A committee of MVC national stakeholders comprised of government representatives and national level implementing partners responsible for provision of guidance and monitoring of MVC QI related activities.
MVC QI Guideline	A set of outlined illustrative activities that are essential to bring change in the lives of MVC, intended to guide and strengthen harmonization among partners to ensure equity, consistency, efficiency in service provision to MVC. The guideline offers a range of essential actions to be implemented based on specific needs of individual child.
MVC service providers	Stakeholders implementing different activities in relation to support, protection and providing services to MVC at different levels.
Quality Improvement	A systematic process of assessing performance in service delivery and identifying gaps and causes as well as introducing measures to improve quality and monitor output/outcome and impact.
National Costed Plan of Action (NCPA)	A national plan that guides the implementation of interventions designed to enhance protection, care and support of MVC within the framework of a well–resourced and coordinated national multisectoral response. The first plan was of 2007-2012 (NCPA-I), followed by a second plan of 2013-2017(NCPA II).
Service areas	Different services which should be provided to vulnerable children as per need of each child. Includes health, HIV care and support, nutrition, shelter, child protection, legal protection, household economic strengthening, psychosocial care and support, education, early children development.
MVC	Children under the age of 18 years living in extreme conditions that may endanger their health, well-being and long-term development.
MVCC	A committee formed at the Local Government Authority levels aimed at strengthening and coordinating implementation of activities related to care, support and protection of vulnerable children.

1. Introduction

In Tanzania, the Department of Social Welfare (DSW) of the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), is responsible for guiding and coordinating activities and interventions to ensure care, support and protection of Most Vulnerable Children (MVC). MVC are defined as children under the age of 18 years, living in high-risk circumstances whose prospects for continued growth and development are seriously impaired. Vulnerable children, including those who are affected by and living with HIV, are vulnerable to chronic diseases, developmental delays, and reduced educational opportunities as well as potential abuse, stigma, and discrimination by family members, caregivers, and community.

The implementation of community-based Quality Improvement (QI) in MVC service delivery was initiated in 2010 through support of the USAID Health Care Improvement (HCI) project, followed by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project of 2012 to 2017. From 2010-2017, community QI went through numerous stages at different structures and levels of the government, as described below.

1.1 National Quality Improvement Guideline for Most Vulnerable Children

In 2009, the DSW led the development of the National Quality Improvement Guideline for Most Vulnerable Children to standardize and improve the quality of services provided by various stakeholders. The guideline incorporated an overview of QI, roles and responsibilities for stakeholders, and specific service standards for different service areas. For each of the service area standards, the guideline detailed the desired outcomes, essential actions, illustrative activities, best practice notes, and quality indicators. The MVC QI guideline was developed to complement the implementation of the National Costed Plan of Action, 2007-201 (NCPA I).

The eight service areas included in the guideline:

1. *Food and Nutrition*
2. *Shelter*
3. *Family-based Care and Support*
4. *Social Protection and Security*
5. *Primary Healthcare*
6. *Psychosocial Care and Support*
7. *Education and Vocational Training*
8. *Household Economic Strengthening*

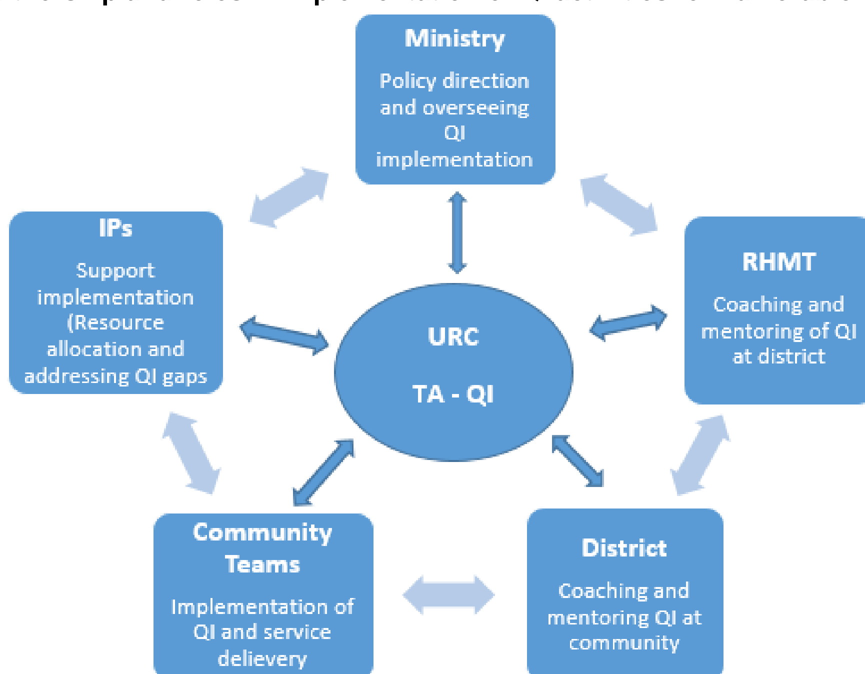
The National MVC QI guideline represented a shift in the type of programming for vulnerable children from distribution of commodities to standards-oriented programming that ensures an improved quality of life among vulnerable children and families.

In 2015 the implementation of MVC QI activities added a focus on contribution towards UNAIDS and PEPFAR 90-90-90 goals: that by 2020, 90% of PLHIV know their HIV status; 90% of those who are HIV-positive are on HIV treatment; and 90% of those on HIV treatment are virally suppressed. Improving access to HIV services for vulnerable children and adolescents living with and affected by HIV, and their families, including HIV testing and counselling, enrollment in care and treatment, and retention to care received more emphasis in MVC QI activities. A community linkage approach has proven essential to identifying and linking vulnerable children to HIV services.

1.2 Setting the Stage for Community Quality Improvement

The initiation of community QI activities for MVC service delivery started at the national level to create buy-in from government and paving the way towards actual implementation at the community level. Multiple stakeholders were ultimately included in the design and implementation of community QI. As shown in Figure 1, ASSIST provided QI technical assistance to the Ministry, Regional Health Management Teams (RHMT) and District Health Management Teams (DHMTs), implementing partners (IPs), and community teams, all of which collaborated with one another on activities. The aim was to make sure different parties are involved to ensure smooth implementation of QI activities at various level to bring positive results to vulnerable children and families.

Figure 1. Partnership and roles in implementation of QI activities for vulnerable children



Through collaboration between DSW and MVC IPs, major key issues/gaps in service delivery for vulnerable children were identified before embarking on implementation at the community level. Table 1 below highlights the gaps identified by the partners and the steps taken to strengthen the MVC response.

1.3 Purpose of this document

This document details the specific changes and activities that were implemented and the best practices for initiation and follow-up when supporting community QI activities for vulnerable children. This document describes what was done from the national level to the community level. The implementation sites are termed as learning sites for different stakeholders to learn and spread the QI learning across councils, wards and villages. The objectives of this guidance document are:

- To describe the process undertaken to improve quality of services for vulnerable children.
- To document change ideas that were used to strengthen capacity of community QI teams on improving access to HIV and social services among vulnerable children.
- To display lessons learned and recommendations based on efforts that resulted in improved access to HIV and social services among vulnerable children using locally available resources.
- To present tested change ideas and activities that strengthened facility and community linkage in improving retention to HIV care.

This document highlights key information and experiences in implementing QI activities in community settings in ensuring vulnerable children are identified and linked to HIV and social services.

It demonstrates a simple methodology on how QI can be implemented at community level and used to improve functionality of structures to support access of services among vulnerable children.

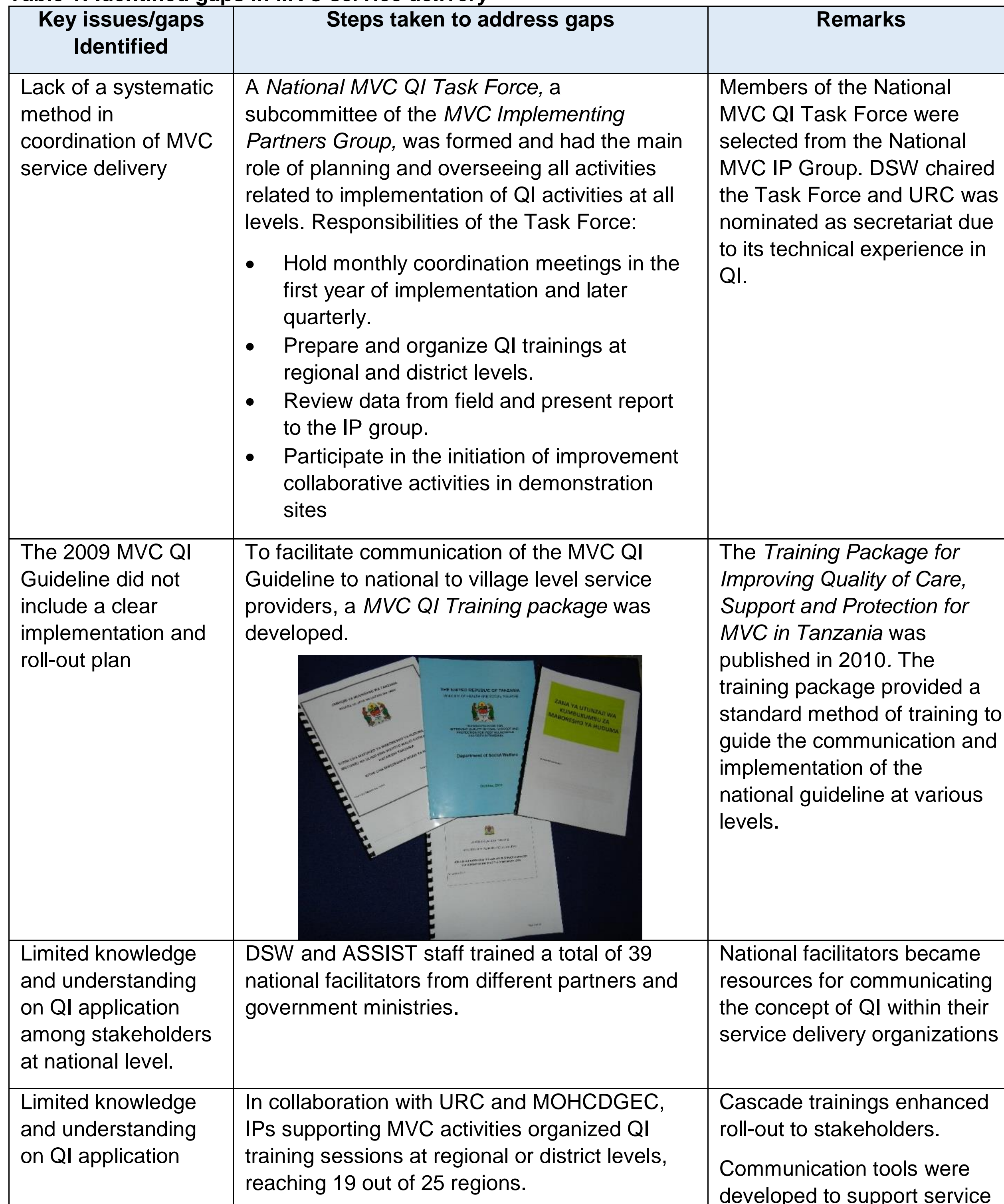
2 Quality Improvement Activities in MVC Service Delivery

The community improvement activities in improving quality of services for vulnerable children and caregivers are explained in three major phases, which are:

- Initiation phase
- Implementation phase
- Sustaining the gains phase.

During the initiation phase, teams identified gaps in MVC service delivery (Table 1).

Table 1: Identified gaps in MVC service delivery

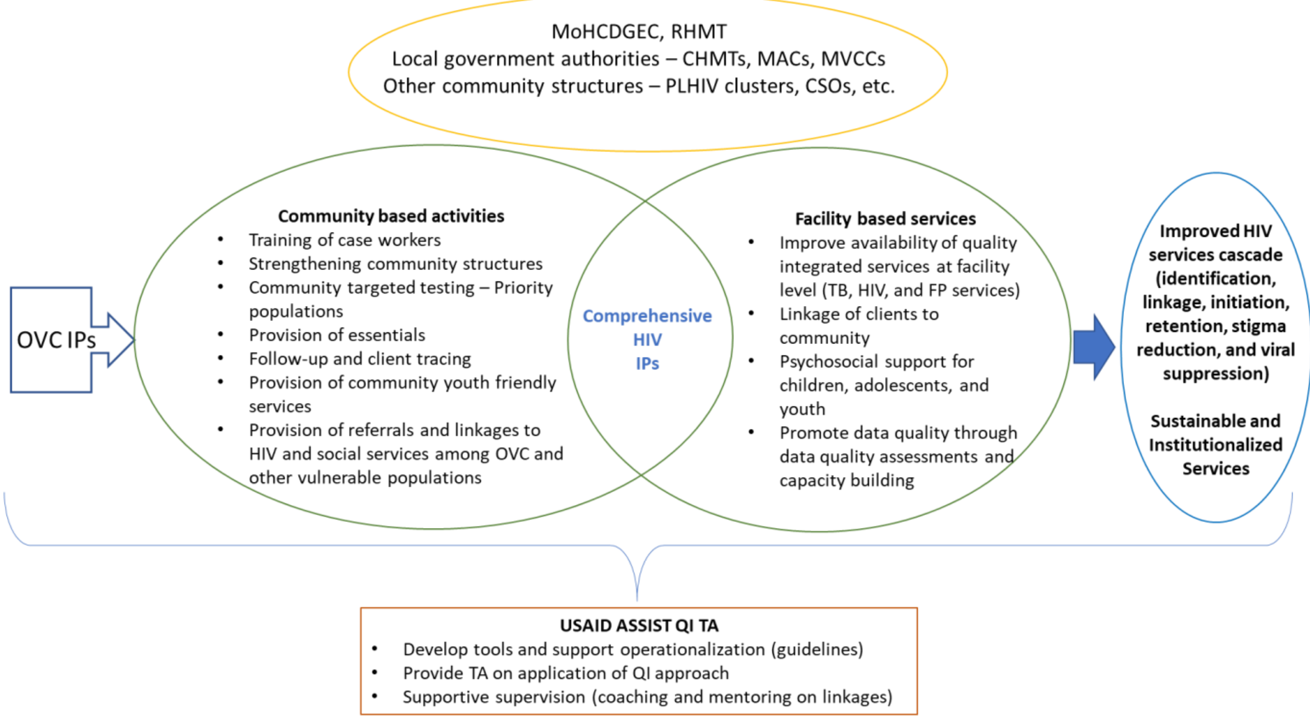
Key issues/gaps Identified	Steps taken to address gaps	Remarks
Lack of a systematic method in coordination of MVC service delivery	A *National MVC QI Task Force,* a subcommittee of the *MVC Implementing Partners Group,* was formed and had the main role of planning and overseeing all activities related to implementation of QI activities at all levels. Responsibilities of the Task Force: • Hold monthly coordination meetings in the first year of implementation and later quarterly. • Prepare and organize QI trainings at regional and district levels. • Review data from field and present report to the IP group. • Participate in the initiation of improvement collaborative activities in demonstration sites	Members of the National MVC QI Task Force were selected from the National MVC IP Group. DSW chaired the Task Force and URC was nominated as secretariat due to its technical experience in QI.
The 2009 MVC QI Guideline did not include a clear implementation and roll-out plan	To facilitate communication of the MVC QI Guideline to national to village level service providers, a *MVC QI Training package* was developed. 	The *Training Package for Improving Quality of Care, Support and Protection for MVC in Tanzania* was published in 2010. The training package provided a standard method of training to guide the communication and implementation of the national guideline at various levels.
Limited knowledge and understanding on QI application among stakeholders at national level.	DSW and ASSIST staff trained a total of 39 national facilitators from different partners and government ministries.	National facilitators became resources for communicating the concept of QI within their service delivery organizations
Limited knowledge and understanding on QI application	In collaboration with URC and MOHCDGEC, IPs supporting MVC activities organized QI training sessions at regional or district levels, reaching 19 out of 25 regions.	Cascade trainings enhanced roll-out to stakeholders. Communication tools were developed to support service

Key issues/gaps Identified	Steps taken to address gaps	Remarks
among stakeholders at community level.		providers in applying QI guidelines to MVC.

2.1 Collaborative Conceptual Framework in HIV Care Cascade

An essential goal of the USAID ASSIST MVC activities was to contribute towards the 90-90-90 goals, linking vulnerable children and adolescents and their families from the communities to clinical HIV services. Tanzanian MVC partners implementing community linkage activities agreed to develop a Collaborative Conceptual Framework to harmonize efforts. Figure 2 below shows the community implementation framework for ensuring that vulnerable children and adolescents are identified and linked to HIV services including HIV testing and counselling, and enrollment and retention to care with linkage to other MVC services within communities. The framework is intended to guide various partners working in different regions, ranging from community to health facilities in ensuring vulnerable children and families have access to HIV services within a collaborative approach in supporting 90-90-90 goals.

Figure 2: Collaborative Conceptual Framework in HIV Care Cascade



2.2 Implementation plan

The community improvement activities in improving quality of services among vulnerable children and caregivers were implemented in different stages referred as baseline, orientation, and implementation and coaching as detailed below.

2.2.1 Baseline Stage

The baseline assessment was conducted in collaboration with ASSIST staff, DSW, RHMT, and IPs in respective regions. Teams conducted introductory visits to districts aimed at familiarization of ongoing community MVC activities (what is available and not based on national guidance) and collection of preliminary data to identify quality gaps in identification and linkage of vulnerable children to HIV services.

Teams also conducted actual visits to selected wards/villages for quick discussion on implementation and service delivery to vulnerable children as per national policy and guidelines such as the NCPA, child protection guidelines, and the Child Act. Visits involved a series of small meetings with specific targeted departments and organizations within councils, such as visits to local NGOs providing services for vulnerable children.

After baseline assessments were conducted, feedback was given to respective authorities including Village Executive Officers (VEOs), Ward Executive Officers (WEOs), Council HIV and AIDS Control Coordinators (CHACCs), District AIDS Control Coordinators (DACCs), Social Welfare Officers (SWOs), and Most Vulnerable Children Committees (MVCCs) on identified gaps so they could start thinking how to address them. Table 2 below show identified gaps and changes tested to address gaps.

Due to weakness of community interventions at the village and ward level concerning vulnerable children's welfare, ASSIST provided support to form MVC QI teams. These teams were comprised of 10-12 members who were representatives from various community groups within the village including community health workers (CHWs), community home-based care (CHBC) volunteers, a teacher, PLHIV, Para-social worker, Community Justice Facilitator (CJF), member from Community Based Organization (CBO), religious institutions, and community groups in a particular village. Teams had regular QI sharing meetings bringing together facility personnel and community QI teams regularly to discuss progress changes, successes, challenges and way forward.

Table 2: Baseline stage

Key issues/gaps Identified	Addressing gaps	Remarks
Weak functionality of community systems in protecting and supporting MVC services.	Existing MVCC or Child Protection teams were transformed to perform QI activities. CHBC providers were incorporated in the teams to strengthen the HIV component.	The team supported identification, linkage to health facility for HIV testing and counseling, and further supported linkage and retention to care
Lack of updated MVC data at the ward and village level to support planning and allocation of resources	The team held specific discussions with the SWO in the district to explore the district's engagement and gaps towards strengthening community structures and systems for care, support, and protection of vulnerable children.	The meeting came up with list of QI team members and work plan
Weak community referral system and networking	Enable vulnerable children to access HIV and social services through a community linkage approach by: • Mapping available community resources • Community groups incorporating MVC agenda in their social activities • Facility staff identified MVC focal person among health staff. • Facility staff linked with CHBC and community leaders to conduct targeted HIV testing within community and tracking vulnerable children who were LTFU bringing them back to care.	HBCs worked as bridge between health service providers and community members
Self-stigmatization among individuals affecting	Representation of PLHIV member who was open to disclose his/her HIV status from	Self-disclosure among PLHIV is encouraged to

accessing of HIV services in the community	PLHIV group become a member of community QI team. PLHIV member in the team mobilized other PLHIV to join PLHIV group (e.g. in one village in Mufindi, members in one group increased from 8 to 19 within three months). HBC and CHW provided continuous support on positive living to PLHIV. Village authorities invited HBC provider, CHW, or any member from community QI team (who was able to speak in public) to create awareness on HIV issues such as importance of knowing HIV status, enrollment and adherence to care during community meetings.	minimize self-stigma and increase community awareness.
Inadequate HBC service providers in the village/ ward to support community HIV issues	The Community Development Officer (CDO), in collaboration with other staff at ward level and facility HBC in-charge, was assigned to provide immediate guidance to teams. The IP worked with district and respective ward and village authority to identify community members (in Mufindi, for example, following criteria for selection of CHBS) and were trained as per CHBCS guideline.	There is a national guideline for community-based HIV services where all issues of identification of community-based HIV service providers are stipulated. There is also a standardized community-based HIV service training.

2.2.2 Orientation Stage

The orientation of community QI linkage activities to council and community level was done by a team of ASSIST, MOHCDGEC staff, and representatives from the regional level DSW. MVC IPs in the specific region were also involved in the orientation session. Table 3 below gives detailed information on the gaps identified and measures taken to address those gaps.

Table 3: Orientation stage

Key Issues/gaps identified	Addressing gaps	Remarks
Inadequate understanding of community QI initiatives for vulnerable children at the district level	District/council staff who are involved in HIV and MVC activities, such as CHACC, SWO, CDO, District Education Officer, DACC, Planning Officer, Tanzania Social Action Fund (TASAF) Coordinator oriented on MVC national policies including QI guideline.	The orientation focused on QI on how to support teams; coordination and networking among sectors in ensuring vulnerable children are identified and linked to HIV and social services.
Inadequate knowledge of identification of key actions for follow-up by districts	During the orientation session, coaches were also identified at district and ward level to support actual implementation and coaching to teams, these coaches were	At district level, coaches were mainly SWO, CDO, and CHACC; and from ward level were CDO, WEO and

	identified from department/sections involved or related in MVC service provision such as the education department.	respective facility staff responsible for HBC services.
Inadequate prioritization and details of gaps which were identified by baseline team or any quality gap which was left out during the baseline	Community QI teams were oriented at their specific location on: • Basic issues related to QI (identification of gaps, planning for changes, and implementation) • Indicators for MVC • National MVC policy and guidelines • Roles and responsibilities of teams • Resource mapping and networking • Use of Plan do study act (PDSA) cycle in testing and monitoring outputs of changes.	At the end of the session, teams came up with their own identified gaps and a plan for changes to address those gaps.

2.2.3 Implementation Stage

From the guidance received during orientation on the QI guideline and the real situation in respective villages, teams were able to identify key gaps and performance measures to improve identification and linkage to HIV and social services among vulnerable children (Table 4).

Table 4: Actual implementation stage

Key issues/gaps identified	Addressing gaps	Remarks
Communities depend on external support from projects and government support for vulnerable children and families for support beyond HIV services	MVCC/community QI team developed a list of vulnerable children with their specific needs. MVCC/community QI teams mobilized resources from stakeholders within and outside their communities by writing letters explaining needs of vulnerable children. MVCC presented requests to village authorities and other individuals within communities which helped to mobilize various resources such as money, food support, scholastic materials, and school fees for those in secondary education.	Empowering communities paves the way towards ownership of MVC program at local level.
Inadequate knowledge on the realistic number of registered vulnerable children in the community and lack of updated vulnerable children data after the first identification.	All MVCCs, with the help of village leaders, identified vulnerable children and all names were approved at village/community meetings. Approved names of vulnerable children were registered in the MVC registration book for each village.	MVCC used the set criteria for identification of vulnerable children in each village through collaboration with village leaders. The national identification process was used with the guidance of the ward level CDO.

	Where printed National MVC registers were unavailable, counter books were used to ensure proper record-keeping.	Updated MVC lists were shared with district level. The DSW at the national level has developed MVC registers for the MVC program.
Low motivation and recognition of community QI teams by other community members	MVCC teams were introduced at community meetings and their roles were explained to make sure they are recognized by community members. IPs oriented teams to form income generating activities (IGA) groups to facilitate them to raise income and be motivated to support each other beyond MVC activities.	
Limited access to services among vulnerable children including health (HIV and primary health care), birth certificates, food, and child protection services.	QI teams identified and maintained a list of those vulnerable children in need of specific services. QI team members who are Village Community Banking (VICOBA) representatives extended the request to their members for contributions to facilitate transport costs for caregivers who were residing far from health facilities for supporting MVC to access HIV services. Some village authorities allocated pieces of land for cultivation of food and cash crops to benefit vulnerable children as found in two villages of Bagamoyo and three villages in Mufindi.	VICOBA allows members to save and borrow money within a set criteria and conditions. It brings people together and provides a sense of supporting each other as a group. In Bagamoyo, Mkenge village cultivated 2 hactres of maize which benefited vulnerable children and families in 2014, 2015, and 2016.
Community, parents/caregivers are not aware on the importance of testing HIV among vulnerable children.	Parents and caregivers were visited by HBC volunteers to reiterate the importance of HIV testing among children. HBC volunteer visited index clients (those known by HBC) and encouraged them to send their children for HIV testing. Community teams created general awareness to community members on importance of HIV testing. Community teams divided households to visit by neighborhood (those who live close or the same street with individual team member) to ensure all households are reached with HIV information and other social services.	Facility staff supported to prioritize vulnerable children for testing and counselling and link those testing HIV-positive to care.

Lack of transport and long distance from village to health facilities to access HIV services	Community QI teams and other community members contributed some cash to support caregivers and their children to access HIV services. Two villages from Mufindi managed to support 23 of 32 vulnerable children to access HIV services. The community HBC volunteer worked with facility staff in collaboration with village authorities to plan and conduct outreach testing by health workers.	
Team members faced with challenges in sustaining their own families, causing difficulties in supporting or providing guidance to MVC households on issues related to household IGA.	Community QI teams created their own groups for Saving and Internal Lending Communities (SILC) and VICOBA whereby the caregivers of vulnerable children were also guided and encouraged to join these groups. In Mkuranga the IP organized and supported orientation trainings on how to establish and run SILC. In Mufindi one community QI team formed a joint IGA and planted a nursery tree for timber and avocado trees. After selling, they allocated some percentage for themselves and other percent to benefit vulnerable children in need.	In Hoyoyo three households with malnourished vulnerable children under 5 were linked to the health facility in Mkuranga Town with support from funds in SILC. A total of 25,000/= was used as a transport fare to and from the facility and they were escorted with the HBC. As a result, all three children are progressing well.
Inadequate awareness among community members on importance of Birth certificates and Community Health Fund (CHF) cards.	Teams created awareness using village meetings and other village platforms to speak about the importance of supporting vulnerable children to access basic needs such as food, birth certificates, and CHF cards. Teams educated village authorities to allocate funds for supporting vulnerable children and use available programs and activities to ensure vulnerable children benefited from ongoing programs and activities within their communities. An example is the use of TASAF platform in Mufindi whereby families that benefited with cash transfers were educated to deduct 10,000 for CHF for family members. Teams also used a private-public partnership whereby they approached potential individuals engaged in business or any other individual members willing to contribute and offer support to vulnerable children. In Shinyanga some shop owners	All 6 sites in Kambarage in Shinyanga implemented these changes and achieved the following results between Oct 2015 to Feb 2017. Vulnerable children with CHF: Kambarage: 0% to 98% Majengo: 43% to 100% Jomu: 4% to 53% Mwasele B: 0% to 85% Mwasele A: 0% to 100% Miogoni: 80% to 100% Vulnerable children with birth certificates: Kambarage: 0% to 84% Majengo: 65% to 100%

	contributed to support payment for CHF cards for vulnerable children. Teams used to write letters for fundraising from churches, political leaders, CSOs and other institutions in the community to support vulnerable children with CHF cards. Team members were oriented on possible risks of missing CHF cards at time their children get sick and may not have money to pay for health services. CHWs led group education sessions where possible during meetings with caregivers. Some team members divided the work load among team members by neighborhood. Vulnerable families were served by team members in their neighborhood. Providers from the team would talk to care givers individually on importance of CHF cards for vulnerable children and taking care of their health.	Jomu: 13% to 93% Mwasele B: 0% to 73% Mwasele A: 0% to 35% Miogoni: 0% to 52%

2.2.4 Coaching Stage

Each month or two, coaching was conducted to support community teams to continue identifying gaps, test changes to address the gaps, reviewing data collected and guide teams on how to use and interpret data in linking vulnerable children to various services. Coaching was conducted as joint efforts by coaches from ASSIST, national, district, and ward level.

MVCC members participating in coaching and mentoring visit at Fukayosi Ward, in Bagamoyo. Photo: Delphina Ntangeki, URC

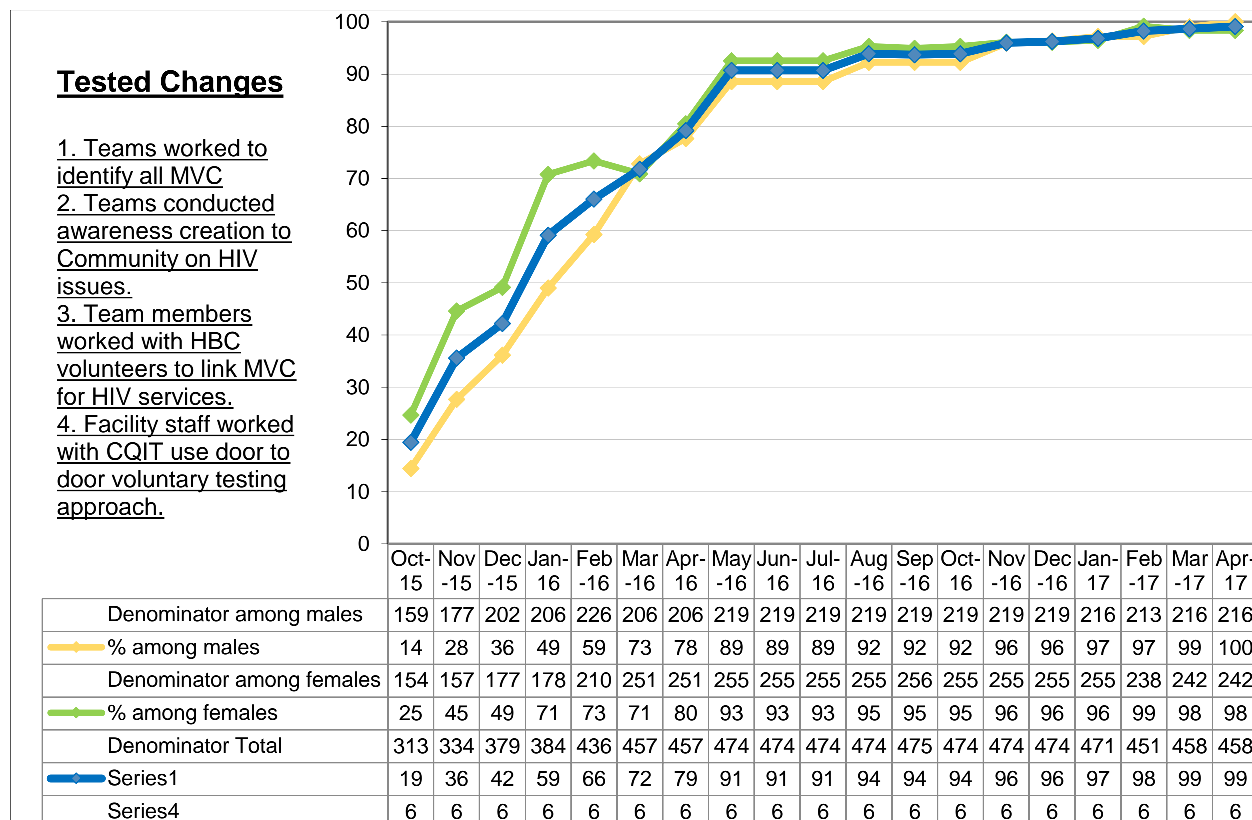
3 Results

Results achieved by teams in sites in Njombe Town Council in 9 sites, Shinyanga Municipal Council in 6 sites, and Mufindi District Council in 18 sites revealed improved access to HIV testing and counselling among vulnerable children through community mobilization and sensitization of caretakers to facilitate HIV testing among vulnerable children. See Table 5 and Figure 3 for more.

Table 5: Results achieved by April 2017

District	Total # of vulnerable children by April 2017)		# of vulnerable children tested (April 2017)		# of positive vulnerable children (April 2017)	
	Male	Female	Male	Female	Male	Female
Njombe (9 sites)	230	206	96	82	26	24
Mufindi (18 sites)	650	737	208	224	33	30
Shinyanga (6 sites)	216	242	216	238	33	23

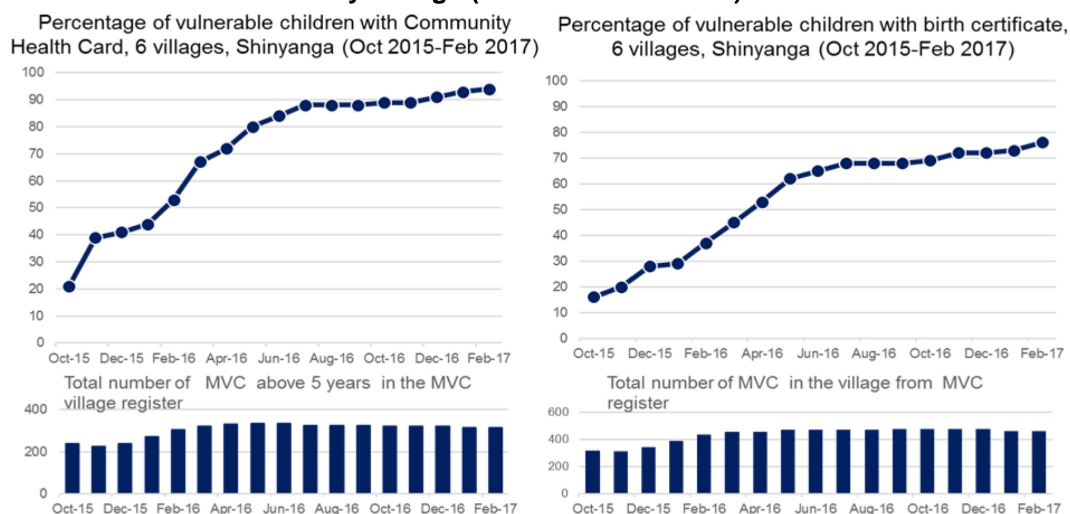
Figure 3: Increased access to HIV testing and counselling for vulnerable children through community mobilization in six neighborhoods of Kambarage Ward, Shinyanga Region (Oct 2015-May 2017)



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Denominator among males	159	177	202	206	226	206	206	219	219	219	219	219	219	219	219	216	213	216	216
% among males	14	28	36	49	59	73	78	89	89	89	92	92	92	96	96	97	97	99	100
Denominator among females	154	157	177	178	210	251	251	255	255	255	255	256	255	255	255	255	238	242	242
% among females	25	45	49	71	73	71	80	93	93	93	95	95	95	96	96	96	99	98	98
Denominator Total	313	334	379	384	436	457	457	474	474	474	474	475	474	474	474	471	451	458	458
Series1	19	36	42	59	66	72	79	91	91	91	94	94	94	96	96	97	98	99	99
Series4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6

Access to CHF cards among vulnerable children in Shinyanga Municipal Council increased following community awareness messages by MVCCs to community members on the importance of CHF cards and birth certificates (Figure 4).

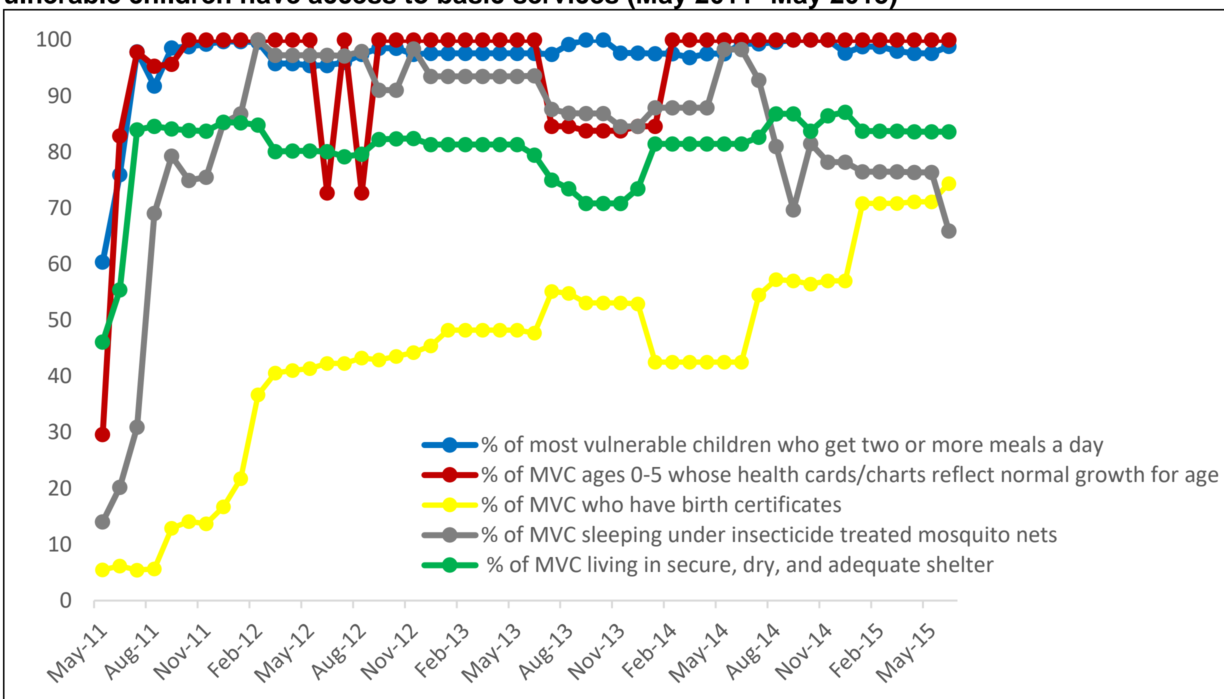
Figure 4: Improvement in accessibility of CHF card and birth certificates in Shinyanga, demonstration sites for community linkage (Oct 2015 – Feb 2017)



3.1 Sustaining the gains

Successful implementation of QI activities depend on sustaining the results of improvement over time. For example in Bagamoyo district council, the 25 community teams have been able to show that QI knowledge has enabled them to sustain improvement over five years as shown in Figure 5 below.

Figure 5: Sustaining improvement efforts by 25 community QI teams in Bagamoyo in ensuring vulnerable children have access to basic services (May 2011- May 2015)



4 Conclusion

4.1 Best practices

Community QI teams conducted regular meetings. Formally it was once a month, but the frequency was dependent on situations within communities including season and activities. For example, during cultivation season it was hard for them to meet formally, though as community members residing in the same location, they often met informally and updated each other regarding vulnerable children they visited.

Teams met to review data they had collected regarding children's welfare and updated what they had supported using an indicator matrix. During these meetings they discussed ways of supporting and linking vulnerable children to access HIV and social services based on their specific needs.

Teams updated each other through discussions on services available within community and other current issues learned from different sources, as each member had an opportunity to interact with various service providers, MVC partners. and stakeholders.

MVCCs advocated for HIV testing among vulnerable children by the HBC. Health providers at facilities gave health talks to caregivers living with HIV on importance of testing their children. MVCCs emphasized the importance of HIV testing among vulnerable children during village meetings, group meetings, prayer times at churches and mosques, and one to one. MVCC planned and divided hamlets for visiting whereby each vulnerable household was visited. The head of the household was approached for discussions on the importance of HIV testing. PLHIV who were part and parcel of the QI teams shared the information to

other PLHIV members on their own. PLHIV groups talked about the importance of HIV testing for children, enrollment to care and adherence to treatment. Health workers went to villages for testing at a point agreed upon with vulnerable families and health workers went to villages for door to door testing.

4.2 Challenges in implementing community QI activities

- Low community awareness on supporting vulnerable children with other social services.
- Inadequate supportive supervision due to limited budget for RHMT/CHMT to conduct frequent visits to empower community teams.
- Donor/government dependency among community members.

4.3 Lessons learned/Summary of key findings

- Identification, engagement and involvement of influential individuals or groups within spread sites is the first critical step for successful spread.
- Involving local community leaders increase the ownership of QI processes.
- Community QI teams can be very effective to increase uptake of health and legal services for vulnerable children and caregivers provided they are: involved on awareness creation, mobilized and supported by respective leadership structures.
- When initiating a community initiative, do not create new ones. Use available structures and community groups. Strengthen them if they are weak or non-functional.
- Frequent coaching/mentoring support to community teams is key to supporting action.
- Let community teams lead what they want to do. Technical advisors can only provide guidance but not directives.

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