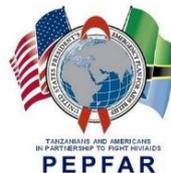


Pamoja Tuwalee



PAMOJA TUWALEE PROGRAM/FHI360 - COAST ZONE
Cooperative Agreement No. 621-A-00-10-00027-00
Quarterly Performance Narrative Report
July to September 2015

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CRP	Community Resource Person
CSO	Civil Society Organization
DCPT	District Child Protection Team
DED	District Executive Director
DIPG	District Implementing Partner Group
DSW	Department of Social Welfare
DSWO	District Social Welfare Officers
GBV	Gender Based Violence
FHI 360	Family Health International
HACOCA	Huruma AIDS Concern and Care
HIV	Human Immune deficiency Virus
IPG	Implementing Partners Group
LGA	Local Government Authority
MCDGC	Ministry of Community Development Gender and Children
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium-Term Expenditure Framework
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committee
NCPA II	National Coasted Plan of Action for Most Vulnerable Children
NGO	Non-Governmental Organization
OSC	One Stop Centre
OVC	Orphans and Vulnerable Children

PEPFAR	President's Emergency Plan for AIDS Relief
PSS	Psychosocial Support
SILC	Savings and Internal Lending Communities
TZS	Tanzanian Shillings
UNICEF	United Nations International Children's Emergency Fund
US \$	United States of America Dollar
USAID	United States Agency for International Development
USG	United States Government
VAC	Violence Against Children
WAMATA	Walio Katika Mapambano ya Ukimwi Tanzania (Fight against HIV)
YAM	Youth Alive Movement
ZAMWASO	Zanzibar Muslim Women Association to Support Orphans
ZCPA	Zanzibar Costed Plan of Action

EXECUTIVE SUMMARY

Pamoja Tuwalee Program is a five year USAID funded program that was initially to operate from June 2010 to May 2015 and it has been extended to March 2016. The program covers five zones of Coast, Central, Lake, Northern and Southern and is implemented by four partners with FHI 360 covering the Coast Zone i.e. Dar es Salaam, Morogoro and Pwani regions in the mainland and Zanzibar. The project is implemented in partnership with nine Local Civil Society Organizations (CSOs), and in collaboration with 25 Local Government Authorities (LGAs) and community members. The Program goal is to improve the quality of life and well-being of Most Vulnerable Children (MVC) and their households.

This report covers the fourth quarter of FY 2015 and provides progress on what has been done in the entire FY 2015. It narrates the implementation of the planned activities, achievements, challenges and lessons learnt.

As part of the preparation in the implementation of the six months extension period, the program focus for this quarter has been to validate the MVC transitioning tools and conducting the actual exercise in the selected districts. The program further continued to work with LGAs, CSO partners and community volunteers to ensure uninterrupted services to OVC with a focus on HIV services.

As part of transitioning 30-40% of MVC to the LGAs and community structures, the program built on its previous handover meetings with Council Management Teams (CMTs) in all its sustained districts to ensure smooth transitioning process. The District Executive Directors (DEDs) were briefed on the graduation and transitioning exercise and worked with the DSWOs to discuss the same with MVCC members, SILC groups, TASAF focal persons and other stakeholders. All of them took the exercise positively and accepted to take full responsibilities of caring for the transitioned MVC. A total of 14,866 MVC in 4,976 households have been either graduated or transitioned to community structures during this quarter. This covered four out of five sustained districts in Morogoro and eight in Unguja and Pemba out of 10 sustained districts. This represents 62% of all MVC that need to be transitioned in these 14 districts. This exercise will continue in the remaining districts of Morogoro and in Pwani regions in the next quarters.

On the other hand, the program continued with its efforts to contribute to PEPFAR 3.0 and the Global 90-90-90 initiatives that aim to end the AIDS epidemic by 2030. These efforts include discussions with the relevant District Medical Officers, Care and Treatment partners, and Care and Treatment Clinics (CTC) staff to foster OVC testing and counselling, enrolment to CTC, retention and adherence to Anti-Retroviral Therapy (ART) through bi-directional referrals.

Through collaborative efforts with DMOs offices and health facilities, a total of 8,311 OVC with care, support protection and HIV counselling and testing where by 2,472 equal to 30% are OVC who are HIV+

To ensure suitability of MVC care, support and protection, the program continued to work very closely with MVCCs and other public and private entities to mobilize resources for MVC. As a result, a total of TZS 152,105,700 (US\$ 76,053) was realized and used to support about 4,202 (male 1,987 and 2,215) MVC. This makes a cumulative total of TZS 364,513,100 (US\$ 182,257) collected in FY 2015.

Savings and Internal Lending Communities (SILC) groups continue to be vital for continuation of MVC and caretakers' support especially during this transitioning period. This quarter a total of 47 new SILC groups were formed with 1,005 (171 male and 834 members, 20% of them being MVC and MVC caretakers. A total of TZS 51,001,500 (US\$ 25,501) was collected through bought shares while about TZS 5,919,450 (US\$ 2,960) were contributed for MVC funds. This makes a cumulative total of TZS 1,921,247,721 (US\$ 960,624) and contribution to OVC funds amounting to TZS 134,278,040 (US\$ 67,139). This is an increase of 7% on the savings and 12% on MVC fund from. Through SILC groups the program provides community members and MVC caretakers with HIV prevention services including encouraging them for counselling and testing of their children as well as education on how to care for HIV+ family member.

Through community volunteers and program staff, a total of 100,910 (48,541 male and 52,369 female) MVC and their caretakers in this quarter were provided with core services while for the whole FY 2015 a total of 121,558 MVC and their caretakers were reached as part of representing 185% increase from the original target of 65,781. The increase is associated with the shift in the PEPFAR indicator that includes both OVC and their caretakers unlike in the past where OVC_SERV counted only OVC. The program support has contributed to improving lives of 12% of OVC out of national target in the program operation districts.

In line with PEPFAR 3.0, a total of 109 adolescent OVC and caretakers were trained on memory and hero books as well as peer education on HIV prevention, all aiming at encouraging HIV diagnosis, treatment and viral suppression (the 90-90-90 initiative). We also continued to reach youth with Sexual and Reproductive Health; and HIV/AIDS prevention to children and youth mainly through children clubs.

Table 1: Summary of progress against annual targets for FY 2015

Indicator	Target FY 2015	Reached		Contribution
		Number	Percentage	
OVC_SERV	65,781	121,558	185	12% of region OVC
TZ_ECON	36,078	60,384	167	50% of OVC_SERV
TZ_NUT	35,074	90,809	259	75% of OVC_SERV
OVC_ACC	9,867	8,311	84	10% of OVC in the program
GEND_NORM	5,467	6,242	106	31% of youth in children clubs
FN_ASSES	5,467	2,472	37	20% of OVC_ACC

PROGRAM IMPLIMENTATION

INTRODUCTION

Pamoja Tuwalee is a five year program that was to operate from June 2010 to May 2015 initially and recently has been extended to March 2016. The program is funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). It is implemented by four partners in five zones namely: Coast, Central, Lake, Northern and Southern. FHI 360 covers the coast zone which includes Dar es Salaam, Morogoro and Pwani regions in the Mainland, Unguja and Pemba in Zanzibar. The goal of this program is to improve the quality of life and well-being of Most Vulnerable Children (MVC) and their households by empowering households and communities to provide comprehensive and sustainable care.

Coast zone is bordered by Indian Ocean on the East Coast and regions of Iringa, Dodoma, Tanga and Lindi on the other sides in mainland Tanzania. Unguja and Pemba are islands, surrounded by the Indian Ocean. The program target was to cover all 26 districts in the zone. However, it was noted that PASADA who is a major partner also receives funds from USAID and operates in Temeke district in Dar es Salaam region, thus, it was decided to leave Temeke to PASADA and Pamoja Tuwalee/FHI360 to cover Ilala and Kinondoni districts in order to avoid overlapping and double counting of results. Hence, the program covers a total of 25 districts: 2 in Dar es Salaam, 6 in Morogoro, 7 in Pwani and 10 in Zanzibar.

The current population¹ in Coast zone is estimated at 8, 985,270. Dar es Salaam has the highest number of people (4,364,541) followed by Morogoro (2,218,492), Zanzibar islands (1,303,569) and Pwani region (1,098,668). Based on the estimated proportion of 51% children in the general population, the estimate of children in Coast zone is 4,582,488.

HIV prevalence is highest in Dar es Salaam recorded at 6.9% which is above the National prevalence rate of 5.1%². Next is Pwani region with a prevalence rate of 5.9%, followed by Morogoro 3.8% and Zanzibar with 1%. HIV/AIDS has adverse multiplier effects to the Tanzanian society in all socio-economic arenas leading to economic instability and leaving many children as orphans.

During this quarter, the program managed to reach a total of 100,910 (48,541 male and 52,369 female) MVC and their caretakers with one core service which is equal to 83% of total OVC-SERV for FY 2015. In this FY 2015, the program reached a total of 121, 558 MVC and their caretakers, equal to 185% achievement of annual target. The high achievement is associated with the change of OVC_SERV indicator that includes both children and caretakers in the OVC households since all of these benefit from the program interventions unlike the previous targeting that counted only MVC identified through the National identification process. These children have been reached through direct support, referrals and linkages while caretakers have received

¹ National census 2012

² TACAIDS

different training and support including HIV education, economic strengthening, nutritional counselling and caretaking skills.

Table 2: Program Geographical Coverage and MVC Reach

Region	Dar es Salaam	Pwani	Morogoro	Zanzibar	Total
Total # of Sub grantee per region	2	2	3	2	9
Total # of districts	3	7	6	10	26
Total # of districts reached	2	7	6	10	25
Total # of wards in the covered region	60	97	170	321	648
# (%) of wards covered by the program	20 (33%)	97 (100 %)	108 (64%)	74 (23%)	299 (46%)
Total # of villages in the region	273	621	916	NA	1810
# (%) villages covered by the program	92 (34%)	432 (70%)	587 (65%)	NA	1111 (61%)
5 years targeted # of Households	2,500	7,101	1,568	901	12,070
5 years Initial targeted # of MVC	5,001	28,405	6,272	3,605	43,283
Revised 5 years targeted # of MVC	12,738	29,817	14,974	8,253	65,782
# of MVC and Caregivers ever enrolled	22,351	69,885	34,745	15,986	142,967
# of MVC and Caregivers current in the program	16154	49180	32,523	14815	112,672
# of MVC and caregivers Served: July 2015 to September 2015	13,598	46,423	27,060	13,829	100,910
# of MVC and caregivers Served: Oct 2014 to Sept 2015	20,381	55,525	31,807	13,845	121,558
MVC Served: sex disaggregation: July - September 2015					
Male	5,532	23,071	13,104	6,834	48,541
Female	8,066	23,352	13,956	6,995	52,369
MVC Served: Age disaggregation: July -September 2015					
<1 Years	9	289	49	80	427
1-4 Years	740	3,453	1369	1688	7250
5-9 Years	2,107	8,489	5,093	3,462	19151
10-14 Years	3,486	12,328	6,952	3,629	26395
15-17 Years	1,865	5,712	2,557	1,380	11514
18-24 Years	660	731	481	268	2140
25+ Years	4,731	15,421	10,559	3,322	34033
Total	13,598	46,423	27,060	13,829	100,910

PROGRAM ADMINISTRATION AND MANAGEMENT

Staffing

The program managed to fill in the position of Senior Technical Officer for Monitoring and Evaluation. Also, a new technical officer for Dar es Salaam region was recruited to address the increased workload in this scale up region. Fortunately, there were no staff attrition during the quarter.

Funds Disbursed to Partners

The program continued to work closely with its local CSO and FBO partners in building their capacity to implement their plans. A total of **TZS 402,708,600.00³** was disbursed to all 7 Sub grantees in the Coast zone as depicted in table 3 below:

Table 3: Sub grantees Funds Disbursements and Expenditures - July to September 2015

Sub Grantee	Disbursements (TZS)	Expenditure (TZS)
Faraja Trust Fund	43,683,000.00	33,129,150.00
Roman Catholic Dioceses of Mahenge	66,304,000.00	65,528,520.00
Huruma Aids Concern and Care (HACOCA)	44,599,500.00	47,955,200.00
Jipeni Moyo Women and Community Organization (JIMOWACO)	79,875,200.00	63,441,142.00
Walio katika Mapambano na UKIMWI Tanzania (WAMATA DSM)	116,258,400.00	105,628,400.00
Walio katika Mapambano na UKIMWI Tanzania (WAMATA Pemba)	24,626,500.00	23,954,500.00
Zanzibar Muslim Women Association to Support Orphans (ZAMWASO)	27,362,000.00	25,958,575.00
Balance from Previous Quarter	84,373,476.00	
Program Total Disbursements/Expenditures	487,082,076.00	365,595,487.00

³ The total fund disbursement figure is generated from reviewed and approved Sub Grantees requests.

OBJECTIVE 1: Increase the capacity of communities and local governments to meet the needs of OVC and their households in an innovative, efficient and sustainable manner by enhancing their competencies to provide support and by improving communication, coordination and collaboration across sectors

Since its inception in 2010, Pamoja Tuwalee Program/FHI 360 has been strengthening the capacity of LGAs, local implementing partner organizations, MVCCs, community volunteers, MVC caretakers and other stakeholders to care, protect and support OVC. Further, it has been providing inputs to the national policy and guidelines that aim at improving the wellbeing of MVC including sharing best practices and providing monthly updates on implementation. This has been fundamental in developing a sustainable system that is capable of meeting children's needs.

Following the new PEPFAR dimension and the six month extension, the focus this quarter has been mainly on two issues under this objective: transitioning of MVC into the LGAs and other community structures; and implementing activities that aim at reaching more OVC, adolescents and their caretakers with HIV services.

As part of preparation for MVC and their household transition process, the program developed a tool that guided the discussions and interactions with different stakeholders at different levels on issues of MVC care, support and protection as the program gets to an end in the sustained districts. In the course of discussions with LGAs, TASAF, SILC group members, MVCC members and community volunteers, commitments commitment to take on full responsibilities of supporting the MVC and their households were sought from these stakeholders. Learning from those discussions, it can be confidently reported that, there is local ownership and as the program ends, most of the children are left in safe and capable hands - there is greater willingness and commitment to continue supporting these children and caretakers especially from MVCCs and SILC groups as well as the LGAs.

On the other hand, the program continued to reach more stakeholders at the LGA level, especially in the scale up districts to ensure OVC and their caretakers have access to HIV services. This quarter, in addition to meeting with DSWOs, DEDs and DCDOs we met with District Medical Officers (DMOs), Council HIV/AIDS Coordinators (CHAC) and District AIDS Control Coordinators (DACC) in Dar es Salaam, Pwani and Morogoro to discuss bi-directional referrals between Pamoja Tuwalee program and health facilities and care and treatment partners. This is unlike in the past where most of our work involved DED and community/social welfare departments.

Also, efforts continued on advocacy for increased participation and support of public private partners and other community providers in care, protection and support to MVC. Below are specific activities performed under this objective.

1.1 Mobilise support for OVC through advocacy campaign

For more than five years of program implementation, the program has been advocating for increased resources to support MVC from LGAs, MVCCs, Public Private Partners and other community members. As a result of the advocacy campaign, community awareness and community members, private companies and individuals have continued to contribute either in cash or in kind to ensure MVC needs are met in their respective areas. Unlike in the past years, where the focus was to raise awareness among big private and public entities such as mobile companies or social security funds, we work closely with the small and medium public and private companies to ensure they play their role as well. The big companies have cooperate social responsibility that they would like to adhere to, hence it was difficult to get long term commitments. The local implementing partners and the community volunteers have identified small and medium private and public companies and engage them in providing support to MVC, currently carpenters, tailors and farmers among others are providing different support to MVC and their households.

Based on this initiative a total of TZS 152,105,700 (US\$ 76,053) was collected this quarter and used to support a total of 4,202 (male 1,987 and 2,215) MVC. The support ranged from cash, food, start-up capital, and scholastic materials. Compared to last quarter, there is an increase of 68%. Cumulatively in this financial year a total of TZS 364,513,100 (US\$ 182,256) has been contributed and more than 10,000 MVC have benefited with different services. See further details under activity 1.5 below.

1.2. Strengthen LGAs to implement the NCPA II/ZCPA

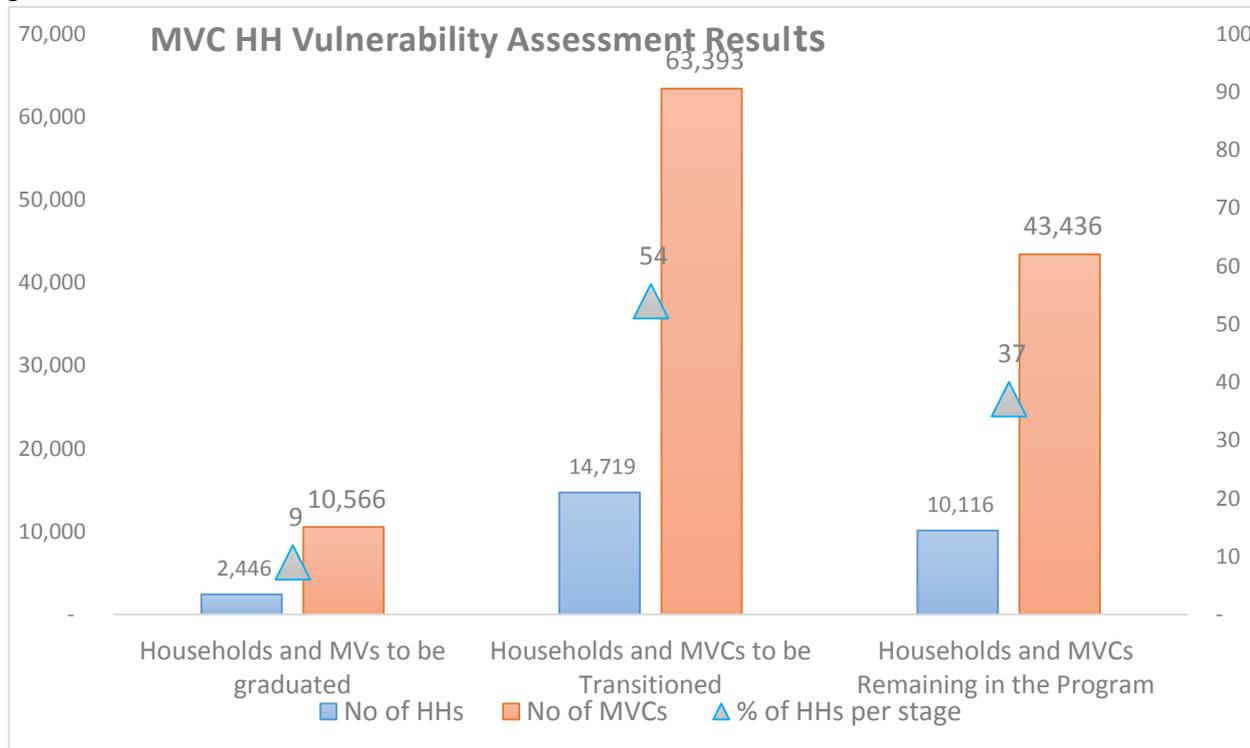
The program strengthen the capacity of LGA staff through trainings, mentoring and coaching; involving them in joint supportive supervision; training of MVCC members and DSWOs on MVC Identification and Nutrition Assessment Counselling and Support (NACS) among others.

In the last quarter, the program started closeout activities in the sustained districts. Prior to that we had meetings with 17 Council Management Teams (CMTs), 153 Ward Development Committees (WDCs) and more than 1000 community volunteers in all operational districts. This quarter the major activity involved MVC and their household graduation and transitioning in four districts of Morogoro and 10 districts of Unguja and Pemba in addition to other capacity building activities. Below are details on graduating and transitioning MVC and their household.

1.2.1. Facilitate smooth transitioning of all MVC in the sustained districts to LGAs and other community structures by September 2016

Transition and graduation of the MVC and their Caretakers exercise entailed a series of activities, including preparation of MVC household vulnerability assessment tool, testing and validating it, training community volunteers and program staff on data collection, analysis i and interpretation and conducting the actual exercise. The exercise includes meetings with government officials, MVCCs, SILC groups and other stakeholders. All these aimed at ensuring MVC and their household transitioned to the government structures or the local groups continue to receive services accordingly.

The results of MVC households vulnerability assessment indicated that: about 9% (2,446) households with 10,566 MVC meet graduation criteria; 54% (14,719) households with 63,393 MVC meet transition criteria; and 37% (10,116) households with 43,436 MVC meet the criteria for remaining in the program as seen in the pie chart below



Based on the above results, the program conducted graduation and transition activities in the sustained districts in Morogoro region and Zanzibar as a starting point. The table below shows graduation and transitioning results.

Table 4: Summary of Transition and Graduation Conducted in Morogoro and Zanzibar

Name of District	HHs Graduated	HHs Transitioned	HHs remaining in program	Children graduated	Children Transitioned	Children remaining in program
Morogoro	605	3,237	2,590	1,364	7,501	6,408
Zanzibar	319	815	752	796	5,205	6,001
Total	924	4,052	3,342	2,160	12,706	9,084

Table 5: MVC and caretakers transitioned and graduated in Morogoro and Zanzibar per different categories

<i>Category</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
<i>Aging out</i>	278	235	513
<i>Graduation</i>	1,121	1,158	2,279
<i>Transition to TASAF</i>	98	87	185
<i>Transition to other programs</i>	-	27	27
<i>Transition to SILC groups</i>	903	401	1,304
<i>Transition to MVCC</i>	5,369	5,147	10,516
<i>Attrition</i>	388	354	742

As part of ensuring ownership of MVC support in the respective LGAs, meetings with MVCCs and SILC groups were conducted in collaboration with the DSWOs. The transitioning exercise involved a total of 78 government officials; 572 MVCC members; and 203 SILC group members, community volunteers and program staff.

1.3 Strengthening MVCCs to Lead Community Support for OVC

Most Vulnerable Children Committee is a government established structure responsible for leading, coordinating and leveraging care, support and protection for MVC at village/mtaa/shehia level. The NCPA II places MVCC under the public and social welfare/social services committees. These are the entry point for any implementing partner working within the mtaa or village level. Strengthening the capacity of MVCCs to assume their roles has been among program's strategy for sustainability.

1.3.1 Develop and Implement capacity building plans for MVCCs

In this reporting quarter, the program continued to work very closely with the 627 MVCCs. As elaborated under 1.2 above, MVCCs in the sustained districts were well engaged in the graduation and transitioning exercise. Apart from discussion on transitioning, there was discussion between the very successful committees and those lagging behind in fulfilling their responsibilities. That motivated those functioning well while challenging the ones not functioning so well. As a result some of the MVCCs raised funds that they partly used to support MVC and also opened MVC account for sustainability purposes - this was done by eight villages in Ulanga district which raised about TZS 540,500 (US\$ 270) through village Harambee (funds mobilization) soon after the experience sharing that went hand in hand with graduation and transitioning exercise. The amount was used to support 100 (42 male and 58 female).

1.3.2 Advocate for membership of current community volunteers on MVCC

Past experience indicates that having community volunteers as MVCC members benefit both the committee and the program. Volunteers use their expertise to facilitate linkages among stakeholders as well as share program activities and reports. Throughout program implementation, it has been promoted to have community volunteers becoming MVCC members. During this reporting period, the number of volunteers who are MVCC members remained at 1033 (95%) as reported last quarter. This is because the program focussed on transitioning MVC.

Table 6: Current status of volunteer membership in MVCC

District	Number of Volunteers			# of Volunteers who are members of MVCCs			% of MVCC members
	Male	Female	Total	Male	Female	Total	
MOROGORO							
Morogoro Rural	23	24	47	23	24	47	100%
Morogoro Municipal	7	19	26	7	19	26	100%
Mvomero	19	31	50	11	22	33	66%
Kilosa	16	24	40	7	12	19	48%
Kilombero	33	30	63	26	21	47	75%
Ulanga	55	52	107	55	45	100	93%
Total Morogoro	153	180	333	129	143	272	82%
DAR ES SALAAM							
Ilala	32	36	68	32	36	68	100%
Kinondoni	30	51	81	30	51	81	100%
Total Dar es salaam	62	87	149	62	87	149	100%
ZANZIBAR							
Wete	5	17	22	4	10	14	64%
Micheweni	4	7	11	3	5	8	73%
Chakechake	5	12	17	5	6	11	65%
Mkoani	4	1	5	4	1	5	100%
North A	6	4	10	6	4	10	100%
North B	5	9	14	5	9	14	100%
Central	6	8	14	6	8	14	100%
South	2	3	5	2	3	5	100%
Urban	2	6	8	2	6	8	100%
West	6	13	19	6	13	19	100%
Total Zanzibar	45	80	125	43	65	108	86%
PWANI							
Bagamoyo	63	52	115	56	51	107	93%
Kisarawe	32	27	59	32	27	59	100%

Mafia	12	11	23	12	11	23	100%
Kibaha TC	40	2	42	40	32	72	171%
Kibaha DC	28	36	64	28	36	64	100%
Rufiji	25	47	72	25	47	72	100%
Mkuranga	63	44	107	63	44	107	100%
Total Pwani	263	219	482	256	248	504	105%
Total	523	566	1089	490	543	1033	95%

Source: Quarterly Report: April-June 2015

1.3.3 Support creation of MVCCs where they do not exist

As stated above, this quarter focused on graduating and transitioning MVC and their households in the sustained districts, hence no new MVCCs formed. From next quarter, the program expect to facilitate formation of new 200 MVCCs and identify more MVC with a focus on those who are HIV + or are at a higher risk of being affected or infected. This will be done in the 6 scale up districts as part of contributing to PEFAR 3.0 that aim at controlling the HIV pandemic.

1.3.4 Support Local Authorities to develop village level fund to support OVC

As part of sustainability strategy the program collaborates with LGAs to support MVCCs to establish MVC funds that are used to cater for basic needs of MVC and their households. Though the amount contributed is relatively small, it indeed makes a difference and it is sustainable. This has become part of the culture where community members feel obliged to support MVC in their respective localities. During this quarter, a total of TZS 6,243,500 (US\$ 3,122) was contributed and used to support 769 (376 male and 393) as indicated below.

Table 7: Funds contributed to support MVC in Quarter IV- FY 2015

Region	Equivalent TZS	Number of MVC supported		
		Male	Female	Total
Morogoro	564,500	42	58	100
Dar es Salaam	1,010,000	49	72	121
Zanzibar	83,000	6	5	11
Pwani	4,586,000	279	258	537
Total	6,243,500	376	393	769

Source: Quarterly Report: July-September 2015

The amount contributed has decreased by 10% from last quarter i.e. from TZS 6,906,500 to 6,243,500. This is normal trend as the contributions increase or decrease according to the needs of MVC and their households in the specific quarter. As it is in other quarters, Pwani is leading in the MVCC contributions followed by Dar es Salaam. This is mainly due to the fact that Pwani has 45% of all MVC in the program followed by Morogoro

(30%). However due to availability of many stakeholders in Dar es Salaam, normally its contribution becomes higher than Morogoro and Zanzibar.

1.3.5 Support savings, income-generation and food security activities among MVCC

While MVCC members are willing to coordinate and provide services to MVC, it is important to note that these members are living in the same communities where poverty level is high due to different factors including HIV. Based on that, it necessary to support some of the MVCC members who are in need to improve economic status of their own families as they continue to contribute to MVC well-being. When providing training on household economic strengthening such as entrepreneurship skills, MVCC are given opportunity to participate. Also, they are encouraged to join SILC groups so that they can benefit from savings and lending scheme. To date, approximately 19% of the 6270 MVCC members are in SILC groups. Currently SILC groups have a total of TZS 1,921,247,721(US\$ 960,624) and TZS 134,278,040 (US \$ 67,139) for MVC funds.

1.4. Strengthen Local CSO Partners to Support MVC Services

In the past five years, the program has made significant investment in strengthening institutional and technical capacity of partner CSOs. This has enabled them to fulfil their missions in an effective manner, including acquiring necessary competencies and strategies. Their institutional and technical capacities strengthened are in the areas of: project management and execution; organizational systems and structures; leadership and management; grants management; and MVC care, support and protection.

During this reporting quarter, the support focused on financial management that included intensive reconciliation as part of preparations for closing accounts. This was done because the implementation with these partners was expected to end by December 2015.

1.4.1 Develop and implement capacity building plans for local CSOs

Based on the institutional and organization capacity assessment, the program supported the CSO partners to develop action plans and has been supporting them to implement the same. . To date, six partner CSOs have drafted and submitted proposals targeting potential local funders; two successfully obtained local funding; three have implemented internal staff development programs; and five have re-drafted their constitutions.

During this reporting period the program continued to provide coaching and mentoring on use of Quick Book binding and signing of reviewed Human Resource and Financial manuals.

1.4.2 Assist high-functioning CSOs to graduate to self-sustaining status by end of FY 5

One of the program commitments was to enable at least four CSOs to graduate to self-sustaining status by year 5. Abiding to the commitment and after the assessment of the CSOs and capacity building support provided, four high functioning CSOs have been identified namely: Faraja Trust Fund, HACOCA, WAMATA Pemba and WAMATA Dar es Salaam.

During this quarter, out of the above four high performing organizations, two (WAMATA Dar es Salaam and Faraja Trust Fund) were selected for further assessment through BOCAR – a USAID program under Deloitte

Consulting Limited. Both of them scored high, that is 3.3 (WAMATA) and 3.2 (Faraja) out of 5.0. Both are engaged with BOCAR to address the gaps and have been invited to attend the Human Centered Design Think and Innovation Training. Further to that, the program grants officers and technical staff continue to provide coaching and mentoring depending on the need of individual partners.

1.5 Facilitate Meaningful Participation of the Business Community in MVC Support

Private and public partnership is essential in contributing to sustainable care, support and protection of MVC and their caretakers. The program has been using different approaches that target to engage public and private sectors to contribute to the wellbeing of MVC and as a result, increased contributions have been realized in each quarter. For example, in the last quarter a total of TZS 77,048,700 (US\$ 48,091) was contributed to support 4,016 (male 1,869 and 2,147 female) while this quarter a total of TZS 152,105,700 (US\$ 76,053) has been realized and used to support about 4,202 (male 1,987 and 2,215) MVC. TASAF from Pwani continue to be a major contributor.

Table 8: Summary of MVC supported through PPP during this quarter

Region	Total TZS equivalent	Number of MVC supported		
		Male	Female	Total
Morogoro	7,307,700	132	245	377
Dar es salaam	3,461,000	155	175	330
Zanzibar	2,940,000	61	52	113
Pwani	138,397,000	1,639	1,743	3,382
Total	152,105,700	1,987	2,215	4,202

Source: Quarterly Report – July to September 2015

1.6: Improve Coordination Among and Across Sectors and Zones

The program has commitment to improve coordination, collaboration, linkages and partnership at different level. Due to its contributions, the program has been granted opportunity to be a member of various national forums including technical working groups, advisory boards and different committees. At the district level, the program spearhead the District Implementing Partners Groups (DIPG) in partnership with the LGAs. Below are further details.

1.6.1: Coordination among implementing partners across zones through monthly Implementing Partners Group meetings

The program contributes to the MVC care, support and protection; HIV care, treatment and prevention, GBV and VAC national policies, guidelines and regulations through experience sharing from the implementation level. In recognition of the contributions it has been invited to other technical/working groups including the Social Welfare and Social Protection of Children under the Ministry of Health and Social Welfare; HIV/AIDS

Impact Mitigation under TACAIDS; the Police Partners Implementing Group under the Ministry of Home Affairs; the Monitoring and Evaluation Working Group; and recently the HIV/AIDS Prevention Technical Working Group under TACAIDS. During this quarter the program participated and provided updates to the implementing partners group chaired by the department of social welfare, provided inputs into the milestones implementation of the Impact Mitigation Technical Working Group and also facilitated the One Stop Centre (OSC) quarterly meetings that bring together all stakeholders addressing GBV and VAC through OSC in the health facility setting. See further details on enhancing inter-sectoral coordination and collaboration.

1.6.2 Support coordination and networking through DIPGs at district/zonal level

District Implementing Partners Group forum has proved to be significant in providing different stakeholders with an opportunity to share information, experience as well as enhance coordination and network among members. To date, the program has facilitate formation of 17 DIPGs (15 in the Mainland and 2 in Zanzibar). This quarter the focus was on transitioning where some of the DIPG members were part of the exercise hence the meeting were conducted in only three districts in Pwani Region where the exercise did not take place. In the scale up districts, the focus was on meeting with CTC in- charge to raise awareness on the needs to strengthen bi-directional linkages between health facilities and the social services hence did not conduct DIPG.

OBJECTIVE 2: Increase the capacity of households to protect, care and meet the basic needs of OVC in a sustained way by improving their caretaking, livelihood and health-seeking skills

Low income remains a constraint among MVC households. This affects their ability to cope with life shocks as well as their capacity to protect and meet the basic needs of VC including: proper nutrition and shelter, access to education and health care. To address this, the program works to improve the MVC households' economic and social protection capacity as an approach to increase their resilient. Economic and non-economic intervention geared to supports skill-based capacity building activities that target MVC household are undertaken. These include: psychosocial support, caretaking skills, entrepreneurship skills, livelihood and savings skills and food security.

During this reporting period MVC households were reached through community volunteers while mobilizing more caregivers and community members for more support to HIV+ MVC and youth. Household were linked with different stakeholders who provide economic strengthening support. Also, caretakers were linked with other program including TASAF III.

2.1 Provide training to household caretakers in caretaking skills, PSS and reducing stigma/discrimination

Enhancing the capacity of caretakers to provide care, support and protection is vital for increasing caretaker's confidence in caring for MVC. Through community volunteers, caretakers are provided with education and

counselling on different areas aimed at strengthening their capacities to provide comprehensive and quality care, support and protection to children. The areas covered include MVC care taking skills, psychosocial and stigma reduction. This has resulted into improved caretaking skills among caretakers who are able to meet their children needs. During this reporting period, 16,987 caretakers were reached with PSS; 7,793 health care; 11,194 care taking skills; 13,850 food and nutrition; 66 legal support; and 2,986 with education on child protection.

2.1.1 Training on hero book and memory work for PLHIV adolescents and caretakers

HIV and AIDS related illnesses and stigma often cause poor families to suffer from emotional problems. When poor children become orphans, they fall victim to a whole host of dangers. To support themselves and younger siblings, they frequently drop out of school. They fall prey to risky behaviour including sexual exploitation and prostitution. High vulnerability among HIV+ MVC and youth put them in greater need of psychosocial care and support.

In addressing this, during this reporting period the program conducted a five day training on hero book and memory work to HIV+MVC and caretakers. The former aimed at equipping MVC with knowledge and skills to help them gain more power over obstacles or life challenges, while the latter will increase caretaker's skills and techniques in helping their children to cope with death and grief. The training aimed at guiding caretakers to plan for the children's future adjustment and well-being, including preparation of succession plan and will writing - the latter will minimize grabbing of MVC property which is oftentimes experienced by children once their parents or guardians pass-away.

2.2 Provide training and other support to increase savings and improve livelihood for MVC households

The program strives to empower MVC households to actively engage in economic activities through various interventions which focus on promoting savings and credit scheme suitable for individual household needs and capacity. To pursue this, various economic strengthening opportunities are offered to support caretakers to establish and manage economic activities. The opportunities include: establishment of SILC groups; training on local chicken rearing, home gardening and business skills; and linking caretakers to cash transfer support like TASAF III. For the latter, 2,912 (1365 males and 1449 females) MVC and their MVC households benefitted from TASAF III cash transfer amounting to TZS 131,776,400 – this was in Mkuranga, Kibaha DC and Bagamoyo Districts in Pwani region.

Additionally, the program reached caregivers with the following economic services: SILC – 12,380; link to job opportunities - 231; small scale gardening and agriculture -1,212; local chicken keeping - 3,778; training on basic business skills 1,401; and small business development - 2,286.

To date the total savings in SILC groups amounts to TZS 1,921,247,721 (US\$ 960,624) and contributions to OVC funds amount to TZS 134,278,040 (US\$ 67,139). This is an increase of 7% on the savings and 12% on MVC fund. The increase in both savings and OVC fund is associated with the program efforts to mobilize

both caretakers and community members to join SILC groups in order to save towards a common fund and access affordable loans for economic activities.

Table 9: Summary of composition and financial status of SILC groups

Region	Group name	Sex			Member category					Total Savings	Contribution for OVC fund
		Male	Female	Total	MVC	MVC HH	MVCC	Volunteer	Other Community		
Morogoro	237	1,308	4,583	5,891	14	1,013	202	233	4,429	761,007,713	41,850,460
Dar es Salaam	148	503	3,487	3,990	32	921	166	158	2,713	559,708,900	48,442,150
Zanzibar	80	430	1,842	2,272	10	499	72	60	1,631	242,830,728	9,960,300
Pwani	206	1,284	3,735	5,019	316	2,194	311	158	2,040	357,700,380	34,025,130
Total	671	3,525	1,3647	1,7172	372	4,627	751	609	10,813	1,921,247,721	134,278,040

Source: Regional quarterly report July –September 2015

2.2.1: Training on entrepreneurship skills and SILC initiative to community resource persons and DSWOs

The program promotes entrepreneurship and business skills through community resource persons who in turn support caretakers with skills in managing their economic activities. In line with that the programme facilitates establishment of SILC groups to encourage more caregivers to save and access affordable loans.

Community Resource Persons (CRPs) who were trained in FY 2014 continued to use the same to facilitate formation and strengthening of SILC groups. They mobilize caregivers to form/join SILC groups and are encouraged to start IGAs. The CRPs provide technical support on proper record keeping; how to track and ascertain accuracy of records in individual passbooks; and loans and cash management. These SILC groups usually contribute a certain agreed amount towards MVC fund.

Furthermore, during this year program has facilitated linkages of 15 (3males and 12females) care takers with other partners for economic strengthening support in Mkuranga and Bagamoyo districts. The care takers were supported with training on local chicken keeping, cost for veterinary services and dairy goats. The support amounted to TZS 13,460,000 (US\$7,918).

Community Resource Persons Training

Savings and Internal Lending Communities (SILC) is one of the economic strengthening component that Pamoja Tuwalee program uses to mobilize OVC caretakers and community members to save towards a common fund. The SILC group is generally built around the principle of members buying shares and executing loans on weekly bases. In this quarter a training was conducted to 100 CRPs on establishment and management of SILC groups. Trained CRPs will use the acquired skills to mobilize community members and MVC caretakers to form SILC groups.

The CRP training was advanced with a refresher training to 8 experienced focal persons and CRPs. These in turn trained new CRPs in their localities who have started to form new SILC groups in which some members are expected to be HIV+ MVC caretakers and youth. This is a deliberate effort by the program to increase the number



Facilitator emphasizing a point during CRP training

of MVC caretakers participating in SILC groups and subsequently increased household capacity to meet MVC needs. At the end of the training, the participants developed individual action plans to achieve the target. Each CRP is expected to establish and manage at least two SILC groups.

2.2.2: Regular CRP meetings

Based on the role of CRPs, in addition to the trainings they are encouraged to meet on quarterly basis. During this reporting period CRP meetings emphasized SILC group registration and establishment of new SILC groups. Among issues discussed were:

- Upcoming transitioning in the remaining sustained districts.
- Sensitization of HIV+ MVC households to join SILC groups.
- SILC groups registration in collaboration with Community Development Officers.
- Use of MVC funds to support children in need.
- Increase of SILC groups' contributions to MVC fund as it was noted that in many groups contributions are still very little.
- How to effect bidirectional referral to increase access to HIV related services among MVC and their caretakers.
- Enhancement of SILC groups meetings as a platform to provide education on food and nutrition, encourage self-disclosure, adherence and other HIV/AIDS related issues.

- CRP were reminded to encourage every member in SILC groups to ensure that they pay CHF for their families.

2.2.3: Conduct joint market assessment

The program explores opportunities to link caretakers with potential markets. During this reporting period in Bagamoyo in Bwilingu ward/village a female caretaker who is a single mother of 4 (1 male and 3 females) MVC was taught by the community volunteer on how to make and local mats for sell to increase her income. Later the volunteer linked the caretaker to market. The caretaker can now make 3-4 mats per week and an average of 12-16 per month and earn more than TZS 75,000 (US\$ 44) depending on the size, color and design. The caretaker also engage in farming activities. The diversification of economic activities helps to increase her income and be able to meet needs for her children.



Caretaker making Local mat

2.2.4: Training on entrepreneurship skills and provision of start-up kits to MVC caretakers

The program aims to ensure that MVC caretakers are economically empowered and meet the basics of their children. In attaining this, caretakers are trained on entrepreneurship skills and supported with start-up kits for economic activities.

During the reporting period, caretakers who were supported with start-up kits in previous quarters have continued to increase income from their economic activities. In Kisarawe District Council 4 women in Chole and Mzenga supported with cooking pots have increase income from TZS 30,000 (US\$ 18) per day to TZS 60,000 (US\$ 35) per day. In Mkuranga DC 3 caretakers who were supported with chicken feeding vessels have increase their sales within four months with an average of 10-30 chicken. Within four months the caretakers have earned more than 200,000 (US\$118) each through selling chicken.

Kibaha DC caretaker who is also HIV+ was supported with vegetable gardening start-up kit. The support helped to expand her vegetable garden and has resulted into increased income from TZS 7,000 (US\$ 4) per week to TZS 50,000. (US\$ 29) per week. This has enabled her to open a small kiosk for food stuff and groceries earn an average of TZS 70,000 (US\$ 41) per week.

The increased income has enabled the caretaker to cater for her family needs. She affords to provide meals for her children three times a day something which was a dream in the past. She also pays school fees and

buys school materials for her children as well as health insurance (Community Health Fund) through which she and her children access health services.



Caretaker watering her vegetable garden using the can provided as startup

2.3. Support training and linkages to improve MVC households' food security and nutrition

Food and nutrition contributes to good health of MVC. However, most of MVC households have insufficient food which result in poor nutrition. To address this, the program train MVC households on food and nutrition and encourage them to establish home and backyard gardening for those with access to land; poultry keeping; and small scale agriculture. Through volunteers, MVC households are encouraged to produce sufficient food to meet their needs; and facilitated on nutrition assessment, counselling and referrals/linkages for support. During this reporting period 2 village councils in Bagamoyo and 3 SILC groups in Mkuranga supported 41 (18 males and 23 females) MVC with food worth TZS 502,000 (US\$ 295).

2.3.1 Training on households' nutritional assessment counselling and promotion of households food security

In FY 2014 the programme collaborated with FANTA III to train 50 trainers on Nutrition Assessment Counselling and Support (NACS). The trainers cascaded the skills to community volunteers and the latter has continued to conduct nutritional assessment to MVC and their caretakers by using MUAC tapes. Those who malnourished are referred to health facility for further support including testing for HIV for the severely malnourished. During the assessment, caretakers are educated on the utilization of balanced diet through using locally available food stuff and establishments of vegetable gardens to promote MVC health status and household food security.

During this quarter community volunteers continued to use their skills acquired from NACS training in conducting nutritional assessment to MVC using MUAC tapes. Table 10 below shows the nutritional status of assessed MVC in the four regions. The results indicated that among the 24,154 MVC assessed, 96% (23,262) were healthy; 3.5% (837) were slightly malnourished; and 0.2 % (55) were severely malnourished. In all four regions, majority MVC were healthy, partly due to deliberate efforts by the program to continue provide nutrition education to MVC households to ensure that the MVC are benefiting from the knowledge their caretakers receive in preparing nutritious food for their children. Community volunteers referred the MVC with malnutrition to health facility for more support and provided nutrition counselling to their caretakers. They will continue to monitor progress of the referred MVC and act accordingly.

Table 10: Results of MVC Nutritional Status Assessment

Region	Total MVC involved		Healthy MVC (Green)		Slight malnutrition MVC (Yellow)		Severe Malnutrition MVC (Red)		Referred MVC	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Morogoro	2,951	2,898	2,659	2,657	283	223	20	7	37	32
Dares Salaam	4,406	4,469	4,404	4,464	0	1	2	4	2	4
Pwani	3,065	2,854	2,958	2,757	106	96	1	1	51	43
Zanzibar	1,869	1,642	1,789	1,574	70	58	9	11	9	11
Total	12,291	11,863	11,810	11,452	459	378	32	23	99	90

Source: Regional quarterly report July-September 2015

2.4 Strengthening of community child protection structures

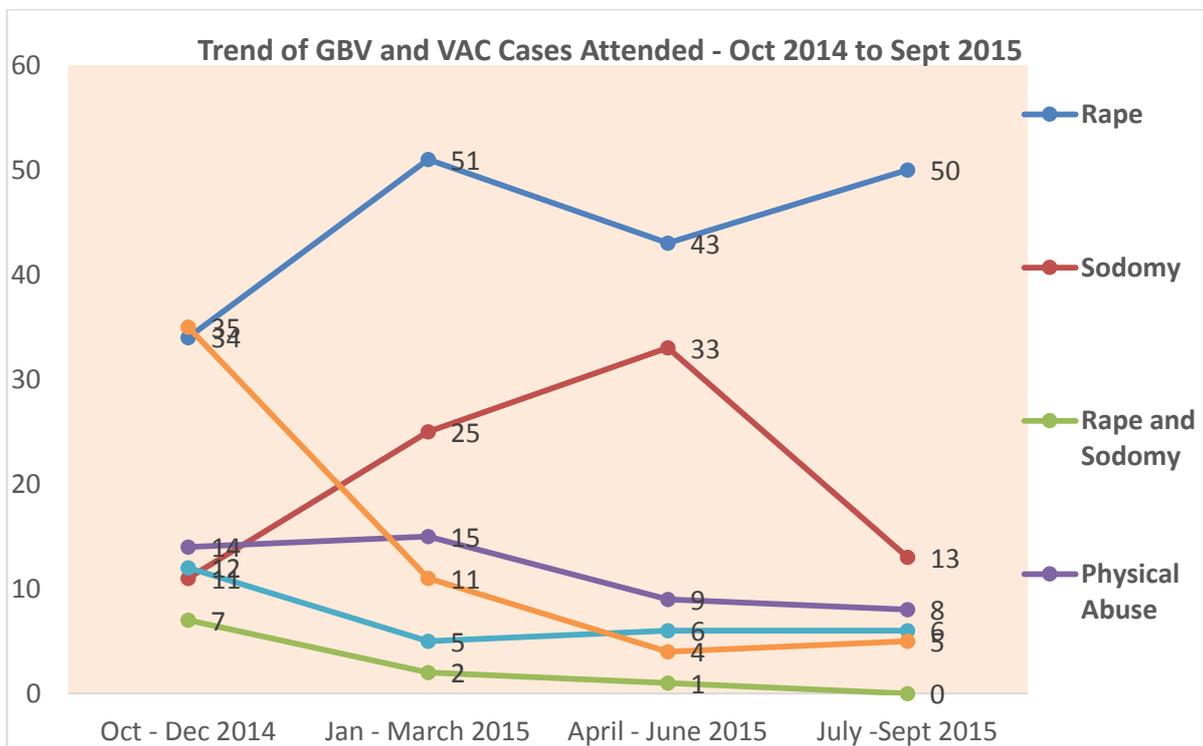
One of the key roles of community child protection structure is to ensure that the issue of child protection is visible, and that children and families know where they can go for help if they experience or become aware of abuse. Community-based child protection groups have an important role in supporting the prevention of sexual abuse and exploitation through targeted family support, and by directing social protection to the most vulnerable children and households in the community.

The program for the past five years has invested in capacity building of community structures such as MVCCs and Child protection teams to play a key role of enabling children and families to access preventive and responsive services. This is more easily achieved if communities are able to work with, and refer cases to, government services, including medical, social, police or judicial services. Below are activities carried out by the program to enhance child protection.

2.4.1 Pilot One Stop Center services in Ilala District

Gender Based Violence (GBV) and Violence Against Children (VAC) are pervasive social phenomenon which impacts to health and social economic development of the society specifically women and children. The government has been in the forefront in addressing GBV and VAC through legislation, policies, strategies and other measures. Laws, guidelines and policies have been enacted to enable prevention and response to GBV and VAC by relevant sectors including health, social welfare, police and others. The program established One Stop Center (OSC) at Amana Regional Referral Hospital to enable GBV and VAC survivors access comprehensive, friendly and coordinated services. Service providers at OSC i.e. medical, police and social welfare officers work in collaboration with other key actors to minimize the secondary trauma which are expected in ensuring justice and safety for survivors.

During this quarter a total of 82 cases of GBV and VAC were handled out of which 50 were cases of rape equal to 60%; 13 were sodomy equal to 16%; 8 were physical abuse; 6 cases of neglect; and 5 cases of emotional and psychological abuse. This makes a total of 400 survivors reached with GBV and VAC services in FY 2015 at OSC: 178 (44.5%) were rape; 82 (20.5%) sodomy; 55 (13.7%) emotional and psychological abuse; and 46 (11.5%) physical abuse. The chart below provides details on trend of cases attended in this FY 2015.



Source quarterly report July- September 2015

One Stop Center quarterly meeting

Through OSC quarterly progress review meetings, the program has witnessed increased service provision to survivors of GBV and VAC and scaled up from one OSC in 2014 to seven in 2015. The latter has been achieved through other stakeholders in collaboration with the MOHSW. This quarter the meeting was attended by 32 members from the government including MOHSW- RCHS, MCDGC, Government Chemist Laboratory Agency, Ilala Municipal council, Police Ilala Region, Attorney General's Chamber-DPP, Amana Regional Referral Hospital; TAYOA; MARIE STOPES; and FHI360. During the meeting, the following were shared:

The MOHSW shared feedback from the monitoring visits to OSC in Iringa and Mbeya which are under MARIE STOPES. The two centers were officially launched in September 2015. Among the issues reported included:

- ◇ Well setup of the centers, but the one for Mbeya has no privacy and confidentiality, they were advised to look for another room which will make a client comfortable by knowing that other people are not listening to his/her story.
- ◇ Both centers have no sufficient staff in Mbeya the health facility has only one doctor
- ◇ There are no budgets to run centers.
- ◇ In Iringa the council agreed to place more staff at the center and promised to include OSC budget in their MTEF.

TAYOA informed that they have shifted their services from Shinyanga Regional Referral Hospital where they were having a drop-in center and have established One Stop Center in Simiyu Region that was planned to be launched in October.

Amana OSC at Amana Regional Referral Hospital shared their progress, achievements and challenges. The achievements included:

- ◇ Improved collaboration among service providers across section within the hospital.
- ◇ Police officers who are working at the center have been provided with clinical coats with hospital logo and police logo. This identify them when they visit patient wards following up GBV and VAC survivors who did not report to the police station or post.

Despite these achievements the center still has some challenges, these are:

- ◇ Lack of forensic evidence tool for sample storage, there are samples which have been collected to be taken to the laboratory but are still at the center.
- ◇ Not all service providers have undergone training on dealing with /handling GBV and VAC cases.
- ◇ Members admitted that there is no clear linkages and communication among GBV and VAC service providers which develops a gap in service provision. There are other partners who are very key in providing services to GBV and VAC survivors but they are not part of this team, for instance those who provide temporary shelter (safe houses) to GBV and VAC survivors.

The following action points were agreed on:

- Branding of OSC - it was agreed that MOHSW in collaboration with partners to organize a technical meeting that will involve professionals on ICE materials and logos to brainstorm on the branding, development of IEC materials and OSC reporting template.
- MOHSW to follow up with the Department of Social Welfare to see whether the Circular for social welfare services at OSC to be offered 24 hours has been submitted to PMORALG for approval.
- Amana Regional Referral Hospital to photocopy the document on how to collect quality samples and post on walls for medical service practitioners to know what they are supposed to do
- MOHSW to invite other key partners who were not part of previous OSC progress review meetings such as Tanzania Law Society, CSEMA, KIWOHEDE and other NGOs who provide safe house/ temporary shelter to victims.
- The National GBV coordinator said that GBV and VAC directory is ready and OSCs will be first users, hence more referrals to survivors for appropriate services.

2.4.2 Pilot protection of children living on the street

Children live and work on the street because their parents are poor, or they are orphans, or they have run away from home, often to escape abuse. They are always malnourished, receive scant education or medical treatment, and are involved in child labour from an early age. Tragically, their homelessness can lead to further abuse through exploitative child labour and or prostitution. Street children live and work amidst trash, robbers, rapist and open drains. Pamoja Tuwalee program engaged KIWOHEDE as a local partner in piloting intervention to support Children Living and Working in the Streets (CLWS) and their guardians. The intervention was for 15 months and ended in June 2015.

The aim was to strengthen response to the needs of children living and working in streets by: enhancing knowledge and understanding of decision makers, front line workers, households and public about the issue of CLWS in selected 15 wards in Dar es Salaam region; increased access to, and utilization of basic services (including reproductive health, HIV/AIDS education, psychosocial support, vocational and entrepreneurship skills and legal services) through the child protection system; and improved access for children without adequate family care to family based, community and/or institutional care placement.

A total 760 CLWS and 173 parents/ guardians of CLWS were reached and among them 440 CLWS received different services at Bunju drop-in centre. Such services include basic education, life skills, weaving, tailoring and batiki making. 217 CLWS were provided with temporary shelter and 31 reunified with their families. Additionally 60 older CLSW and 15 guardians were provided with entrepreneurship training and provided with start-up kits to enable them live independent and stop begging in streets.

During this quarter and the subsequent periods, DSWOs, MVCC members and community volunteers within their localities will closely monitor progress of those CLSW provided with entrepreneurship training and supported with start-up kits as well as the ones reunified with families.

2.4.3 Strengthening Community Child Protection structures

Community based child protection structures have been recognized as an important way of mobilizing communities around child protection, and for preventing and responding to child abuse, neglect, exploitation and violence. Different elements and actors both formal and informal are working together at the community level to provide a protective environment for children. However, families and communities are considered to be the primary actors in protecting children against exploitation and abuse. The established child protection teams aim at increasing knowledge and awareness on children’s rights issues, monitoring and reporting violation of children rights, conducting advocacy and sensitization on child protection priorities.

The program through MVCCs and child protection teams in Ilala and Kinondoni have been raising awareness to the community on child protection issues including reporting abuse cases to respective authorities for timely services.

In this reporting quarter a total of 87 clients with GBV and VAC services through OSC (82) and community child protection structures (5). This is a decrease of 29% when compared to 123 cases reported last quarter. The decrease is partly associated with community awareness raising which is being done by MVCCs and program community volunteers on child protection and child rights.

Activity 2.5 Facilitate access to community health insurance for MVC households.

The program has been playing a role to ensure all MVC households are facilitated to join health insurance schemes such CHF in rural and TIKA in urban settings. During this quarter, in Pwani and Morogoro regions through linkages and community sensitization 167 (74 male and 937 female) MVC were supported with CHF as detailed per below details.

Table 11: Summary of MVC supported with CHF

District	Source of support	Male	Female	Total
Bagamoyo	MVCC, Village council	13	12	25
Kibaha TC	MVCC	2	2	4
Kibaha DC	TASAF III	8	13	21
Mkuranga	Kikwabi SILC group	32	40	72
Mvomero	Maendeleo SILC group	5	7	12

Mvomero	Homboza and Manza MVCCs	14	19	33
Total		74	93	167

Source quarterly report July- September 2015

Activity 2.7 Link OVC caretakers to comprehensive health and psychosocial services along the continuum of care

Provision of comprehensive health and PSS to MVC caretakers is very crucial for the latter to provide quality care, support and protection to their children. The program strives to build strong networks and referrals to ensure both MVC and their caretakers are receiving comprehensive services along continuum of care. Community volunteers through home visits have been providing health and psychosocial support to caretakers. During this reporting period 16,987 caretakers received PSS and 7,793 caretakers received health care services.

2.8 Sensitize and support families to support MVC

Program continued with its efforts towards ensuring sustainability of support after program phase out. As a result, volunteers continued to sensitize and support MVC families to engage in economic activities in order to increase their income that will enable them meet their family needs.

In this reporting period as a result of MVC caretakers' engagement in economic activities they were able to support their 266 (130 male, 136 female). The support included food, education support, health and shelter which amounted to TZS 2,135,500 (US\$ 1,067).

OBJECTIVE 3: Increase OVC household access to comprehensive, high-quality, age appropriate and gender-sensitive services by creating integrated community-level referral networks that strengthen the continuum of care

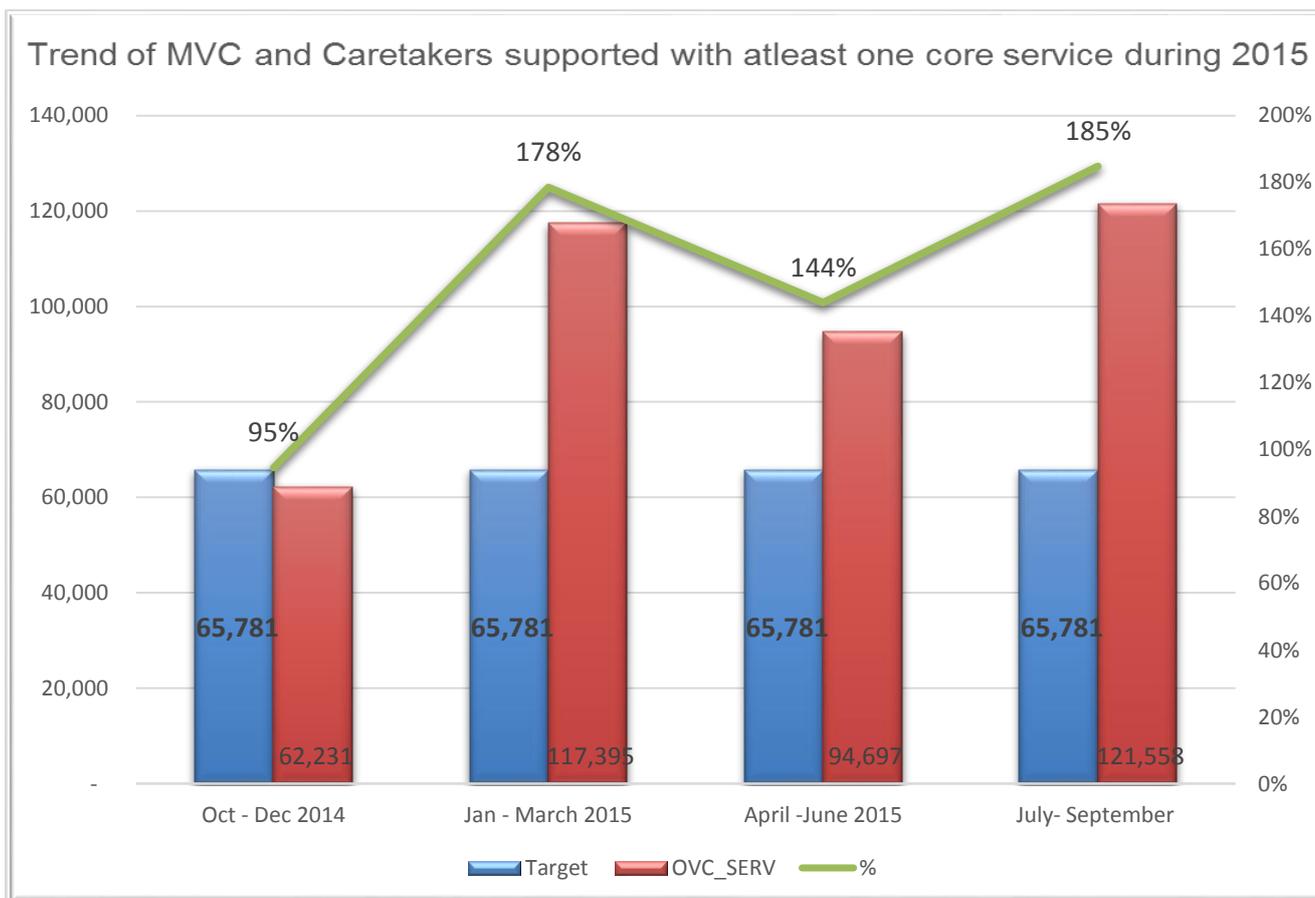
Children have distinctive needs that must be addressed in a comprehensive, multi-sectoral way, with high-quality programs that can be sustained by governments and communities for a long term. The program for the past five years has been building and strengthening the capacity of community groups and structures such as MVCCs, SILC groups, volunteers, CRPs, and specifically MVC caretakers to enhance sustainable care, support and protection to MVC. Through community volunteers, direct and referral services have been delivered to MVC and their caretakers. Linkages have been established with clinical partners to ensure access to care and treatment to beneficiaries. Below are details of services provided during this reporting period.

3.1 Continue to provide core, age-appropriate service package to OVC

Program community volunteers and local partner focal persons have continued to provide direct and indirect services to ensure that MVC and their households receive comprehensive services. In this reporting period through program funds, referrals and networking, the program reached a total number of 100,910 MVC and

caretakers (48,541 male and 52,369 female) equal to 83% of total OVC-SERV in FY 2015. Services provided include psychosocial support, health care, food and nutrition counselling, education, shelter, protection and HIV/AIDS related services.

For the APR, the program has achieved 185% of OVC _SERV of the new indicator set for FY2015 with an increase of 7% from 178% reported during SARP. The over achievement is associated with the change of the OVC_SERV definition that has now been extended to include OVC caretakers and other children in the households. Additionally, the granted extension period provided the program with opportunity to do more and reach more OVC and their households with various services, while moving the closeout activities into the next financial year. The chart below shows details on the trend of OVC who received at least one core service.



Source: Quarterly report July – September 2015

3.1.1 Provide support to HIV+ adolescents and those at high risk of HIV infection

The program has made deliberate efforts to ensure PLHIV and those at high risk of HIV infection receive education on sexual and reproductive health, HIV prevention, care and positive living with HIV. Also, efforts have been made to promote and refer beneficiaries to HTC, CTC and other services.

In this quarter, the program trained 30 (16 males and 14 females) adolescents in Ilala and Kinondoni districts as youth educators, amongst them 50% were HIV+. The trained youth educators were those who consented to disclose their HIV status and committed to encourage other youth for HTC, CTC enrolment and ART adherence. It is expected that many adolescents will be facilitated and linked to CTC and other non-clinical services through the work of these youth educators.

Moreover, the program built the skills and capacity of 19 HIV+ MVC and adolescents (9 males and 10 females) on positive living with HIV, life skills, overcoming challenges and life planning through memory book training. The trained MVC and adolescents were also those consented to disclose their HIV status. Through community volunteers, close follow-ups will continue to ensure they apply acquired skills in their daily life. Meanwhile, caretakers of the 19 HIV+ OVC were empowered on handling / caring for HIV+ children, importance of disclosure of HIV status, developing succession plan, helping their children in all situations and promoting adherence to ART through hero book training.

Furthermore, the program in collaboration with DMOs office in Kinondoni district facilitated HTC services at six orphanage centers located in areas of high risk of HIV infection whereby a total of 256 MVC received HTC services. Out of the 256 MVC tested 6 MVC tested positive and were referred to a nearby CTC for further diagnosis and enrolled into the program for psychosocial and other social supports.

3.1.2 Provide education support and vocational training

Education is a basic human right for all children, as recognized in the Convention on the Rights of the Child. Education is critically important to children's social integration and psychosocial well-being. School attendance helps children affected by trauma to regain a sense of normality and to recover from the psychosocial impacts of their experiences and disrupted lives. Without education and vocational training, the skills children and young people need for economic independence can be lost.

Through program direct support, community engagement and contributions as well as referral networks, a total of 29,363 MVC (14,559 male and 14,804 female) were reached with education support during this reporting period. The support provided included: school fees, scholastic materials and other school contributions. This is equal to 29% of the total OVC_SERV during this quarter. This makes a total of 50,085 MVC (25,000 male and 25,085 female) reached with education support in FY 2015 equal to 41.2 % of the total MVC served.

Additionally, the program core partner Deloitte through contributions from staff members provided support to 9 MVC (6 male and 3 female) who joined advanced level secondary education in different government schools across the country. The support included school fees, school uniforms, scholastic materials and other school contributions with a total cost of TZS 2,459,400 (US\$ 1230).

In Kilosa district, CAMFED - a non-government organization provided support to 14 female MVC from Tindiga village with school uniforms and stationary worth TZS 527,500 (US\$ 263). One (1) male MVC was supported with NECTA and Mock examination fees costing TZS 65,000 (US\$32). In Mvomero district, MVCC supported 13 MVC (8 males and 9 females) with examination fees, school uniforms and stationeries

worth TZS 98, 200 (US\$49). Below is the table that shows number of MVC received education support this quarter.

Table 12: Summary of MVC supported with education – July to Sept 2015

Region	Primary Education		Secondary Education		Vocational Training		Total
	Male	Female	Male	Female	Male	Female	
Morogoro	2,461	2,386	746	624	26	12	6,255
Dar es salaam	705	701	300	313	44	32	2,095
Zanzibar	2,033	1,931	616	685	-	-	5,265
Pwani	5,798	6,553	1,797	1,533	33	34	15,748
Total	10,997	11,571	3,459	3,155	103	78	29,363

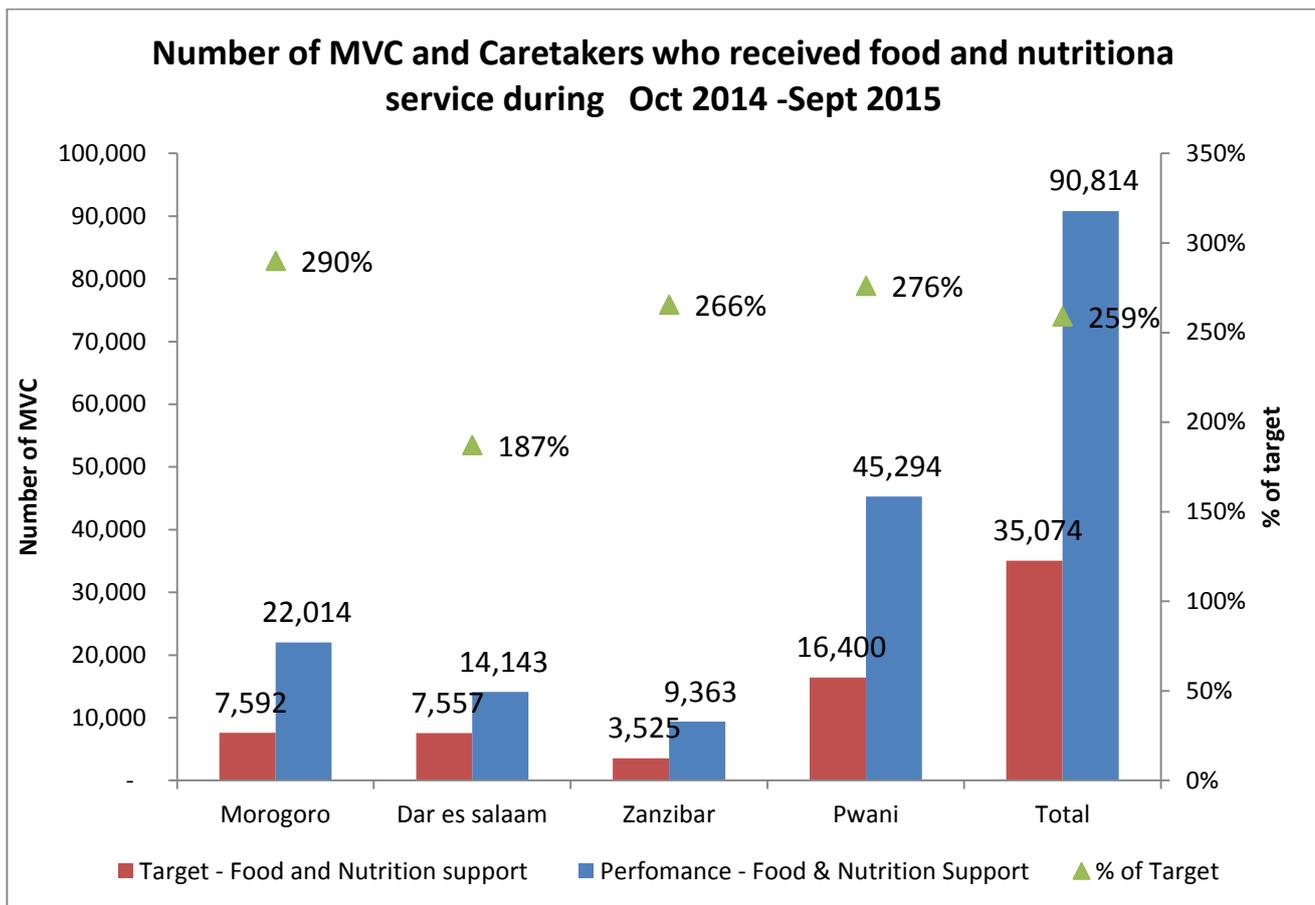
Source. *Quarterly report July–September 2015*

3.1.2 Provide food and nutrition support

Nutrition is very important for everyone, however, it is especially important for children because it directly links to all aspects of their growth and development. A healthy, balanced diet provides children with essential vitamins, minerals and other nutrients needed for healthy growth and development.

The program has been ensuring that MVC and their caretakers are counselled on the importance of eating nutritious food and how they can easily access the same from locally available foods. Caretakers were trained on vegetable gardening and local chicken keeping with the aim of improving economic status of the households and improving the nutrition status of their children.

Community volunteers and CSO staff have been putting efforts to ensure HIV+MVC and adolescents access food and nutrition support including nutritional assessment through direct services as well as through referrals and linkages. In this reporting period, a total number of 55,845 MVC and caretakers (27,769 male and 28,076 female) received food and nutrition services. This is equal to 55% of the total MVC reached during this quarter. This makes annual cumulative total of 90,814 (44,244 male and 46,570 female) provided with nutrition support - equal to 75% of the total annual OVC_SERV of 121,558 and 259% of FY 2015 target of 35,074 MVC. The below chart provides details of MVC and caretakers who received food and nutrition services from October 2014 to September 2015.



Source: Quarterly report July- September 2015

The program has continued to build community engagement in meeting food and nutritional needs of MVC and their caretakers LGAs, MVCC, community members and other existing programs within the program operation areas have been providing food support to MVC and their households. In Mkuranga, Kibaha and Bagamoyo Districts in Pwani, a total of 102 (46 males and 56 females) MVC were supported with food staff worth TZS 721,000 (US\$ 361). The support was provided by SIC groups, MVCCs, TASAF III and a Good Samaritan.

3.1.3 Support Access to Primary Health Care

The program has maintained its commitment to promote access to and utilization of health care services by MVC, adolescents and caretakers. Through community volunteers it has been educating, counselling, promoting and referring MVC, adolescent and caretakers to health facilities for services including HIV testing and counseling. Furthermore, the program has been working with CTCs and other HTC partners to identify HIV+ MVC, adolescents and caretakers and enroll them into the program and support them with community based services including ART adherence counselling.

In this quarter, 3,701 HIV+MVC adolescents and caretakers were provided with different primary health care services, in collaborations with clinical partners. HIV+ clients were provided with nutritional counseling, education on hygiene, positive living, psychosocial support and other community support.

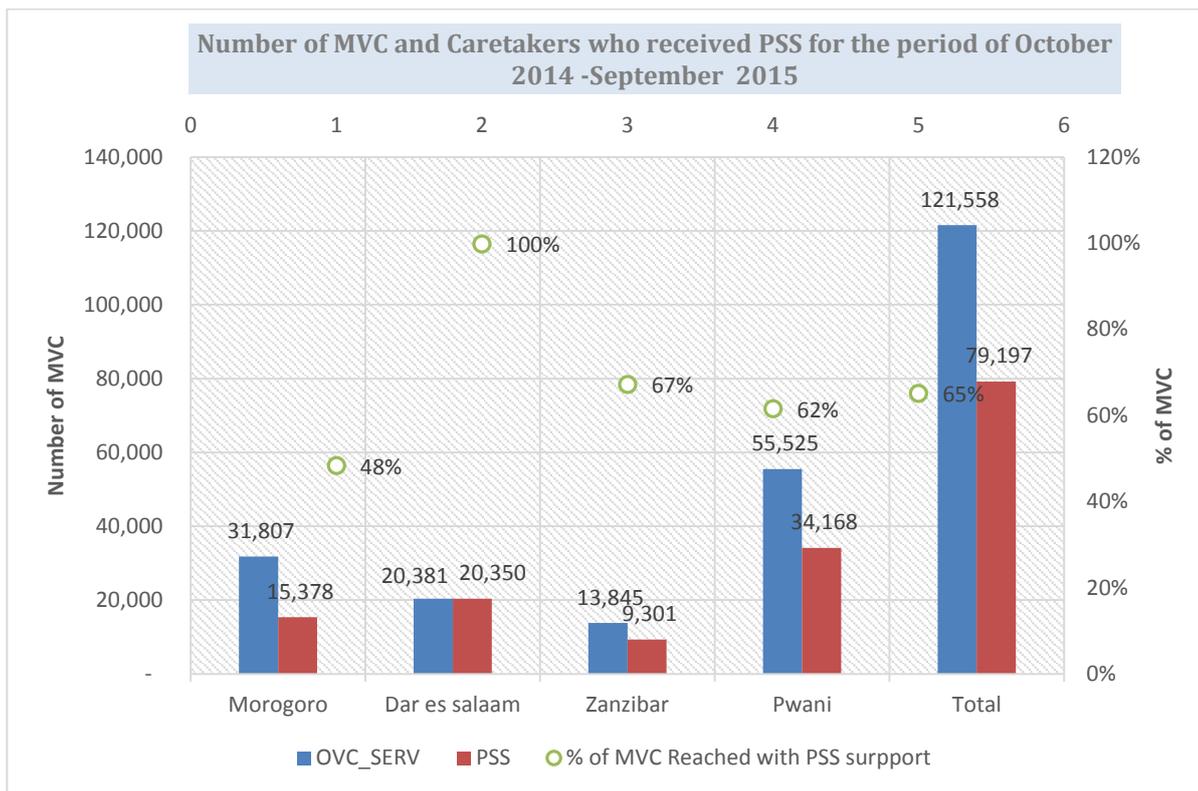
In all areas of operations, the program through volunteers provided different health related services with emphasis on HIV prevention, care and treatment services to 8,292 MVC and their caretakers. Community volunteers continued to build skills of MVC and adolescents on HIV prevention, sexual reproductive health, life skills, children rights and responsibilities and promoted referrals for HTC through children clubs and home visits. In Dar es Salaam region the program promoted HTC services to MVC, adolescents and caretakers and as a result, a total of 118 MVC (58 male and 60 female) were consented by their caretakers to receive HTC. Hence MVC and caretakers were escorted to nearby health facilities for such services.

3.1.4 Provide Family Based Care/Psychosocial Support

Psychosocial support is an interventions used to meet a person's emotional, social, mental, and spiritual needs. Psychosocial support is very important for the development of all children and critical for most vulnerable children as it provides them with the necessary skills to overcome depression.

The community volunteers have been trained on psychological and social factors that affect children's psychosocial well-being, they have developed competencies in identifying, addressing, and managing the emotional needs of vulnerable children and their caretakers and know the importance of fostering children's resilience, as well as ways to help vulnerable children to express and overcome sorrows and hardships. Hence, they provide psychosocial through children clubs where their self- esteem, confidence and resilient features are built, and through home and school visits.

During this reporting period, a total of 66,052 MVC (31,718 male and 34,334 female) MVC received PSS support equal to 65.4% of total MVC served. This has resulted to 79,197 MVC (39,227 and 39,970 female) reached during FY 2015, equivalent to 65% of annual target. The below chart provides the trend on MVC provided with PSS during October 2014-September 2015.



Source: Regional quarterly report July – September 2015

3.1.5 Support shelter improvement

The National Guidelines for Improving Quality of Care, Support, and Protection for Most Vulnerable Children (2009) requires that MVC in their caregiver’s families have the same access to clothing, bedding, and shelter as the other children in the family unit and for caregiver.

The program through community volunteers has been assisting, and counselling MVC caregivers to repair their houses, and building the capacity of the households to maintain their shelters using locally available materials. Through self-help approach, during this reporting period communities have provided support on shelter improvement to MVC households. For instance, in Pwani region 77 (41 male and 36 female) MVC were supported with shelter worth TZS 1,077,000 (US\$536) by community members. The support included: house repair; clothes; mosquito nets; and construction of a pit latrine.

3.1.6 Child Protection

No one sector or profession has all the skills, knowledge or resources necessary to comprehensively meet all the requirements of a child’s protection needs. It is essential therefore that a coordinated, multi-sectoral response is used in working with children and their families in need of care and protection. The program has taken deliberate efforts in ensuring that children are protected from all forms of abuse and neglect.

The program priority was to build child protection system that has the mandate, capacity and resources to prevent and respond holistically to children with single or multiple child protection needs. The interventions that the program has engaged in include raising awareness among community volunteers, MVCC members, established Child Protection Teams in Ilala and Kinondoni in Dar es Salaam and the OSC at Amana Regional Referral Hospital for responding to GBV and VAC cases.

In this reporting quarter the program has continued using DIPG forums to discuss and share issues pertaining to child protection. Emphasis has been on using the child helpline 116 to report abuse cases on time for quick response. Additionally, coordinators for child protection teams in Kinondoni and Ilala districts were also invited in the OSC quarterly meeting to share their experience but also explore more on areas to collaborate with OSC in ensuring children who are abuse receive comprehensive services.

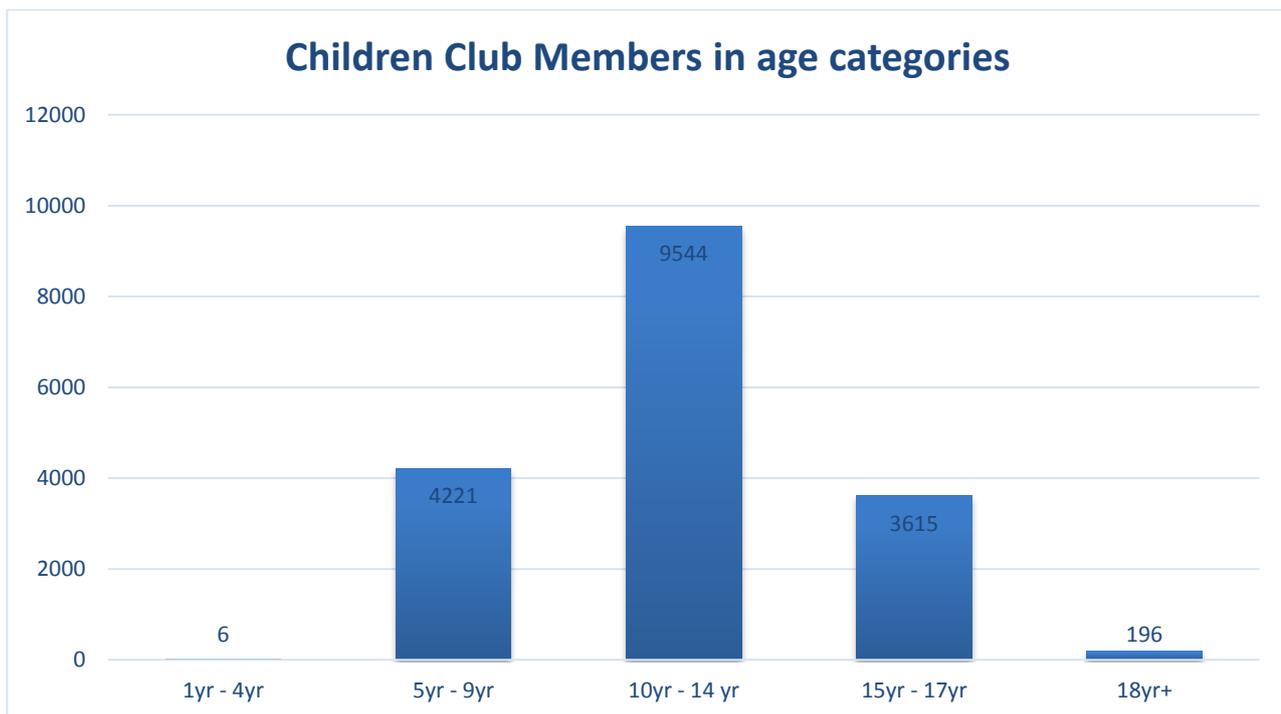
OBJECTIVE 4: Empower OVC, particularly females; contribute to their own wellbeing by improving their resilience as well as their livelihood and self-care skills

Pamoja Tuwalee program has been implementing its activities to ensure improved wellbeing of MVC particularly girls and disabled children. Communities, families and individuals especially children and adolescent females are made aware of their responsibility to care for their health and socio-wellbeing including: maintaining their good hygiene, prevent illnesses, eating nutritious food and protect themselves from emotional disorders among others.

4.1. Establish and expand children clubs

The program has been using children clubs as important forum to directly empower children and young adolescents on their wellbeing by providing them with knowledge and skills on HIV prevention, sexual and reproductive health, basic rights and self-confidence among others. Children experience social interactions and practice how to speak out their mind around their peers, older people and community members.

In this quarter, 23 new children clubs with 580 (296 males and 284 females) members were established, in Morogoro and Dar es Salaam regions. This makes a cumulative total of 575 children clubs with 18,126 MVC and adolescent membership (8,842 males and 9,284 females). Meanwhile, one children club Kichangani in Morogoro, exited the program while in Mafia, as a result of transitioned MVC 23 children clubs with 589 MVC (287 males and 302 females) also exited. Hence, currently there are 551 functional children clubs with 17,582 (8,575 males and 9,007 females) members. The children participation in the clubs remains almost similar among boys and girls, 49% and 51%, respectively. Like in other quarters, community volunteers played a primary role in establishment and operation of the clubs.



4.2. Provide gender and age appropriate HIV and AIDS education

The program has been providing HIV prevention and AIDS, life skills and SRH education to MVC, adolescents and their caretakers while respecting gender and age. Through organized trainings, children clubs and home visits, community volunteers have been influencing attitudes, promoting positive values, skills as well as knowledge of MVC and caretakers so that they live healthy life styles and reduce possibilities of engaging in risk behaviour. The program promoted health decisions that affirm personal standards as well as care and support of children/people with HIV/AIDS.

In this quarter, 49 (25 males and 24 females) MVC and adolescents in Dar es Salaam (Kinondoni and Ilala districts) received training on HIV prevention, SRH, HIV positive living, basic facts on STIs, adolescent pregnancy and life skills. Among them, 30 MVC (16 males and 14 females) and adolescents were trained as youth educators; and 19 HIV+ MVC and adolescents (9 males and 10 females) were trained on positive living with HIV, life planning, and ART adherence. Both groups are expected to be ambassadors of positive living amongst MVC and adolescents in the communities.

4.3. Support to victims of GBV and child abuse

GBV and VAC are human rights violation, a public health challenge, and a barrier to civic, social, political, and economic participation. GBV and VAC undermines not only the safety, dignity, overall health status, and

human rights of the millions of individuals who experience it, but also the public health, economic stability, and security of nations. GBV and VAC cut across ethnicity, race, class, religion, education level, and international borders. The National Survey on Violence against Children, (VAC) report (2009) revealed that almost a third of females aged 13 to 24 experienced at least one incident of sexual violence before the age of 18. Although statistics on the prevalence of violence vary, the scale is tremendous, the scope is massive, and the consequences to individuals, families, communities, and countries are shocking.

The program through community volunteers, MVCCs and child protection teams has been responding to GBV and VAC cases directly at the OSC through referral and linkages from and to other service providers in ensuring provision of comprehensive services. A total of 87 cases of GBV and VAC were attended this quarter - 82 at the OSC and 5 through existing child protection structures in Morogoro and Dar es Salaam.

4.4. Provide disabled OVC with accurate and appropriate information about their rights and HIV/AIDS

MVC and adolescents with disabilities are at a higher risk of HIV infection compared to non-disabled. They are highly vulnerable to physical and/ or other different forms of violence and abuse from community members including their close relatives. To address this, the program has been working closely and directly with MVC and adolescents and/ or through their caretakers to improve access to information and provide education on HIV/AIDS; SRH, nutrition and primary health care counselling.

Since October 2014 to September 2015, a total 1,274 children with disability were reached with different services. In this quarter, 982 (539 males and 443 females) MVC and adolescents; and 578 caretakers were provided with information on their rights. Other services provided to MVC and adolescents with disability are as mentioned below:

- Strengthened family-based care for children living with disabilities i.e. reaching their caretakers with information about the rights of their children and HIV prevention
- Provided disabled children with the opportunity to participate in community gatherings including children clubs to reduce stigma/self-stigma and improved social skills Awareness raising on disability issues among community members Conducted PSS activities/programs to identify children with disabilities and community members so as to contribute towards addressing their health, rehabilitation, education and social inclusion needs
- Referred for medical assessment, treatment and possible surgery by specialists within the public health institutions; clinical rehabilitation and provision of assistive devices (wheel chairs, tri-cycle and walking sticks).

ENHANCING INTER-SECTORAL COORDINATION AND COLLABORATION

(i) Most Vulnerable Children Implementing Partners Group

The government coordinates a National forum that brings together all MVC Implementing Partners (IPG). The group meets on monthly basis for experience sharing as well as progress made by each partner. In this

reporting period, the program continued to attend the monthly MVC IPG meetings and shared the monthly updates accordingly.

(ii) Gender Based Violence and Violence Against Children Quarterly Stakeholders Meeting

The meeting was organized by the Ministry of Health and Social Welfare with support from CDC and attended by participants from the government and partners supporting the government in fight against GBV and VAC. The objective of the meeting was to share among partners, experiences and best practices on preventing and responding to GBV and VAC issues and providing updates on the upcoming events particularly the Girl Child Day and 16 days of activism. The MOHSW in collaboration with partners from Mbeya, Iringa and Dar es Salaam shared different initiatives, trainings conducted to GBV service providers and their experiences in mapping GBV and VAC referral and linkages.

GBV and VAC interventions still experience challenges as shared in the meeting such as; i) lack of safe place/drop in centers for the victims who are brought for immediate and emergency services; ii) Fit Person Guideline was only meant for children and so working with adult victims of GBV is difficult.

(iii) PEPFAR Tanzania Implementing Partners Meeting:

This meeting was hosted by USAID/PEPFAR coordinator with the aim of discussing significant PEPFAR changes and or directions to its strategy and planning that impacts the partner and mechanism-level information. The key discussion included Target Revisions Guidance for Implementing Partners; District-level prioritization that aims to reach 80% coverage in priority areas by end of FY 2017 with a focus on Scale-up Districts

The discussion also included OVC Pivot to Contribution to epidemic control in which it was explained that OVC IPs are required to reduce the districts coverage and align with PLHIV; i.e. from 136 to 23 saturation districts.

(iv) Write up workshop for health GBV and VAC monitoring and evaluation plan.

This was a workshop organized by the Ministry of Health and Social Welfare in collaboration with the University of California San Francisco to prepare the final draft of the Health GBV and VAC Monitoring and Evaluation Plan. The workshop was attended by 25 participants including staff from the reproductive and maternal health section, Department of Social Welfare, Ministry of Constitution and Legal Affairs, National Bureau of Statistics, University of Dar es Salaam, FHI 360, MDH, Engender Health and TAYOA. The developed GBV and VAC M&E plan will be used to strengthen GBV and VAC monitoring and evaluation activities in Tanzania.

(v) Preparedness and responding in emergencies or disasters within the child protection system

The Department of Social Welfare organized partners meeting on strengthening the department's engagement in the preparedness and responding in emergencies or disasters within the child protection system. This was an emergency meeting to discuss how DSW in collaboration with partners can engage in responding to

emergencies or disasters which may occur due to (i) the El Nino warning by Tanzania Meteorological Agency and (ii) the forthcoming Tanzania General election.

Both incidences may have direct or indirect effects to children such as separation from their parents, exposure to sexual abuse, children can be killed or injured, increase chances of child trafficking, increase number of children living and working in streets, increase child labour, illness as many children cannot easily access health services, and suffering emotionally and psychologically. One of the meeting proposals was to develop a concept note and advise the permanent secretary of the MOHSW to have a stand by response team at DSW that will work with child protection teams at the council level.

(vi) Meetings to review the minimum package for most vulnerable children and adolescents living with HIV

The program attended two meetings convened by the DSW and URC with aimed to review and provide inputs on the minimum package for OVC and adolescents living with HIV. While the first meeting focused on proposing what could be done before revision, the second meeting aimed at reviewing the first draft of the package. By end of this reporting period, a revised draft of 'Minimum Package for MVC and Adolescents Living With HIV: A Guide for Community Providers' had been developed.

MONITORING AND EVALUATION

Supporting sub grantees on proper documentation and case management filing per SIMS requirement

During this quarter M&E team visited sub grantees for the purpose of mentoring and reorienting staffs on improved monitoring of activities using SIMS tool. The exercise verified availability of all documents such as: volunteers service delivery monthly and quarterly reports; children clubs and QI meeting minutes; SILC group and volunteers monthly meeting minutes; and training and support supervision reports. Staff were oriented and supported to develop case file for individual MVC starting with those who have special cases, such as HIV+ MVC, Disabled children and MVC with acute malnutrition.

Joint Partner Performance Meeting

The quarterly Joint Partner Performance Meeting (JPPM) was conducted in September 2015. The meeting was attended by program staff and three USAID staff including the AOR for Pamoja Tuwalee. The following were action points from the meeting:

- Provide TA to PACT to ensure effective function of their GBV OSC including how to ensure other stakeholders, communities and government counterparts continue to collaborate
- Provide strategy for building the capacity of caregivers /volunteers to support HIV+ children
- Provide data on HIV status of children with acute malnutrition referred to health facilities for counselling and testing

- Analyze GBV and VAC data to determine number of OVC including non-OVC and provide data on the number of victims who access GBV services
- Provide disaggregated data on malnourished children reported if they are on ART, on first appointment or lost to follow up cases
- Provide feedback on how the program works with other stakeholders (private sector) to contribute to the wellbeing of the OVC

PRIORITY ACTIVITIES FOR NEXT QUARTER – OCT TO DEC 2015

- Conduct NACS training to community volunteers
- Conduct entrepreneurship training to SILC group members
- Conduct MVC identification in 3 scale up districts of Kinondoni, Ilala and Morogoro Municipal Council
- Facilitate selection of additional volunteers in the scale up districts
- Facilitate formation and training of new MVCCs within the scale up Mtaa/Villages

SUCCESS STORY

HOPE LOST DUE TO HIV/AIDS RESTORED: THE STORY OF OMARI MOHAMED

Omari Mohamed Mchuchuli is an older OVC of 21 years living in Mgomba ward in Rufiji district, Pwani region. He is a second born among three children of Mohamed Mchuchuli. Omari's parents who were both HIV positive died in 2001. When he was still 7 years old, Omari and his two brothers (12 years old and 3 years old) were left with nothing because all the family resources were used to care for their parents during sickness. Due to the extreme poverty, Omari's elder brother abandoned them and went to Mafia district where he joined delinquent groups.

One year after death, Omari and brother were grandfather who for their mentally Life continued to Their grandfather their educational Omari dropped when he was in Omari lost hope of studying and



their parent's his young taken by their is also caring disabled uncle. be very tough. could not meet needs hence out of school class six. and his dream becoming

independent and responsible adult got lost. When explaining how he managed to cope with life despite the difficulties, he said *“Swala la UKIMWI ni tete, nilipoteza matumaini yangu ya maisha baada ya huu ugonjwa kuondoa wazazi wangu wote wawili, hata hivyo namshukuru Mungu, tuliendelea kuishi hivyo mpaka Pamoja Tuwalee ikatufikia”* meaning *‘HIV/AIDS pandemic is a big issue, I lost hope after this disease took both my parents, nevertheless I’m grateful to God as we continued to live until Pamoja Tuwalee Program reached us’*

The poor economic condition at home forced him to work as a casual laborer in order to take care of his young brothers, old grandfather and mentally retarded uncle. His family depended on him for everything including food, medical expenses and school needs for his young brother. *“Wakati mwingine sikuweza kupata kibarua kabisa na kujikuta narudi nyumbani nikiwa mikono mitupu, ili niumiza sana hasa pale mdogo wangu aliponiuliza kaka usiku tutakula nini? Meaning “Sometimes I could not get casual work so I would go back home empty handed, it was very painful to me especially when my young brother used to ask me “brother what are we going to eat to night?”* Said Omari in a shaking voice with tears down his cheeks. In 2003 Omari was employed to do planting and weeding in a small scale farms. He earned an average of TZS

60,000 (US\$ 32) per month and although this was little it was stable income and it helped to meet family basic needs especially food.

In 2012 Pamoja Tuwalee/FHI 360 program conducted MVC identification exercise in Rufiji district, Omari and his sibling were also identified and enrolled into the program. The Program staff and community volunteer



through home visits continued to provide counselling and advised him to join vocational training. He agreed and was enrolled at Ikwiriri Ushirika Carpentry Union for six month carpentry course in 2013. Omari graduated in 2014 and the program supported him with start-up kit to his carpentry work. Omari is now a carpenter making beds, chairs, tables, cupboards, frames, doors, windows of different designs per customer's choice. He is able to earn TZS 170,000 (US\$ 89) to TZS 200,000 (US\$ 105) per month which is used to meet his

family needs. ***“Nakosa maneno mazuri ya kushukuru mradi wa Pamoja Tuwalee kwa kuweza kutimiza ndoto zangu. Sasa ninajitegemea na ninaweza kuihudumia familia yangu. Mwenyezi Mungu awalipe kwa jinsi mnavyo wasaidia watoto yatima.”*** Meaning ***“I don't have good words to thank Pamoja Tuwalee Program for making my dream come true, now I am an independent man supporting my family, may almighty God pay you for supporting orphans”***. He said. Omari is committed through altruism to pay back to what the program has done to him by supporting other most vulnerable children through on-job training. He has promised to assist 2 most vulnerable children each year. Omari's future plan is to purchase modern machines and expand his workshop so that he can support many Most Vulnerable Children and he intends to find his elder brother who run away from home due to the poverty.

LIST OF APPENDIXES

Appendix I: Number of MVC served with at least one core service During July – September

Appendix II: Number of MVC served with at least one core service During Oct 2014 - Sept 2015

Appendix III: Number of PLHIV or OVC (MVC) who received food and/or other nutrition services outside a health facility during July-September 2015

Appendix IV: Number of PLHIV or OVC (MVC) who received food and/or other nutrition services outside a health facility during October 2014 -September 2015

Appendix V: Proportion of PLHIV who were nutritionally assessed via anthropometric measurement during October 2014 – September 2015

Appendix VI: Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services during October 2014-September 2015

Appendix VII: Number of people completing an intervention pertaining to gender norms that meets minimum criteria during October 2014-September 2015

Appendix VIII: Number of MVC who received Education support during October 2014-September 2015

Appendix IX: Number of people reached with an intervention that explicitly aim to increase access to income and productive resources, including vocational training support disaggregated by Sex and Age during July – September 2015

Appendix X: Number of people reached with an intervention that explicitly aim to increase access to income and productive resources, including vocational training support disaggregated by Sex and Age during October 2014– September 2015

Appendix XI: Number of MVC provided with psychosocial support during July – September 2015

Appendix XII: Number of MVC provided with psychosocial support during Oct 2014 – Sept 2015

Appendix XIII: Number of New SILC Groups established during July – September 2015

Appendix XIV: Number of Current SILC Groups (both direct and indirect caretakers) with their membership disaggregated by sex and membership category during July – September 2015

Appendix XV: Number of cumulative SILC groups as of December 2014 disaggregated by membership category as of September 2015

Appendix XVI: New children clubs established during July – September 2015

Appendix XVII: Status of existing children clubs As of September 2015

Appendix XVIII: Number of MVCCs that have supported MVC through their established MVC funds during July – September 2015 and the type of support

Appendix XIX: Number of other support providers who have supported MVC households through Public Private Partnership during July –September 2015

Appendix XX: Number of MVC supported by caregivers as a result of economic strengthening activities during July– September 2015