



**Systems Strengthening Project:  
Technical Assistance for HIV/AIDS Emergency Plan in Tanzania**

**Cooperative Agreement No. 623-A-00-05-0317-00**

4<sup>th</sup> Quarterly Report  
July to September 2009

Submitted: 15 December 2009

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## ACRONYMS

ART	Antiretroviral Treatment
ARV	Antiretroviral
APHTA	Association of Private Hospitals in Tanzania
CBO	Community-based Organization
CMO	Chief Medical Officer
CSSU	Care and Social Support Unit
CTC	Care and Treatment Clinic
DMS	Data Management System
DSW	Department of Social Welfare
FHI	Family Health International
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GoT	Government of Tanzania
HBC	Home-based Care
HBHCT	Home-based HIV Counseling and Testing
ICRW	International Center for Research on Women
IEC	Information, Education and Communication
IDU	Intravenous Drug Users
IPT	INH Preventive Therapy
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MUHAS	Muhimbili University of Health and Allied Sciences
MVC	Most Vulnerable Children
NACP	National AIDS Control Program
NCPA	National Costed Plan of Action
NTLP	National Tuberculosis and Leprosy Program
NSCTHR	National Subcommittee in Training and Human Resources on HIV/AIDS
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMORALG	Prime Minister's Office Regional Administration and Local Government
PS	Permanent Secretary
SOPs	Standard Operating Procedures
TOT	Training of Trainers
USAID	United States Agency for International Development
USG	United States Government
WAVUMO	Waishio na Virusi vya Ukimwi Morogoro
WHO	World Health Organization

## **I. OVERVIEW**

Under the Systems Strengthening Project, a United States Agency for International Development (USAID)-supported project, Family Health International (FHI) in Tanzania has been providing high-quality technical assistance to the Ministry of Health and Social Welfare (MOHSW), the National AIDS Control Program's (NACP's) Care and Treatment Unit (CTU), the Care and Social Support Unit (CSSU), and the Department of Social Welfare (DSW) in the roll-out of the anti-retroviral treatment, community-based palliative care, and orphans and vulnerable children support programs. FHI has also extended its technical support to the Prime Minister's Office Regional Administration and Local Governments (PMORALG)'s Department of Local Governments (DLG), implementing partners group (IPG) and the Department of Social Welfare Zanzibar in the expansion of most vulnerable children support programs.

During this quarter FHI continued to support USAID/Tanzania's Strategic Objective of "Enhanced Multi-sectoral Response to HIV/AIDS in Tanzania" and to contribute to the President's Emergency Plan for AIDS Relief (PEPFAR) targets. Specifically, FHI will support USAID/Tanzania's aim to provide sustainable and quality comprehensive care. We will ensure that the Government of Tanzania's National Care and Treatment Plan links individuals and families affected by HIV and AIDS to supportive and well-trained civil society organizations (NGO, FBO, CBO, PLHIV support groups and others), and to health facilities in the network model to ensure quality continuum of care.

Key highlights of the quarter included the launch of the national HIV/AIDS Stigma Reduction Guide by his Excellency Mr. P. Marmo, Minister of State, in the presence of the Tanzania Commission for AIDS (TACAIDS), all ministries, civil society and other stakeholders. It was an important example of research to practice for Tanzania health and development systems. Additionally, the National Guidelines for Improving Quality of Care, Support and Protection of Most Vulnerable Children in Tanzania was finalized, approved and released. Another highlight was the valuable feedback obtained through visits to HBC service providers/supervisors and PLHIV support groups on their experiences with implementing positive prevention interventions. Information obtained through these discussions is being evaluated and will shape future strategies.

Below is the quarterly progress report, which covers the period July to September 2009.

## II. OBJECTIVES AND ACTIVITIES

### **A. Objective 1. Strengthened capacity of the National AIDS Control Program to lead and coordinate the scale-up of national care and treatment services through effective policies, manpower and management of the program**

#### *Activity 1.1 Strengthen leadership and management capacity of NACP*

- a) Lack of a government operational activity budget for the NACP this financial year seriously hampered its leadership role and management capacity to facilitate a harmonized and shared approach by the program manager and heads of units. The only budgets to manage and translate into activities are the project-focused, externally-funded activities by WHO, JICA, CDC, PharmAccess and FHI. This led to various useful but often uncoordinated workshops.
- b) The FHI-facilitated management retreat will now be fully funded through FHI. A national consultancy group, TRACE, was assigned to conduct a team-performance analysis of NACP staff and units, design an agenda and hold the retreat. The performance analysis was implemented from 28-31 September through group and individual interviews with NACP staff. The retreat is scheduled for 19-22 October in Morogoro.
- c) The FHI-seconded health planner to the NACP focused efforts this quarter on implementing systems for the NACP. This included creating a workplan with activities, responsible parties and timelines compiled from all units into a single document and developing a template report format to facilitate submission of weekly reports. Additionally, the health planner compiled, reviewed and edited monthly and quarterly reports for submission, and assisted with TRACE's needs assessment of NACP staff.

#### *Activity 1.2 Strengthen health systems through transitioning and program integration*

- a) The USG-GoT Partnership framework was presented in September to partners as the umbrella for all systems strengthening activities. It builds further on the vision of the new PEPFAR Administrator for all partners to work towards transitioning of activities to government programs. This quarter, FHI initiated discussions with PMORALG via Mr. Nyimbi, Director, Department Local Government, to see how FHI can support a more strategic approach for planning and budgeting of HIV care and treatment activities by local councils and regional authorities.
- b) Within the MOHSW, FHI (through research funding) works closely with the Reproductive Child Health Department of the MOHSW to study the feasibility of integrated family planning (FP) and treatment activities at care and treatment clinics (CTCs). Meanwhile, a costed action plan is being drafted and supported by FHI for a revival of a national FP strategy. FHI, through this Systems Strengthening project, did discuss with the CSSU and the CTU of the NACP the relevance of FP integration and the need for advocacy to reflect that it in the

national Positive Prevention (PP) strategy, national SOPs and the national home-based care (HBC) guidelines. During the July/August final review of the revised national HBC guidelines and the finalization of the national SOPs in August, these integration aspects were reflected. Additionally, a taskforce was called for by the NACP IEC Unit to develop a national PP strategy of which FHI is a member.

*Activity 1.3 Maximize the use of human resources in health*

- a) With support of the donor committee, the Permanent Secretary (PS) MOHSW decided to reactivate the Human Resource Working Group with broad and full membership of non-governmental bodies and clear deliverables from the various strategic objectives of the national HR Strategic Framework 08-12. Through the Systems Strengthening project and the Capacity project, FHI and IntraHealth are the only two USG partners that are members of the working group. Meetings will be held every two weeks with the first meeting taking place on 12<sup>th</sup> August. This quarter, FHI used the meeting as an opportunity to promote and revive the task shifting (TS) discussion resulting in an invitation to present TS realities and opportunities in Tanzania to the senior management team of the MOHSW in November/December. FHI will prepare the presentation (concept note and slides) together with the WHO.
- b) Pre-service training was strengthened this quarter through FHI membership in the Advisory Committee on Nurse Education chaired by the Director, School of Nursing, MUHAS and with the participation of the Tanzania nurses association, AIHA and I-TECH, which met on 30 September. With FHI support, the nurse tutor curriculum has been finalized and is in use now at all nurse tutor schools in the country. So far 398 nurse tutors have been trained and activities have been initiated with the MOHSW nurse training section to revise the national nursing curricula. The next step of the committee is to address TS through the nurse council and association.
- c) In-service quality improvement (QI) through supportive supervision and clinical mentoring is gradually being accepted by the NACP and regional medical officers (RMOs). This was further clarified and promoted at the JICA-ITECH-supported series of workshops on the development of a national training manual for supportive supervision and clinical mentoring. Two of FHI's programs, System Strengthening and Tunajali, contributed to this draft manual although QI through mentoring remains a very new concept for government health authorities that are used to control, inspect and supervise.
- d) Strengthening the role of the Regional Health Management Team (RHMT) in management, including of care and treatment services, was boosted with the new allocation of government funds to regional authorities through PMORALG. With JICA and GoT, presentations were made and discussions held to ensure this in the training packages developed by JICA. Harmonization with the GoT package was discussed as well.

*Activity 1.3 Strengthen effectiveness of National Subcommittee Training and Human Resources for HIV/AIDS (NSCTHR) to ensure sufficient numbers of health care workers are competent and motivated*

The subcommittee met on 9<sup>th</sup> September at which time an FHI initiative was agreed upon to strengthen the capacity of the NACP secretariat of this subcommittee to have a co-secretariat shared with Mkapa Foundation. Dr. Alphoncina Nanai will join Lillian Chovenge to form a joint secretariat to put human resource issues on the agenda for action.

*Activity 1.4 Build the capacity of Care and Treatment Unit (CTU) of the NACP in the development of effective policies and norms and standards for care and treatment*

- a) The national subcommittee on clinical management met on 23<sup>rd</sup> July to discuss the implications of changing the CD4 cut off point for ART eligibility in Tanzania from 200 to 350. Dr. Kaushik (Hindu Mandal) and Dr. van Praag (FHI) presented clinical and public health/programmatic implications. As a way forward it was decided that the NACP, with CDC and WHO, support will study the operational and financial consequences of a multi-stage scenario varying from no change to all-eligible stage. A likely scenario could be to start very gradually with pregnant women, people with opportunistic infections and/or special professions such as teachers or nurses/clinicians.
- b) The TB/HIV operational manual and piloting of the 3Is (Improve screening, IMM prophylaxis, Infection control of airborne diseases), as strongly promoted by FHI, did have some setbacks due to staff changes in the National Tuberculosis and Leprosy Program (NTLP) and persistence by the NTLP and the CDC to introduce isoniazid preventive therapy (IPT) only after extensive multi-site piloting of its feasibility with an internationally-approved study protocol requiring multiple IRBs. So far the NACP has not been able to take the lead in the 3Is despite ICAP/FHI support.
- c) The NACP is still finalizing the technical editing of a Health Sector HIV and AIDS Strategic Plan 2008-2012 with support from the FHI-seconded health planner in the NACP.
- d) On 29<sup>th</sup> September, the Minister of State, his Excellency Mr. P. Marmo, launched the National HIV/AIDS Stigma Reduction Guide in the presence of over 90 participants from all sectors of society fighting HIV/AIDS, all sector ministries, experts and media. FHI made a presentation on "from research to action" and a vote of thanks highlighting this pioneering example of community-based research that led to a practical guide for field implementation. Copies of the guide in Kiswahili and English were widely disseminated by the core developers of the guide - MUHAS Department of Psychiatry in close collaboration with ICRW and FHI. ICRW's detailed report on this event is available separately upon request.

*Activity 1.5 To ensure quality of care, FHI will facilitate and provide TA to NACP to finalize care and treatment national guidelines and standardized procedures*

- a) FHI had a formal handover of 100 library copies of the National Guidelines for the Management of HIV and AIDS on 7th September to Professor Karim, Dean of the School of Medicine of the Muhimbili University of Health and Allied Sciences and Professor Mugusi, Head of the Internal Medicine Department, Dar es Salaam.
- b) The CTU, in collaboration with FHI, organized a key expert meeting for a final review of the national SOPs on 2-4 August. One expert was contracted to include all suggested changes and a final draft was sent for formatting and graphics. Printing quotations will be obtained early next quarter.
- c) Pharmaccess circulated a first draft of the Clinical HIV Pocket Guide based on the February 2009 revised 3<sup>rd</sup> edition of the national guidelines for the management of HIV and AIDS for review. A series of interactive meetings are planned for next quarter with experts and partners (MUHAS, Hindu Mandal, FHI and other partners) to prepare for field testing.

*Activity 1.6 Strengthen the CTU's capacity to pilot, assess and document interventions which inform policy and standard setting. This activity will focus on the promotion of the continuum of care approach and piloting of the integration of HIV services into general health service delivery.*

- a) Building on FHI's global expertise and resources in comprehensive care and its ongoing work in Tanzania, FHI is working to strengthen the Continuum of Care (CoC) network in Mvomero District. Under this initiative, a truly comprehensive and functional CoC network will be strengthened to promote greater collaboration and coordination among HIV/AIDS partners and key stakeholders in Mvomero, resulting in improved health and other related outcomes for individuals and households. In this quarter, FHI introduced the CoC activity to the Mvomero Council Multisectoral AIDS Committee (CMAC) and obtained buy-in and support from the CMAC. In Q1 2010, FHI will support Mvomero to clearly define the structure and functions of the CoC network coordinating committee and the CoC network itself. Thereafter, FHI will support Mvomero to conduct a baseline assessment to establish which partners are working there, where exactly they are working and what services they are providing.

**B. Objective 2. Increased capacity of the DSW of the MOHSW and Prime Minister's Office for Regional and Local Government (PMORALG) to lead, coordinate and monitor Orphans and Vulnerable Children support programs**

***Section 1: Technical assistance to the DSW and PMORALG in Mainland Tanzania***

*Activity 2.1: Strengthen the capacity of the DSW to plan and catalyze implementation of OVC policies, strategies, and plans (particularly for effective decentralization and manpower)*

- a) In quarter four (Q4), FHI continued to provide TA to DSW's Child and Family Welfare unit to enable it to continue to provide oversight in rolling out and

monitoring implementation of the National Costed Plan of Action (NCPA), the Data Management System (DMS) and quality most vulnerable children (MVC) service standards. In this quarter, TA was provided through designing, planning and holding several meetings to finalize national guidelines for improving the quality of MVC services, and a regional working meeting was held to review implementation of NCPA in Iringa, Mwanza and Dodoma regions.

- b) The simplified Kiswahili version of the NCPA was approved and 5,000 copies were printed in Q4. Copies were distributed to IPG members and local government authorities (LGAs) during regional meetings to review the NCPA implementation organized by PMORALG, DoD, Pact and others. FHI also supported the DSW to print additional copies of the executive summary of the NCPA for dissemination during the national Saba Saba Trade Fair.
- c) The NCPA national-level advocacy meeting with (Wanawake na Maendeleo Foundation) WAMA did not happen, largely due to the unavailability of WAMA focal persons. However, FHI managed to meet with the Permanent Secretary (PS) of the MOHSW to present and discuss the support FHI provides to the Ministry, including presenting a request to hold a national steering committee meeting. The PS pledged to slot this meeting into her October – December 2009 calendar.
- d) The M&E Officer and Data Management Specialist seconded to the DSW continued to provide TA to the DSW to roll out the national DMS to five additional councils in Q4. FHI continued to support the Senior Technical Officer, M&E seconded to the DSW Family and Child Welfare unit to provide support in monitoring the NCPA roll out. In Q4, she spear-headed the preparation of an update on the implementation of the NCPA as of the end of September 2009, which is available separately.
- e) The Ustawi website was not launched in Q4, largely due to a shortage of time to prepare for the event amid competing workplan related activities. This activity has been carried forward to the next fiscal year.

*Activity 2.2: Build capacity of the DSW to develop guidelines and standards for OVC care and support*

- a) FHI continued to support the DSW to provide progress updates on NCPA implementation. DSW has released a fourth update on NCPA implementation countrywide, which is being distributed to all IPG members, including TACAIDS, line ministries, UNICEF and USAID.
- b) FHI supported the DSW to procure furniture for an MVC resource facility within its office.
- c) FHI continued in Q4 to participate in monthly IPG meetings, using the opportunity to share knowledge and lessons learned to inform delivery of quality and sustainable MVC services.

*Activity 2.3 Support DSW to finalize and roll out national guidelines for improving quality of MVC services*

- a) FHI continued in Q4 to co-chair the QI Taskforce, which meets monthly in Dar es Salaam. The QI Taskforce has been spearheading development of national guidelines for improving quality of care, support and protection of MVC at the point of service delivery. The national QI guidelines were finalized and approved in September 2009 by the Permanent Secretary of the MOHSW. FHI hosted a meeting of the QI Taskforce sub-committee, which was formed to plan development of a QI training facilitator's guide. FHI will support the government to develop this guide in Q1 of 2010 in collaboration with URC, Africare, Pact and other MVC implementing partners. Please see the related success story in Appendix A.
- b) In Q1 of 2010, FHI will support the development of a facilitator's manual for training volunteers and members of village committees for MVC. FHI will also take the lead in piloting use of the QI guidelines in councils supported by the Tunajali program.

*Activity 2.6 Strengthen capacity of DLG of PMORALG to operationalize NCPA at council level*

- a) FHI supported PMORALG to review implementation of the NCPA by LGAs through three regional working meetings in Iringa, Mwanza and Dodoma. In these meetings, PMORALG invited key leaders from each council to share MVC care and support activities in their respective councils and how much they had allocated for MVC in the coming financial year. Separate meeting reports provide evidence that councils are allocating resources for MVC and are implementing the NCPA. Such meetings will be used to review progress in integrating and eventually mainstreaming MVC support and care into district plans and functions. PMORALG will use this opportunity to continue advocating for mainstreaming MVC support into council plans and functions. FHI is supporting PMORALG to hold these meetings in Tunajali-supported regions to set an example for other implementing partners to do the same in their respective regions.

*Activity 2.8 Strengthen OVC monitoring and information systems of the DLG and the DSW, in particular build capacity of the DLG and the DSW to analyze and use data for decision making*

- a) FHI continued to support the Data Management Specialist seconded to the DSW who has been available to provide TA to all implementing partners. The data management specialist has been a key resource in the roll out of the national DMS. By the end of Q4, the roll out reached 68 councils in the country, most (75%) of which have inserted MVC data into the DMS and sent reports to the DSW. These reports are analyzed and feedback sent to the councils.
- b) The Data Management Specialist seconded to the DSW continued to provide supportive supervision to councils using the national DMS.

- c) In this reporting period, FHI supported PMORALG to train 19 regional social welfare officers on the national MVC data management system. These regional social welfare officers, who are employees of the Regional Secretariat, will become a sustainable resource to supervise use of the DMS in each region.
- d) FHI continued to advocate for and engage the DSW and the IPG in the roll out of national DMS to additional councils. At the end of this quarter, the DMS had been rolled out to a cumulative total of 68 Councils.

## **Section 2 Technical assistance to the Department of Social Welfare of Zanzibar**

*Activity 2.12: Strengthen capacity of DSW Zanzibar in planning, developing and managing implementation of policies, strategies and standards*

- a) In this reporting period, FHI supported the DSW Zanzibar to engage a local consultant to lead development of the Zanzibar action plan for MVC. The process was initiated with two stakeholder consultative meetings to gather input and comments on the draft plan, which will be finalized in Q1 2010.

*Activity 2.13 Strengthen the DSW Zanzibar information system for tracking MVC/OVC identification, service providers, and service provision*

- a) FHI continued to support the Data Management Specialist seconded to the DSW Zanzibar to provide overall management of the Zanzibar DMS.
- b) FHI supported the DSW Zanzibar to pilot the DMS in Unguja and Pemba. The pilot results revealed some minor technical shortfalls that need to be addressed before the system can be launched and rolled out in Q1 of 2010.

*Activity 2.14 Build the capacity of DSW Zanzibar staff and service providers in the provision of quality psychosocial support for OVC and community participation*

- a) FHI continued to support a psychosocial support counsellor who was seconded to the DSW Zanzibar in Q3. Her additional responsibilities have been to support development and roll out of the Zanzibar MVC program action plan and guidelines.

## **C. Objective 3. Increased capacity of the Counseling and Social Support Unit (CSSU) of the NACP to lead, coordinate and monitor the provision of quality palliative care services**

*Activity 3.1: Strengthen the coordination and management capacity of the NACP Care and Social Support Unit (CSSU)*

- a) FHI continued to support the CSSU of the NACP. In Q4, FHI facilitated the care and support subcommittee meeting, which is comprised of key HBC stakeholder members. One of the items presented and discussed at the meeting was the newly-developed HBC recording and reporting system. Plans for the roll-out of

the national recording and reporting system were discussed and agreed upon. FHI was mandated to start organizing TOTs in consultation with all HBC implementing partners.

- b) Discussions were held with the Tanzania Palliative Care Association (TPCA) and the African Palliative Care Association (APCA) on how to make the collaboration more effective. Some leadership changes were suggested and will be further discussed by the board.

*Activity 3.2: Provide technical assistance to the CSSU to improve the quality of palliative home based care services*

- a) As requested by the NACP, FHI provided technical and financial support for the review of the national guidelines for HBC services. In Q4, FHI organized an HBC key stakeholders meeting to finalize the guidelines. The guidelines are currently being edited and logistics for printing are in progress. Once the guidelines are printed, a workshop will be conducted with key HBC stakeholders to disseminate the guidelines. Additionally, FHI will facilitate review of the national HBC training materials in line with the revised national HBC services guidelines.

*Activity 3.3: Develop and roll-out the HBC Data Management and Monitoring System (DMMS)*

- a) As reported in the previous report, with financial and technical support from FHI, the NACP of the MOHSW, in collaboration with other key HBC stakeholders, continued with the process of finalizing the national recording and reporting system (RRS) for HBC services to be used by all HBC implementing partners countrywide. The system has been developed through a participatory process that involved key HBC stakeholders. In Q4, a technical working group of key HBC stakeholders met and finalized the system.
- b) FHI also participated in the HBC RRS dissemination meeting, which was organized by the NACP. At this meeting, it was decided that the system will be gradually rolled out country wide. Roll out of the HBC RRS will include the following activities:
  - Printing of tools. This activity is currently underway.
  - Dissemination meeting to the RHMT and the Council Health Management Team (CHMT) planned to take place in December 2009.
  - A TOT is planned for November 2009.
  - Training of district HBC coordinators and implementing partner data clerks to enable electronic data capturing.

## **D. Community-Based Positive Prevention**

### **Objective 1. Community-based positive prevention endorsed and coordinated by the NACP**

**Objective 1.1: Approaches and interventions for community – based positive prevention for national implementation defined**

*Activity 1: Finalize the scope and content of the community–based positive prevention training and develop tools for national incorporation*

This is an ongoing process of developing the training materials and monitoring tools for HBC providers and PLHIV support groups in collaboration with the NACP, testing them at the pilot sites, finalizing them and incorporating them into the national strategy for community-based positive prevention. Once they're incorporated into the national strategy, they can be disseminated to all partners for their implementation. This quarter the materials were further refined based on testing during pilot use.

*Activity 2: Establish collaboration with NACP on the proposed strategy for integrating and strengthening community–based positive prevention, including the plan for piloting the initiative*

The pilot activity was initiated in the previous quarter (March 2009). The NACP has been involved throughout the pilot process and has endorsed the approach. The NACP called for a stakeholders meeting to discuss positive prevention and formed a taskforce to develop a national strategy for positive prevention at the facility and community levels.

**Objective 1.2: Expand positive prevention components integrated within the national policy for HBC services**

*Activity 1: Incorporate the community-based positive prevention component within the national guidelines for home-based care services*

A community-based positive prevention component has been incorporated into the current revision of the HBC national guidelines, which was submitted this quarter to the NACP for final approval.

*Activity 2: Revise the draft home–based care recording and reporting tools for monitoring HBC activities to include positive prevention as one of the standard activities*

The activity will be included in next year's plan as the existing national monitoring HBC tools were recently revised before the positive prevention project started.

**Objective 2: Two–pronged strategy for further integrating and strengthening positive prevention at the community level developed**

FHI is implementing the community-based positive prevention project through a two-pronged strategy of first integrating a standardized package of positive prevention services through HBC and second is capacity building of HBC providers and PLHIV support group members to be able to educate, motivate and support PLHIV in practicing positive prevention. As noted in objective 1.1 above, the NACP called for a stakeholders meeting to discuss positive prevention and formed a taskforce to

develop a national strategy for positive prevention at the facility and community levels.

***Objective 2.1: Materials for building capacity and quality improvement of HBC in positive prevention developed***

*Activity 1: Draft a positive prevention training module for HBC providers*

This activity was completed in the quarter ending March 2009 and submitted to the NACP.

*Activity 2: Develop a protocol and materials for conducting ongoing quality improvement of positive prevention delivered by HBC*

Community-based positive prevention supportive supervision tools have been developed and are being revised based on field testing findings.

***Objective 2.2: Build the capacity of PLHIV support group members***

*Activity 1: Adapt a positive prevention training module for PLHIV support groups*

This activity was completed in the quarter ending March 2009. The training material was developed, adapted and submitted to the NACP.

***Objective 3: A six-month initiation of community-based positive prevention interventions conducted, operational assessment outcomes reported and next steps defined.***

***Objective 3.1: Six-month initial phase of positive prevention interventions for HBC providers, PLHIV support groups and HIV+ youth conducted***

The community-based positive prevention interventions for the initial phase were defined and initiated, and four sites for implementing the project were selected. The project has been positively accepted in the communities as many people want to be enrolled. In this quarter, FHI enrolled a total of 1,401 PLHIV (M 492, F 909) among them, 29.5% were PLHIV HIV+ youth (M 158, F 255). Please see Appendix B for further details on numbers reached. There is an ongoing supply of most commodities to new and old clients who are enrolled in this project. However, cotrimoxazole continues to be a great challenge as the medicine is not available in HBC kits and health facilities.

*Activity 1: Identify and prepare four sites to pilot positive prevention interventions for HBC and PLHIV groups and two FHI-supported sites for positive prevention targeting HIV+ youth*

The sites for implementing the positive prevention pilot were identified: three are Tunajali-supported districts (Mvomero, Morogoro urban, and Kilolo) and one is a FHI/ROADS-supported district (Njombe - Makambako). A training was conducted in May 2009 with 100 HBC providers, 100 PLHIV support group members, and 12 HBC supervisors trained to build their capacity in positive prevention services.

### *Activity 2: Pilot the positive prevention intervention for HBC*

Tunajali staff visit HBC providers and supervisors every month and conduct focus-group discussions at all four pilot sites to gather feedback on the delivery of positive prevention services and to mentor the volunteers and supervisors on positive prevention. They also visit selected clients/ beneficiaries to assess their acceptance of the positive prevention-related services provided by the HBC volunteers as well as provision of relevant commodities.

### *Activity 3: Pilot the positive prevention intervention for local PLHIV support groups*

Tunajali staff also visited local PLHIV support groups participating in the positive prevention pilot on a monthly basis to gather information and insights into their experiences supporting their peers on positive prevention.

### *Relevant to activities 2 and 3 above:*

The agenda for the focus-group meetings that were conducted with HBC providers/supervisors and PLHIV support group members included the following:

- Discuss the acceptance of positive prevention services among clients and the community
- Discuss successes and challenges that they are facing in implementing positive prevention-related services or activities
- Discuss receiving, distributing and storing positive prevention commodities and materials and filling out the distribution books
- Review the three components of positive prevention
- Share experiences and daily accomplishments among HBC volunteers and PLHIV support group members

A summary of findings from the assessment/mentoring visits with HBC providers/supervisors and PLHIV support group members with a focus on current successes, challenges and observations follows:

#### a) Successes mentioned during the meetings included the following:

- Positive prevention enables clients to live positively.
- There is a reduction of infections and diarrheal diseases at all sites due to the use of treated water and bed nets.
- It has been reported that clients are adhering well to ARV treatment.
- The project has been well accepted in the community as many clients want to be enrolled.
- The positive prevention initiative promotes testing and disclosure to partners and families.
- Male condom use has been accepted positively.
- PLHIV group members have been increased and some have been able to start small enterprise activities.
- Almost all volunteers and PLHIV support group members managed to identify and enroll clients in the program. Providers from all sites have enrolled an

average of 10–20 clients each while PLHIV support group members have enrolled an average of 5–10 clients each.

- The positive prevention initiative enhances the provision of care and support to PLHIV, and government authority recognizes the program.
- More clients are requesting to be enrolled in the program.

b) Challenges as they were presented at all four implementing sites.

- The providers and support group members have been asking about the availability of cotrimoxazole in CTCs as well as in the HBC kits. (Please refer to table 5 in the appendix.)
- In some CTCs, there are no CD4 machines and, if present, no reagents. This has been reported at Makambako as most clients delay starting ARV treatment.
- Providers and support group members requested female condoms as they have been encountering some difficulties in handling discordant couples. One female who tested positive was ready to use condoms while her partner was not ready to use condoms.
- Testing children has been a big challenge, especially for parents who have discordant results.

c) Observations from the meetings included the following:

- Some religious leaders have been denying their followers the right to get tested and use ARV treatment.
- There is a need to orient community leaders and religious leaders about the concept and approach of community-based positive prevention as they are good resources in supporting people in the community.
- We might need to have a two- or three-day refresher course for HBC providers and PLHIV support groups to strengthen their knowledge and further build their capacity.
- Youth testing has been a challenge in most of the sites. We need to collaborate closely with the UJANA team for sensitization and support of youth clubs.

### III. APPENDIX

#### A. Success Story

## Celebrating New National Guidelines for Improving the Quality of Services Provided for Tanzania's Most Vulnerable Children

*Thirty-one youth ages 12–19 from eight regions of Tanzania came to Morogoro in March 2009 for an unprecedented two-day workshop that provided their expert feedback on services that the country's most vulnerable children receive and how to improve them.*

Until recently, Tanzania did not have national guidelines or quality standards on services that must be provided for its most vulnerable children. This absence created opportunities for wide variations in the content and quality of the services provided by implementing partners.

Supported by USAID funding, FHI co-chaired a quality improvement taskforce providing technical and financial support to the Government of Tanzania as it developed national guidelines for improving quality of care, support, and protection for the country's most vulnerable children.

The taskforce's work followed the government's decision to simplify the national framework on quality service standards and enable them to be applied at the point of service delivery.

The guidelines benefited from the input of a representative group of most vulnerable youth ages 12–19 who attended a workshop held in March 2009 on the proposed service standards. A consensus-building workshop with all key stakeholders followed.

International NGOs, including FHI, Pact, Africare, and University Research Co., LLC, provided technical input and comments before the guidelines were finalized in August 2009 by the Ministry of Health and Social Welfare.

The new guidelines provide a direction for quality service provision for Tanzania's most vulnerable children at all levels, offering a range of essential actions that are based on an understanding of children's needs. They also outline illustrative activities that bring change in the lives of the most vulnerable children and other children in vulnerable households.

Dimensions of quality are incorporated. Services and activities are to be assessed in terms of safety, access, effectiveness, technical performance, efficiency, continuity, compassionate relations, appropriateness, participation, and sustainability. The eight main service areas are food and nutrition, shelter, family-based care and support, social protection and security, primary healthcare, psychosocial care and support, education and vocational training, and household economic strengthening.

Referring to the new guidelines, Acting Commissioner for Social Welfare Donald Charwe said, "I really thank all behind this success for the job well done. Let's not keep [the guidelines] on our shelves.... While we celebrate this tremendous success, may I remind you that there shouldn't be a reason to provide services to our children that are substandard."

Mr. Charwe spoke these words at party in September 2009 that marked his retirement and thanked him for his decade of service to Tanzania's most vulnerable children and his ongoing legacy to them.

## B. Positive Prevention Numbers Reached

Table 1: No. of clients enrolled this quarter

Age Category	Male	Female	Total
10 – 24	158	255	413
Above 24	334	654	988
<b>Total</b>	<b>492</b>	<b>909</b>	<b>1,401</b>

Table 2: No. of clients' partners tested this quarter

Age Category	Positive	Negative	Total Tested
Male 15 and above	164	243	407
Female 15 and above	315	362	677
<b>Total</b>	<b>479</b>	<b>605</b>	<b>1,084</b>

Table 3: No. of clients who disclosed status to partners/ family members/ community this quarter

Age Category	Positive	Negative	Total Tested
10 - 24	113	230	343
Above 24	360	639	999
<b>Total</b>	<b>473</b>	<b>869</b>	<b>1,342</b>

Table 4: No. of clients taking medication/ prevent ill - health/ practicing healthy living this quarter

Age & Sex Category	ARVs	Cotrim (Septirne)	Consistent Condom Use	Use of Bed Net Daily	Use of Safe Water (Water Guard)
Males 10 – 24	161	100	72	45	42
Females 10 -24	245	173	118	74	59
Males above 24	342	153	267	239	234
Females above 24	617	290	430	526	490
<b>Total</b>	<b>1,365</b>	<b>716</b>	<b>887</b>	<b>884</b>	<b>825</b>

Table 5: No. of clients who missed doses this quarter

Age & Sex Category	ARVs	Cotrim (Septrin)	TB Drugs
Males 10 – 24	19	12	3
Females 10 – 24	28	33	3
Males above 24	35	103	3
Females above 24	55	216	3
<b>Total</b>	<b>137</b>	<b>364</b>	<b>12</b>