

Annual Report – Year 4 Tanzania Child Survival Project Karatu District, Tanzania

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Abbreviations

ACNM	American College of Nurse Midwives
ADDO	Accredited Drug Dispensing Outlet
ALu	Artemether-lumefantrine
APHA	American Public Health Association
BCC/CM	Behavior Change Communication/Community Mobilization
CEDHA	Center for Educational Development in Health, Arusha
CBHW	Community-based Health Worker
CBO	Community-based Organization
CHMT	Council Health Management Team
C-IMCI	Community Integrated Management of Childhood Illnesses
CORPs	Community-owned Resource Persons (for C-IMCI)
C-to-C	Child-to-Child
CPAR-TZ	Canadian Physicians for Aid and Relief-Tanzania
CS	Child Spacing or Child Survival
DAHA	Datoga and Hadzabe Development Association
DMO	District Medical Officer
FAME	Foundation for African Medicine and Education
FANC	Focused Ante Natal Care
GoT	Government of the United Republic of Tanzania
HBLSS	Home-based Life Saving Skills
HH	Household
HW-IMCI	Health Worker Integrated Management of Childhood Illnesses
IEC	Information/Education/Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide-Treated Net
ISF	Ingeneres sans Frontiers
MAISHA	Men Active in Sustaining Health Action
MFR	Monthly Financial Reports
MoHSW	Ministry of Health and Social Welfare
MSH	Management Services for Health
MST	Marie Stopes Tanzania
NCAA	Ngorongoro Conservation Area Authority
PHAST	Participatory Hygiene and Sanitation Transformation
PPC	Post-Partum Care
RCH	Reproductive and Child Health
STG	Survive and Thrive Group
TBA	Traditional Birth Attendant
TBS	Tanzanian Broadcasting Service
TFDA	Tanzania Food and Drug Administration
ToT	Training of Trainers
TPHA	Tanzania Public Health Association
TZ	United Republic of Tanzania
VEO	Village Executive Officer
VHC	Village Health Committee
VHW	Village Health Worker
VICOBA	Village Cooperative Bank
VWP	Village Wellness Program
WEO	Ward Executive Officer

A. Main Accomplishments

During Year 4, staff and partners focused on MNC and IMCI interventions along with capacity building, M&E and BCC/CM activities with the primary goal of completing the interventions as planned and building a sustainable program. Year 4 also provided an opportunity to address health issues in the most vulnerable populations (including the Hadzabe and Datoga tribes), to work with local communities to develop innovative and sustainable emergency transport (“*Dawa Donkey*” ambulances-*dawa is the Kiswahili word for medicine*) and expand village-level disease surveillance activities (Village Pregnancy Register and Village Vital Statistics Register). By Year 4, all communities throughout the district were supported by the project in the continued implementation of activities.

In close collaboration with the District Council Health Management Team (CHMT), capacity building among community-level cadres has been critical to project success and an essential core activity. Key accomplishments are outlined below:

- **C-IMCI training to 45 CORPS** was provided by the project team, in close collaboration with the CHMT and utilizing MoHSW curricula. Pre- to post-test knowledge increase across the ward-level training was 22% (range 71% to 93% on disease-specific questions).
- Using curricula developed by the ACNM and project staff, the project team provided training to **84 TBAs in HBLSS**.
- **Refresher training of 272 project trained TBAs** was conducted during supervisory visits.
- As reported by the CHMT, every village now has a functioning **VHC or health related management committee** (at baseline, no village-based committees were engaged in health-related activities). By the end of Year 4, **44 VHC/VHMCs and 8 Water and Sanitation Committees** were trained and responsible for the oversight of health facilities and community health-related projects following capacity-building activities provided by project staff, NGO partners and the CHMT.
- **Intensive hygiene and sanitation interventions** conducted in Mang’ola and Baray Wards (October 2009-July 2010) on hygiene and sanitation practices (handwashing, purification of water, proper disposal of feces and access to latrines) **showed increases on key indicators:** handwashing (from 52% to 89.6%), purification of household water (from 49% to 93%), and access to latrines (from 37% to 83%). An additional 1,138 new latrines were constructed in the 8 project villages.
- **Trained 15 health advocates** to provide community-based services to the Hadzabe and Datoga tribes where there is a high incident of malaria, diarrheal disease and pneumonia. Knowledge among the health advocates on prevention of these diseases increased from 56% to 93% following the training.
- **Identification of an additional 12 MAISHA drivers** scheduled for training in October 2010, for a total of 22 drivers providing emergency transport and health education.

Upon completion of capacity building training, community-level cadres used their strengthened skills to improve the health of their communities.

- With leadership from project-trained TBAs and VHCs, more than **320 young pregnant women/new mothers** are enrolled and **participating in Survive and Thrive Groups™** (STGs) in 15 villages. Forty-seven TBAs have received training and refresher training in key health topics, group dynamics and adult education. These groups, which meet twice a month, provide young women with support, health education and income-generating opportunities. Four STGs have received expanded training in micro-finance through the project's collaboration with Orgut-SEDIT-VICOBA, an expert in the field of community-based banking programs.
- Follow-up **secret shopper surveys in 13 drug shops** with project-trained drug shop keepers in Karatu Town and Qangdend village showed 83.3% refer the sick child to the health facility and 68% refused to provide partial doses. Seventy-two percent provided proper treatment for pneumonia, diarrhea and malaria.
- Project-trained **Community-owned Resource Persons (CORPs) provided household-based education to approximately 28,380 families.**
- TBAs provided MNC, ANC and FP education, information and counseling to approximately 15,000 community members and **post-partum care to 97.5%** of mothers reached (n=1177) and their newborns within 72 hours. A total of 99.9% of newborns reached by TBAs received clean cord care and were dried and wrapped in a clean cloth.

Important gaps noted in the project's mid-term evaluation and on-going monitoring and supervision were limited knowledge of danger signs during and after pregnancy and in sick children and limited practice of prevention behaviors. The AFYA 1-2-3 BCC/CM campaign has developed innovative health messaging that reaches not only Karatu district but elsewhere in Tanzania.

- More than **100,700 people have been reached with BCC/IEC messages** during household visits, community events and meetings (e.g. market day events, international health days, national holidays, village-level meetings, etc.). The **flexibility of the AFYA 1-2-3** campaign permits the adaptation of BCC/IEC activities to the seasonal changes in disease patterns and prevalence.
- WellShare, with 100% support from the private sector and district leaders, raised malaria awareness by hosting the third annual ***Ngorongoro Run: The Race Against Malaria*** which attracted 300 national and international runners from East Africa and North America. This year's race included a "Fun Run" which attracted approximately 450 children. WellShare received 10 minutes of donated airtime on two national television stations (TBS and StarTV) and developed a public awareness piece which was aired during March/April 2010. WellShare staff also coordinated education activities at the event including demonstration of use and care of ITNs during every season.
- An additional drama, following two families, **providing information on handwashing has been developed and recorded on DVD.** This drama is shown during community outreach events and has been provided to long-haul public transport buses.
- **Breaking the chain of infection for diarrheal disease** paintings have been displayed at 9 primary schools in Mang'ola and Baray Wards.
- **Child spacing and family planning messages** were highlighted during World Health Day 2010, Day of the African Child 2010 and during all market outreach sessions. Approximately 40,530 people were reached during events on these special days.

Continuing in close collaboration with the CHMT, DMO, village leaders, TBAs, and 10-cell leaders, WellShare’s project staff has implemented **village-level data collection tools** throughout the district to improve district-level data on pregnant women and children under five years of age.

- The project’s **pregnancy monitoring** tool (Village Pregnancy Register), developed in collaboration with the CHMT to collect ANC, delivery and post-partum care information through trained TBAs is now implemented in 86% (38/44) of Karatu’s villages (see Table 1 for highlighted data collected to date July 2008-September 2010).
- The **Village Vital Statistics Register** collects village-level morbidity and mortality information for children under five years of age through community 10-cell leaders (an administrative division at the village level).

Table 1. Summary of Village Pregnancy Register information for 38/44 villages (Karatu Town not included).

Prevention in Pregnancy	(%) n=1177
Pregnant woman attended at least 1 ANC visit	(97.2)
Pregnant women attended 4 or more ANC visits (n=374)*	(78.1)
Pregnant woman received 2 or more TT doses	(89.4)
Pregnant woman received 1 st dose anti-malarials during pregnancy	(93)
	n=864
Pregnant women received 2 nd dose anti-malarials during pregnancy	(44.5)
Delivery	n=868
Baby born at health facility	(42)
Baby received clean cord care	(99.9)
Baby received immediate drying and wrapping	(99.9)
Baby received immediate breastfeeding	(87)86.8
Maternal/Birth Outcomes	n=868
Premature birth	(2.4)
Still birth	(1.6)
Mother/infant visited within 72 hours post partum	(97.5)
Baby died before 28 days after birth	(0.46)
Mother died before 28 days after birth	(0.11)

*Data collected from 30 villages Feb – August 2010

Overall, WellShare International’s approach through the Tanzania Child Survival Project is country-driven, with its goals, objectives and activities consistent with Tanzania’s overall primary health care and public health initiatives including improving MNC and case management of childhood illness. WellShare has taken a lead role in the support of local CBOs and NGOs, partner agencies and public/private partnerships (see Section J), supporting USAID’s revised focus on local partnerships and country-driven programs. WellShare’s approach, working at community-level, adhering to sustainable and replicable public health principles, building strong ties with the community, and identifying community health needs and priorities has had dramatic effects on the health practices of the communities served (see Annex 1, Table 3).

B. Activity Status

Table 2 below details the status of project activities. See Annex 1 for specific project indicators and progress-to-date.

Table 2. Status of project activities.

Project Objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
Maternal and Newborn Care			
Strategic Objective / Result I. Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.	MNC/child spacing training for HW	On target	34 HWs trained in MNC/CS
	MNC/child spacing training for community cadres	On target	930 community volunteers including TBAs, STG members, VHC members, leaders, Hadzabe and Datoga Health Advocates, etc.
	HBLSS training	On target	84 Focal TBAs trained
	Healthy Mothers, Healthy Babies Centers	Completed	Karatu's HM/HB Center completed; 5 community centers completed.
	BCC/IEC activities	On target	40,530 community members received messages (including HH visits)
Child Spacing			
Strategic Objective / Result II. Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.	MNC/child spacing training for HW	On target	34 HWs trained in HBLSS, MNC, and/or FP
	MNC/child spacing training for community cadres	On target	Training and refresher training of 272 TBAs, 320 STG members, 235 C-IMCI CORPs and 323 community leaders
	BCC/IEC activities	On target	AFYA1-2-3 messages during market days, community events, project-produced DVD provided to approximately 40,530 district residents.
Malaria, Control of Diarrheal Diseases and ARI/Pneumonia			
Strategic Objective / Result III. The impact of malaria, diarrheal disease and pneumonia in infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.	C-IMCI orientation for HW	Not yet on target	5 HWs trained in year 4; C-IMCI training suspended in 2010 as the government prepared revised training materials in conjunction with UNICEF and other donor agencies. Printing of revised materials is not yet completed.
	C-IMCI training for community cadres	Not yet on target	3 wards and 10 villages remain untrained. 30 CORPs and 15 Ward level ToTs trained.
	Hygiene and Sanitation training for community cadres	On target	30 PHAST Facilitators trained; 34 teachers trained in Child-to-Child; 800 student members of school health clubs trained; 120 members of Village Water and Sanitation Committees trained
	BCC/IEC activities	On target	60,230 residents reached with AFYA 1-2-3 messages at HH, community level, during markets/special days, etc. Immediate response in support of CHMT during 2 cholera outbreaks in Mang'ola and Endamarariek.

Capacity-Building			
Each project community establishes a VHC that is well-linked to the beneficiary population.	Mobilization and sensitization meetings held with community leaders, capacity building on VHC roles/responsibilities	On target	44 VHCs/Village Health Management Committees and 8 Water and Sanitation Committees formed in all project villages (excluding Karatu Town).
VHCs develop and manage emergency transportation funds.		On target	Village Councils are identifying options for provision of emergency transport funds in local budgets; additional ambulances available at 3 health centers for a total of 6 district-wide; identification of 5 most isolated villages to receive “dawa donkeys”. Increased enforcement of government policy of free ambulance transport for pregnant women.
Community-health facility connections are strengthened.	Close collaboration between VHC, VHMC and HFs where applicable.	On target	Inclusion of HF staff in all TBA, C-IMCI trainings
The quality and consistency of health worker supervision is increased.	Quarterly supervisory visits.	On target	Collaboration with CHMT, facility-based HWs on HW supervision
CHMT uses HMIS data to inform District Health Reports and Plans.	HW/VHC training on importance of data collection and accuracy of data.	On target	HMIS data is used to complete all reports and planning documents.
A training function is established within the CHMT for IMCI.	Collaboration with CHMT, CEDHA and District Council in the planning for on-going IMCI training for HWs and community CORPs.	On target	District IMCI-Coordinator oversees planning and implementation of all IMCI training
Sustainability			
The quality/consistency of HW supervision established during the project is maintained.	Capacity-building of CHMT.	On target	Logistic challenges remain when planning supervision in conjunction with the CHMT.
The results/IRs achieved by Phase I end will be maintained w/in 10% at EOP.		On target where measured	

C. Factors Impeding/Facilitating Progress

At the project site, the key factors impeding progress remain:

1) Available human resources; 2) Logistics within the project area; 3) Preparations for national elections; 4) Changes/redefining of government policy and priorities; and, 5) Creation of eight additional villages within the boundaries of Karatu District.

Factors facilitating progress include close collaboration at the community level, built on the foundation of training strong cadres of community volunteers (i.e. TBAs, CORPs and PHAST Facilitators). The WellShare team has developed a robust network of support within the district leadership at all levels which is key to the successful implementation and projected sustainability of the project's interventions. Realistic expectations and appropriate support to community needs, within the parameters of the DIP, have provided opportunity to facilitate positive change at community and household levels.

1. Available human resources

The greatest human resource challenge faced by the project has been the transitioning of monitoring and supervision activities from project staff to the appropriate members of the CHMT. Day-to-day demands plus the effect of new and expanded donor programs have resulted in CHMT members unavailability during a majority of quarterly monitoring and supervision visits. Other trained members of the District Council have been mobilized to participate in C-IMCI monitoring activities and local health facility staff have assisted in the monitoring and supervision of trained TBAs.

The Government of Tanzania mandate to construct health facilities in every village has taken resources (both human and financial) from the target communities. Spurred by Millennium Development Goals, this has become a top priority for VHC members and will continue to have an effect on project community mobilization and education activities. To provide trained staff for these new facilities, the Karatu district government, in partnership with the Lutheran and Catholic Diocese, are currently constructing a training center for clinical officers and nurses.

2. Logistics

The project area has limited infrastructure and severe road conditions. Identification of appropriate training locations accessible to all participants has been difficult. The lack of infrastructure will have a negative effect on project sustainability.

3. Preparations for National Elections

In August 2010, Tanzania dissolved its Parliament in preparations for the October 31st national elections. All US-government funded programs were asked to maintain a low-profile during this period. WellShare continued on-going community activities but recognized the importance of curtailing and postponing some activities to ensure that there would be no perceived political preference.

4. Policy changes

The government's policy of establishing Accredited Drug Dispensing Outlets, ADDOs, has been in the district's plan since 2009. This policy change required WellShare to discontinue training of drug shop keepers, although progress has been maintained from the initial training.

5. Creation of new villages

The Karatu District Council created eight additional villages in the project district. This has proposed a challenge in the training of new village leaders and the formation of new VHC/VHMCs. The project has trained members of each of the new villages (including TBAs, CORPs and PHAST Facilitators) prior to the division, but there has been a request for additional training for cadres in the newly delineated villages. There are, however, no additional funds available at this time to provide the requested capacity building.

D. Areas for Technical Assistance

Technical assistance needs include 1) assisting the CHMT in improving the district health management and information systems and 2) identifying income generation activities for Survive and Thrive Groups. There is also a continuing need for technical expertise in the area of audio visual production (i.e. movie making and audio recording). WellShare is expanding recruitment for international volunteers with appropriate technical expertise. As an active member of the CORE Group, the project receives valuable technical assistance and access to partner agencies worldwide.

E. Substantial Changes from the DIP

This section is not applicable to the Year 4 Annual Report.

F. Sustainability and Phase Out Plan

Sustainability for the project is primarily focused on building capacity within government-supported structures at community level (VHC, TBA and VHW) and health facility level (HW and CHMT). Training, supervision, behavior change and monitoring and evaluation are planned in collaboration with the CHMT and village-level cadres to ensure capacity-building and ownership of project goals and outcomes at multiple levels. This approach has been very successful thus far.

To measure sustainability, the project continues to adopt components of the CSTS+ Child Survival Sustainability Assessment framework as noted in the Mid-Term Evaluation (Year 3 Report).

The project staff will work closely with the DMO and his CHMT to ensure the smooth transition of project activities during the phase out period. With the exception of innovative and pilot activities (i.e. training of "tribal health advocates" within the Hadzabe and Datoga tribes, the Ngorongoro Run and "Dawa Donkeys), all project activities have been an integral part of the district's health plan since inception. It is anticipated that STGs will be self-reliant and closely tied to partner NGOs (i.e. Orgut-SEDI-VICOBA) in support of income generation activities prior to September 2011. Continued support of PHAST and Child-to-Child (C-to-C) activities have been written into the Districts Comprehensive Health Plan and Education Plan.

In Year 5, WellShare staff will focus on the handover of project activities and full supervision of community cadres to active VHC/VHMCs for continued implementation. TBAs currently provide monthly reports to existing health facilities and have established referral mechanisms with nurses and nurse midwives. CORPs and PHAST Facilitators currently provide reports to project-trained VEOs. Community volunteers (including CORPs, TBAs, PHAST Facilitators) receive compensation for their work through village budgets or are excused from other community development projects.

G. Specific Information Requested

No specific information was requested following submission of the project's Mid-Term Evaluation.

I. Management System

No substantial changes have occurred with project management systems. WellShare undertook staff capacity building activities, particularly around finances and M & E during 2010.

J. Local Partner Organization Collaboration and Capacity Building

Strong partnerships with political and government leaders have enhanced project success by increasing promotion of project interventions through the district. For example, the District Commissioner led the creation of a planning committee for the Ngorongoro Run, and actively disseminates key project messages as he travels throughout the district. This has also been true of leaders at the highest levels, including the District's Member of Parliament, Executive Director and Council Chairperson.

The project's collaborative and complementary partnership with the CHMT continues to reap rewards with the project's interventions strengthening existing district programs and being incorporated into the continued planning process of the District. Project interventions, including the development of new village pregnancy and disease surveillance systems have strong support from the CHMT and are assisting the CHMT in better planning and care provision throughout the district.

Overall, continued partnership with district leaders and other stakeholders has increased the effectiveness, sustainability and reach of the project. During year 4 of project implementation, key and new collaborative partnership activities have included those outlined below.

- WellShare continues to support and is an active member of the **Karatu District Stakeholders Committee** focused on coordination of health activities throughout the district. This committee is headed by the DMO and meets quarterly to increase collaboration and decrease duplication of services.
- **Continued collaboration with two partner agencies** providing health services in the District (FAME and the Village Wellness Program) increasing access to communities through the coordination of community education sessions during outreach clinics. WellShare has provided technical assistance in the area of community education and

technical support and has assisted in building capacity in these two local organizations in the facilitation of joint field activities and in the training of staff in technical and programmatic topics.

- **Continued collaboration with CPAR-TZ and MST** in the provision of sexual and reproductive health training, increasing access to FP at the community level, and C-IMCI services for women living with HIV/AIDS.
- **Collaboration with ISF** in the expansion of hygiene and sanitation education and training in 9 villages of Mang'ola and Baray Wards. This intervention included education on village-level hygiene and sanitation by-laws and their enforcement.
- **MSH/VLDP M&E Training** was facilitated by the WellShare Team and included representatives from the CHMT (including the DMO), WellShare, CPAR-TZ, ISF and Village Wellness Program.
- **Collaboration with EGPAF** in the provision of IMCI training and support to the district's newly formed HIV Children's Club. The Club conducts monthly activities at the District's Healthy Mothers/Healthy Babies Center (which was created in partnership with WellShare).
- **Newly formed collaboration with Rift Valley Children's Fund** in the provision of community training for vulnerable populations (including orphans and female coffee plantation workers) in the prevention of malaria, diarrheal disease and pneumonia and sexual and reproductive health in Oldeani Ward.
- **Expanded collaboration** with the Datoga and Hadzabe Development Association (DAHA) for the development of training materials and modules for training "health advocates" who provide information on basic disease prevention and sexual and reproductive health to Datoga and Hadzabe communities in Mang'ola and Baray Wards. WellShare staff have worked hard building capacity and strengthening ties with the DAHA as a way to improve the health status of one of Tanzania's most vulnerable and underserved groups, the Hadzabe. Through support of DAHA, the cultivation of relationships with tribal leaders, and the project's decision to work first with Hadzabe children through their school's health clubs, WellShare was invited to train "tribal health advocates" in July 2010. The developed curriculum provided basic information on the community's top health priorities: ARI, malaria, diarrheal disease, HIV/STIs, MNC and substance abuse. Utilizing the AFYA 1-2-3 model, three key prevention messages were developed in each subject area and health advocates were given appropriate training and materials.
- **New collaboration with Orgut-SEDI-VICOBA** in the provision of training materials, technical expertise, program materials and training for STG-related micro-finance activities.
- **Close collaboration with the CHMT and PathFinder and MEDA** in the monitoring and supervision of ITN distribution during the under 5 "catch-up" campaign conducted in Arusha Region in January/February, 2010.

K. USAID Mission Collaboration

The project remains an active partner in contributing to the Mission's overall health objectives as noted in the project's Detailed Implementation Plan. The project interventions and activities are in-line with the goals of the Mission in support of the MoHSW. Importantly, WellShare's CS

project focuses on MNC services, an area of increased interest to the GoT, international partners, and the Mission.

The project reports regularly, is in e-mail communication with, and has met with the (former) Health and Population Officer, Mr. Charles Llewellyn and the Acting Health and Population Officer, Mr. Andrew Rebold, during trips to Dar es Salaam. Prior to his retirement, Mr. Llewellyn made recommendations to the Country Director on establishing collaborative relations/collaborations with other USAID-funded programs and provided valuable insight into the work of these programs. WellShare will continue to work closely with the Mission to ensure our project activities are in line with the objectives of the President's Malaria Initiative and Global Fund.

Karatu District is supported by three USAID-funded NGOs: PATH, PathFinder and EGPAF in the provision of home-based care and HIV VCT/PMTCT programs. Through the training of TBAs and communities on the importance of PMTCT, WellShare assists EGPAF activities through the CHMT, especially the newly formed HIV Children's Club. WellShare collaborates, where appropriate, with PathFinder and PATH through coordination of activities during the quarterly stakeholder meetings.

Annex 1: M & E Tables

Table 1. Training activities for Year 4.

Training	Cadre/number trained	Village(s)/Ward(s)
HBLSS	84 Focal TBAs in HBLSS TOT	Ward level training; 2 TBAs per village
MNC/Safe delivery training Follow-up and refresher training	272 Traditional Birth Attendants	All trained TBAs received refresher training during M&S visits
C-IMCI ToT	15 Ward Leaders	Buger Ward
C-IMCI	30 Village members	Buger, Ayalalio, Endanywet
C-IMCI	5 Health Workers	Buger Ward
C-IMCI ToT	3 Village Executive Officers; 3 Village Chairman and 1 Ward Executive Officer	Buger, Ayalalio, Endanywet
IMCI/MNC/Child Spacing (Health Advocates)	15 Hadzabe and Datoga community members	Mang'ola and Baray Wards
MNC and child health orientation	323 ward and village council members	Refresher training for all wards and villages
C-IMCI Advocacy training	323 ward and village council members	Refresher training for all wards and villages
IMCI/Child Spacing-Refresher training	10 MAISHA Drivers	Karatu Town (Mang'ola drivers)
Emergency care of the newborn	15 HWs, TBAs, CORPs	Kambi ya Simba village
Sexual and Reproductive Health	13 drama troupe members	Oldeani village
Control of diarrheal disease and promotion of hygiene and sanitation	13 drama troupe members	Mang'ola and Baray Wards
FP, sexual and reproductive health	11 staff members and community health providers	Karatu Town
M&E Training – data analysis and use of data for program development/reporting	22 staff members	Karatu office
Income generation and business skills	120 STG members	Jobaj, Malekchand, Lagangarare, Makhooromba
Family nutrition and income generation	60 STG women	Kambi ya Simba, Malekchand, Lagangarare

Table 2. Training by cadre to date.

TRAINING TOPICS		NUMBER OF TRAINEES PER TOPIC OVER LIFE OF PROJECT															FACILITATOR(S)		
				Health Facility Staff				VHC			TBAs								
		Senior MIHV Field Staff (12)	CHMT (10)	Med Officers (1)	Clinical Officers (24)	Nurses (83)	Nurse Midwives (65)	Chairs (45)	Others (405)	VHWs (90)	STG Leaders (55)	Others (45)	Drug Vendors (75)	MAISHA Educators (90)	District Council/Ward Executives	NGOs/Other Stakeholders	TOTAL Trainees	TOTAL Trained to date (cumulative)	
Capacity Building Topics	DIP Workshop	14	10	1	12										30	40	107	105	WellSh.C HMT, DMO
	TOT Training (IMCI, C- IMCI, MNC, HBLSS, AMSTL, Child Spacing, Monitoring and Supervision)	12	10	1	12	24											59	174	WellSh., TS, CHMT, ACNM
	Committee Leadership	8	7					45			55						115	170	TS, CHMT
	Community Mobil. /IEC Training (Adult education methods, communication)	12	10	1	24	83	65	45			55		15	10			320	402	TS, CHMT,
	Basic Computer skills (word processing, internet, data analysis)	3	5														8	37	WellSh.

	Managerial training	5	10	1	24											40	16	TS, MoHSW, MSH
	Grant writing skills	5	5											5	5	20	17	MSH
	Program Supervision	5	5					45						5	5	65	82	TS, MSH
Community Sensitization and Mobilization	Project Orientation (C-IMCI orientation, MNC/Child spacing orientation, health surveillance orientation, familiarization with project goals, interventions and plans)							45		55	45		59		13	217	867	MIHV Staff
Technical Topics	MNC/CS Training for HW	6	4	1	24	83	65									183	140	DMO, MoHSW,
	MNC/CS Training - Comm. Cadre	6	4					45	405	90	55	45	75	90		815	1498	DMO, MoHSW, TS
	HBLSS Training	6	4	1	24	18	65		45		55	45				263	318	ACNM, TS, WellSh.
	IMCI for Health Workers	5	4	1	24	83	65									182	116	MoHSW, CEDHA
	IMCI TOT	2	5	1	2											10	6	CEDHA
	C-IMCI Orientation for HW	5	4	1	24	83	65									182	120	MoHSW, CEDHA
	C-IMCI for Community Cadres	5	4						45	405	90	55	45	75	90		814	1148
	Health Surveillance*	5	10					45	200	90					30	380	1358	TS, CHMT
	Sexual and Reproductive Health	5	5	1	24											35	49	CPAR, TS

Table 3. Detailed project objectives, key activities and status of activities.

The project utilizes a variety of data tools to monitor activities at the community level. During the baseline survey a 30-cluster KPC was conducted. Mid-term evaluation utilized the LQAS method. LQAS was also used during surveys conducted in year 4.

Additionally, the project has introduced a Village Level Pregnancy Register (VPR) to collect data on women accessing education, counseling and services through project-trained TBAs. Data collected from the VPR provides supplemental monitoring of MNC indicators. Since August 2009, the VPR has followed 1,177 pregnant women from their first encounter with the TBA to 42 days post-partum. To date, 864 women have delivered 868 babies. In December 2010, changes were made in the collection of ANC visit data to determine number of visits (1-4) instead of attending any ANC visits (yes/no). This change is reflected in Objective I.A.1 and data was collected in 30 villages. All other data was collected in 38 villages. The data reported here reflects data collected from August 2009 to August 2010.

During implementation of an expanded hygiene and sanitation program in 9 villages of Mang’ola and Baray Wards (an area where cholera outbreaks have occurred), a baseline and final survey was conducted. The questionnaire developed for these surveys included key questions from the baseline KPC survey related to handwashing and purification of water.

Table 3.

PROJECT OBJECTIVES	BASELINE % (CL) KPC (N=323)	MIDTERM (LQAS)	UPDATE (Varied data sources)	EOP Target	KEY ACTIVITIES	COMMENTS
Maternal and Newborn Care						
<i>Result I. Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.</i>						
I.A.1. Increase % of mothers who attended 4 or more ANC sessions during their most recent pregnancy from 39.1% to 70%.	39.1 (32.0,46.1)	48%	78% VPR (N=374, 30 villages)	70%	Formation of Survive and Thrive Groups (STGs).	320 women received training during monthly meetings in 15 groups 47 trained TBA facilitators for STGs received group leadership/adult education training. Curriculum developed by MNC Manager and Training Coordinator.

						Village level Pregnancy Register implemented in 38 villages for collection of data.
					AFYA 1-2-3 MNC campaign.	AFYA 1-2-3 Campaign and IEC messages provided via community video shows, market day performances and at special days (e.g. Day of the African Child, Worker's Day etc.) targeted approx.40,530 community members.
					HW training on MNC.	The project MNC Manager is currently coordinating MNC training with CHMT (RCH Coordinator) for HW including nurses and nurse midwives.
					Healthy Mothers/Healthy Babies Centers at District Health Centers.	Renovations are completed on all Healthy Mothers/Healthy Babies Centers.
I.A.2. Increase % of health workers who counsel ANC clients on the importance of developing a safe birthing plan, the importance of delaying their next pregnancy for at least 36 months and refer for VCT from xx% to xx%.	TBD	N/A	Not available	90%	Coordination with CHMT for VCT and PMTCT referrals.	100% of pregnant women, according to protocol, are counseled and tested for HIV, receive information on birth planning and FP during their first ANC visit (97.2% of women attended at least one ANC visit-VPR data). HFA and client survey to be conducted in year 5.
					Healthy Mothers/Healthy Babies Centers	Renovations complete
					HW training on MNC.	3 HWs training in MNC topics.
I.A.3. Increase % of mothers with children 0-23 months who	78.9 (72.4, 85.3)	N/A	89.4% VPR (N=1177)	85%	Review of quarterly health facility reports.	Data collected from VPR.
					Training of TBAs on	272 TBAs received refresher training.

received at least 2 tetanus toxoid vaccinations before the birth of their youngest child from 78.9% to 85%.					the importance of ANC and TT vaccine.	
					Training of VHC members and VHWs on the importance of ANC and TT vaccine.	The role of the TBA, VHW and VHC has been expanded to encourage pregnant women to attend ANC and access available TT vaccine.
					Community and family-targeted BCC on ANC services.	AFYA 1-2-3 MNC messages on importance of ANC.
					AFYA 1-2-3 BCC campaign messages on planning and supporting safe deliveries.	Community IEC campaigns and TBA, CORPs education activities have reached more than 40,530 people
I.B.1. Increase % of children whose births were attended by a skilled health provider from 70% to 85%.	69.7 (61.6, 77.9)	85%	Not available	85%	Training of TBAs on HBLSS.	272 trained TBAs received refresher training during follow-up visits. 47 TBAs trained in HBLSS for implementation during STG meetings. 84 TBAs trained as trainers in HBLSS. The project continues to focus on increasing births at health facilities.
					Provision of safe birthing kits and equipment for EmOC at health facilities.	All trained TBAs provided with safe birthing kits containing MoHSW required items. Ongoing discussions with local funding sources to support EmOC services.
					Mothers develop safe-birthing plans.	TBAs counseling mothers on the importance of safe birthing plans.
					VHCs develop emergency transport funds.	Village Councils have not yet allocated funds. Working with VHCs to implement and to introduce alternate methods of transport (i.e. "Dawa Donkey")
					HW training of MNC, AMSTL, HBLSS.	Project trained TBAs introduced to HWs at nearest health facilities. Area HWs are invited

						to attend the first day of TBA training.
					VHC, VHW training.	30 CORPs, 272 TBAs and 323 ward and village leaders trained or refresher trained
I.B.1b. Increase % of children who births were attended by a skilled health provider or HBLSS-trained health worker from 70% to 85%.	69.7 (61.6, 77.9)	85%	99.9% VPR (N=864)	85%	HW training on MNC.	84 TBAs trained as ToTs in HBLSS
I.B.2. Increase % of mothers of children 0-23 months who received AMTSL during the birth of her youngest child from 28.1% to 40%.	28.1 (21.6, 34.6)	Not available	Not available	40%	TBA training on referral services.	272 TBAs introduced to HWs. TBA referral card designed currently undergoing field testing. Introduction and training of all TBAs on VPR. Project plans to conduct follow-up HFA during Year 5
					HW and TBA training on MNC.	The project exceeded its objective of training 90 TBA as stated in the DIP. However, the high priority of MNC within the framework of the project, the demand for TBA training and the important role played by the TBA in the provision of MNC has made it necessary to revise the anticipated number of TBAs trained and to determine ways to utilize them to their greatest potential.
I.B.3. Increase % of children 0-23 months who were dried and wrapped with a warm cloth or blanket immediately after birth from 37.2% to 60%.	37.2 (30.0, 44.5)	86%	99.9% VPR (N=868)	60%	HW and TBA training on MNC.	100% of project-trained TBAs receive training on safe delivery and referral services.
I.B.4. Increase % of	54.3 (46.1,	98%	99.9%	70%	Provision of safe	100% of project-trained TBAs receive safe

children 0-23 months who had clean cord care at the time of birth from 54.3% to 70%.	62.4)		VPR (N=868)		birthing kits to project trained TBAs.	birthing kits and additional supplies provided by project and CHMT.
					BCC campaign promoting PPC.	AFYA 1-2-3 campaign messages developed on MNC including importance of PPC.
I.C.1. Increase % of mothers who received PPC within 72 hours of their most recent delivery from 19.6% to 40%.	19.6 (13.9, 25.2)	92%	97.5% VPR (N=864)	40%	TBA training on MNC including PPC.	100% of project-trained TBAs receive safe birthing kits and additional supplies provided by project and CHMT.
					VHC training on MNC and the importance of PPC.	AFYA 1-2-3 campaign messages developed on MNC including importance of PPC.
					TBA training on MNC and the importance of PPC.	The TBA-mother relationship offers a unique opportunity to link new mothers with PPC within 72 hours of delivery because the TBA is the one who will immediately visit the mother post partum. The linking of the TBA to the HW provides an opportunity for reporting on PP visits at the village level. 272 TBAs have been trained in safe delivery, PPC and referral services. 100% of trained TBAs have received refresher training during follow-up visits.
					BCC campaign promoting PPC.	AFYA 1-2-3 campaign messages developed on MNC including importance of PPC
I.C.2. Increase % of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth from 27.8% to 45%.	27.8 (19.7, 35.8)	92%	97% VPR (N=868)	45%	HW training on MNC including PPC.	34 HWs trained in MNC
					VHC training on MNC and the importance of PPC.	The identification and training of VHWS remains influx as the MoHSW determines their role/responsibilities.
					TBA training on MNC and the importance of PPC.	Follow-up on newly delivered mothers by trained TBAs includes PPC for newborns.
					BCC campaigns on danger signs of newborn focused on	Identification of key messages and sub-messages completed in collaboration with the CHMT. Review continues.

					mothers/family members.	320 STG members receive information. 40,530 community members receive information through AFYA 1-2-3.
I.D.1. Increase % of mothers who are able to list 2 or more neonatal danger signs during the PP period from 26.8% to 50%.	26.8 (18.5, 35.1)	20%	Not available	50%	HW training on MNC, IMCI and C-IMCI.	5 HW trained during ward-level C-IMCI training.
					C-IMCI training for VHCs, TBAs and STG participants.	100% of district villages now have VHC, VHMC or Village W&S committees. 272 TBAs trained in neo-natal danger signs. C-IMCI for 1 ward, 3 villages and 30 community members.
					Healthy Mothers/ Healthy Babies Centers.	Renovations completed.
I.D.1b. Increase the % of men (in intervention programs) who are able to list 2 or more neonatal danger signs during the PP period from xx to 80%.	Indicator dropped based on MTE recommendations (2009)					
I.E.1. Increase % of mothers who are able to list 2 or more danger signs during pregnancy from 17.4% to 45%.	17.4 (11.1, 23.6)	42%	Not available	45%	Same as I.D.1	
I.E.1b. Increase % of men (in intervention programs) who are able to list 2 or more dangers signs during pregnancy from xx% to 80%.	Indicator dropped based on MTE recommendations (2009)					

I.E.2. Increase % of mothers who are able to list 2 or more danger signs during the post-partum period from 17% to 45%.	17.0 (11.2, 22.9)	28%	Not available	45%	Same as I.D.1	
I.E.2b. Increase % of men (in intervention programs) who are able to list 2 or more danger signs during the post-partum period from xx% to 80%.	Indicator dropped based on MTE recommendations (2009)					
Child Spacing						
<i>Result II. Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.</i>						
II.A.1. Increase % of children age 0-23 months that were born at least 36 months after the previous surviving child from 49.8% to 75%.	49.8 (43.4, 56.3)	Not available	Not available	75%	BCC campaigns promoting child spacing.	40,530 community members received BCC/IEC during HH visits, community meetings, market days and special events. A CS/FP video has been provided to long-haul bus drivers. Continued education is needed.
					IEC provided by TBAs and mothers who have successfully delivered after stopping FP to STG members and the general population.	272 TBAs trained in child spacing referral and education, 272 project-trained TBAs during refresher and supervisory visits. LQAS survey to be conducted in November 2010.
					Promotion of effective traditional child spacing methods.	OR planned on traditional child spacing methods.
					Condom promotion provided by MAISHA	10 MAISHA drivers received refresher training

					participants.	
					Health Mothers/Health Babies Centers.	Renovations completed
					Community BCC campaigns on FP methods, stressing the importance of child spacing. MAISHA and STG members receiving IEC.	40,530 community members received BCC/IEC during HH visits, community meetings, market days and special events. 10 MAISHA drivers received refresher training 320 STG members receive training during monthly meetings.
II.A.2. Increase % of non-pregnant mothers of children 0-23 months who desire no children in the next two years OR are not sure AND who are using a modern method of child spacing from 31.4% to 50%.	31.4 (24.7, 38.0)	39%	52%* Based on CHMT reported data and collaboration with MST	50%	Training of TBAs, VHCs, VHWs on modern methods of child spacing.	272 TBAs and 30 new and 400 existing C-IMCI-trained CORPs received refresher training on FP/CS methods during supervisory visits. LQAS survey to be conducted in November 2010.
					Drug shopkeeper training on FP methods	Suspended due to changes in government policy
					Coordination with, Marie Stopes TZ, CPAR TZ, and the CHMT to ensure continued supplies of FP methods through the district.	Collaborative meetings held with CPAR-TZ, Marie Stopes Tanzania and the CHMT. Note: There seems to be no problem of access and/or supply of FP methods, all campaigns focus on increasing demand for the services.
					Healthy Mothers/Healthy Babies Centers	Renovations complete.
					Community targeted IEC campaign to promote child spacing.	40,530 community members receive BCC/IEC through HH visits, community meetings, market days and special events.

II.A.3. Increase % of mothers of children 0-23 months who report talking with their partner about family planning methods from 51.2% to 70%.	51.2 (41.7, 60.7)	31%	Not available	70%	IEC provided to MAISHA and STG members.	10 MAISHA drivers received refresher training; 12 additional drivers identified for training in October 2010. 320 STG members provided with FP/CS information LQAS survey to be conducted in November 2010.
Malaria						
<i>Result III. The impact of malaria, diarrheal disease and pneumonia on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>						
III.A.3. Increase % of children 0-23 months who slept under an insecticide-treated bed net the previous night from 56.2% to 75%.	56.2 (46.7, 65.6)	66%	Not available	75%	Drug shopkeeper training	Drug shopkeeper training suspended due to changes in government policy. Collaboration with CHMT during distribution of ITNs during under 5 “catch up” campaign and other PMI/NMCP activities.
					Community IEC campaigns promoting the use of ITNs for children and pregnant women and appropriate treatment.	AFYA 1-2-3 malaria campaign provides prevention information to 60,230 community members through HH visits, community meetings, market days and special events . 3 rd Annual “Ngorongoro Run-The Race Against Malaria” held April 10, 2010. (6,000 community members received information during this event).
					Healthy Mothers/ Healthy Babies Centers.	Renovations complete
					HW IMCI training and supervision.	5 HW trained in C-IMCI. Quarterly supervision of 430 C-IMCI CORPs.
III.A.4. Increase % of mothers who received IPTp at least twice	19.6 (14.2, 24.9)	28%	44.5% VPR (N=864)	50%	Community IEC campaign promoting ANC.	IEC campaign on IPTp.

during their most recent pregnancy from 19.6% to 50%.					TBA malaria training	272 TBAs received refresher training in MNC with information on IPTp during pregnancy.
					C-IMCI and MNC training and supervision.	272 TBAs trained in MNC with information on importance of ITNs during pregnancy. 323 community leaders, 430 CORPs trained in C-IMCI. Supervision provided by District IMCI Trainers, CHMT's IMCI Coordinator and project staff.
					Community IEC campaign promoting the use of ITNs during pregnancy.	AFYA 1-2-3 malaria campaign includes importance of pregnant women sleeping under an ITN. Malaria marathon held April 17, 2010 The project has provided information on ITNs to 60, 230 community members through HH visits, community meetings, market days and special events.
III.A.5. Increase % of mothers of children 0-23 months who always or usually slept under an ITN during their pregnancy with the youngest child from 18.6% to 50%.	18.6 (11.9, 25.3)	52%	Not available	50%	Community IEC campaign promoting the use of ITNs during pregnancy.	AFYA 1-2-3 malaria campaign includes importance of pregnant women sleeping under a bednet. Malaria marathon held April 10, 2010 The project has provided information on ITNs to a wide audience including through the private sector.
					Community IEC campaign promoting the use of ITNs during pregnancy.	AFYA 1-2-3 malaria campaign includes importance of pregnant women sleeping under a bednet. Malaria marathon held April 10, 2010 The project has provided information on ITNs to a wide audience including through the private sector.
Control of Diarrheal Diseases						
<i>Result III. The impact of malaria, diarrheal disease and pneumonia on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>						
III.A.1. Increase % of mothers of children 0-23 who live in a household with soap or	0.0 (0, 0)	11%	95.1% (N=310) Based on final	30%	Community IEC campaigns promoting personal and household hygiene.	CDD drama DVD created and distributed to long-haul bus transport company.

a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview from 0% to 30%.			evaluation in Mang'ola and Baray wards		Training of VHCs, District Water Department, DHO and CHMT on promotion of household hand washing areas.	25 PHAST Facilitators trained in Mang'ola and Baray Wards. 800 children trained in C-to-C; 34 teachers trained in C-to-C
					Healthy Mothers/ Healthy Babies Centers.	Renovations complete
					Collaboration with ISF-trained cadres, CPAR-TZ, District Water Department, DHO and CHMT to promote safe water sources, latrine use, handwashing and treatment and storage.	Collaboration with ISF providing hygiene and sanitation training in Mang'ola and Baray wards and CPAR-TZ providing rain harvesting systems at primary and secondary schools. WellShare provided additional education on DD prevention. Collaboration with existing Water and Sanitation Committees in Mang'ola Ward.
III.A.2. Increase % of households of children age 0-23 months that treat water effectively from 43.5% to 60%.	43.5 (34.7, 52.4)	33%	84.5% (N=310) Based on final evaluation in Mang'ola and Baray wards	60%	Community IEC campaign promoting proper treatment and storage of water.	60,230 community members received BCC/IEC on control of DD through HH visits, community meetings, market programs and special events. CDD video created for use in the community and distributed to long-haul bus transport company. 25 PHAST Facilitators trained in Mang'ola and Baray Wards. 800 children trained in C-to-C; 34 teachers trained in C-to-C Collaboration on-going with CPAR-TZ and district entities.

					C-IMCI training and supervision.	420 community leaders/members trained in C-IMCI. Supervision to be provided by CHMT's IMCI Coordinator and project staff. 323 community leaders received update on C-IMCI activities. 25 PHAST Facilitators trained in Mang'ola and Baray Wards. 800 children trained in C-to-C; 34 teachers trained in C-to-C
III.A.3. Increase % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids from 53.9% to 70%.	53.9 (41.0, 66.8)	56%	75% (LQAS)	70%	Community IEC campaign promoting proper ORS use and suitable alternatives.	CDD video created for use in the community and distributed to long-haul bus transport company. 60,230 community members received BCC/IEC through HH visits, community meetings, market programs and special events.
					Coordination with the CHMT to ensure availability of ORS throughout the District.	ORS available through CHMT and private vendors.
					Train drug shopkeepers on the use of ORS rather than antibiotics.	Training suspended due to changes in government policy.
					Healthy Mothers/Healthy Babies Centers.	All Healthy Mothers/Healthy Babies Centers have DD information and Diarrheal Disease Corner (as available) for intensive education on DD-related issues.
					Healthy Mothers/Healthy Babies Centers.	All Healthy Mothers/Healthy Babies Centers have DD information and a Diarrheal Disease Corner (as available) for intensive education on

						DD-related issues.
ARI / Pneumonia						
<i>Result III. The impact of malaria, diarrheal disease and pneumonia on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>						
III.A.5. Increase % of children 0-5 months who were exclusively breastfed during the last 24 hours from 11.6% to 40%.	11.6 (4.61, 18.6)	27%	32.6% (LQAS)	40%	Training TBAs on importance and definition of exclusive breastfeeding Support provided during STG sessions.	430 community leaders/members trained in C-IMCI including the importance of exclusive breastfeeding for the first 6 months of life. 272 TBAs received refresher training on exclusive breastfeeding. 320 women continue participating in 15 STGs.
					BCC/IEC campaign	Exclusive breastfeeding message part of BCC campaign.
					Healthy Mothers/ Healthy Babies Centers.	EBF information will be made available at health facilities
					Counseling women during ANC and PPC visits.	100% of mothers counseled on BF by project trained TBAs (VPR data)
III.A.6. Increase % of children age 6-23 months who received a dose of Vitamin A in the last 6 months from 53.9% to 70%.	53.9 (44.0, 64.8)	Not available	Not available	70%	Training TBAs on importance and definition of nutrition including Vitamin A.	272 TBAs trained in importance of Vitamin A. LQAS survey to be conducted in November 2010
					Support provided during STG sessions.	Vitamin A message part of approved BCC/IEC campaign.
					Healthy Mothers/ Healthy Babies Centers.	Vitamin A and Immunization information available at health facilities
Malaria, CDD, and ARI/Pneumonia						
<i>Result III. The impact of malaria, diarrheal disease and pneumonia on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>						
III.B.1. Increase % of mothers who report	Avg. feeding:	64%	Not available	64%	Community IEC campaign on proper	Care of the sick child message part of BCC campaign.

continuing to feed the same amount of food and the same amount or more fluids when their child was sick from 29% and 34.8% to 60%.	29% Avg. fluids: 34.8%				homecare of the sick child.	
					Healthy Mothers/ Healthy Babies Centers.	Renovations complete.
					C-IMCI training and supervision.	30 additional CORPs trained, 15 ToTs trained at ward and village levels LQAS survey to be conducted in November 2010.
III.C.1. Increase % of mothers who know at least two signs of childhood illness that require medical treatment from 66.1% to 80%.	66.1%	54%	Not available		Community BCC campaigns (including special days) on the danger signs of the sick child that require prompt referral.	The project has worked closely with the CHMT, District Leaders and NGO partners to have the opportunity to present health messages at key community events including international days and meetings. 60,230 community members received BCC/IEC through HH visits, community meetings, market programs and special events. LQAS survey to be conducted in November 2010.
					BCC/IEC with STG and MAISHA participants.	320 women continue participating in 8 STGs. 10 MAISHA drivers received refresher training
					Healthy Mothers/ Healthy Babies Centers.	Renovations complete.
					Same as III.C.1.	12 MAISHA drivers trained.
III.C.1b. Increase % of men (in intervention programs) who know at least two signs of childhood illness that	Indicator dropped based on MTE recommendations (2009)					

require medical treatment from xx% to 80%.						
III.C.2. Increase % of children under two experiencing danger signs within the past two weeks who were brought to a health facility from 37.9% to 60%.	37.9 (29.6, 46.1)	81%	Pneumonia: 93.5% LQAS (n=31) Fever: 97% (n=95)	60%	IEC campaigns on danger signs that require prompt referral.	Danger signs incorporated into key BCC/IEC messages of AFYA 1-2-3 campaign.
					Healthy Mothers/Healthy Babies Centers at District Health Centers.	Renovations complete.
					HW/C-IMCI training and supervision.	5 HW trained in C-IMCI.
III.D.1. Increase % of sick children under 5 years that are correctly diagnosed at health facilities	Indicator dropped based on MTE recommendations (2009)					
III.D.2. Increase % of drug shopkeepers who provide the correct dosage of antibiotics and/or antimalarials from 0% to 75%.	TBD	Not available	78.6 Based on “secret shopper” survey (N=13)	75%	Advocacy for including a continuing education requirement for Rx re-licensure.	District Pharmacist continues to advocate with the Regional Pharmacist and TFDA. This recommendation will become more important with the identification of ADDOs within the District.
					Advocacy for including a continuing education requirement for RX re-licensure.	District Pharmacist continues to advocate with the Regional Pharmacist and TFDA. This recommendation will become more important with the identification of ADDOs within the District.
Capacity Building						
<i>1. Each project community establishes a VHC that is well-linked to the beneficiary population.</i>						
% of project villages that have established a	0.0	Not available	100%		Review of monthly meeting reports,	On-going review of meeting reports during quarterly visits.

VHC.					<p>participation of CHMT and/or project staff in monthly meetings.</p> <p>Community mobilization; sensitization on role/responsibilities of VHCs; identification of key members of committees; Coordination with District CHMT in training of VHC/VHMCs</p>	<p>The establishment of VHCs has been orchestrated at the village and district level with project staff and CHMT members providing technical support based on MoHSW guidelines.</p> <p>The CHMT reports all Karatu villages have a functioning VHC/VHMC or W&S Committee.</p>
% of VHCs with list of participants from monthly meetings and key points noted.	0.0	Not available	100%		<p>Focus group discussions; key informant interviews; surveys.</p>	<p>Newly established VHCs will need time to raise community awareness and become known.</p> <p>Names and contact information for VHC/VHMC and W&S committee members are posted in all village offices.</p>
% of mothers of children under 2 who can name at least one member of their VHC.	0.0	Not available	Not available		<p>Monthly reports of VHCs.</p> <p>Collaborative activities with the CHMT and project staff.</p>	<p>All village health related committees were involved in the distribution of ITNs during the under 5 “catch up” campaign held in January/February 2010.</p> <p>The names of all VHC/VHMC members are posted in the village office.</p> <p>Newly established VHCs are currently building capacity and working with the project and CHMT to determine health needs at the</p>

						community level.
% of VHCs that hosted a community health activity in the past month.	0.0	Not available	Not available* On-going national election activities have eclipsed all village activities		Monthly reports of VHCs. Collaborative activities with the CHMT and project staff.	All village health related committees were involved in the distribution of ITNs during the under 5 “catch up” campaign. VHCs and W&S committees in Mang’ola and Baray Wards were active during 2 cholera outbreaks and in the mobilization of community members in improving hygiene and sanitation practices including the building of public latrines and the enforcement of community hygiene and sanitation by-laws. 100% of VHC/VHMCs are active in the building and/or maintaining of health facilities
2. VHCs develop and manage emergency transportation funds.						
% of VHCs that have developed emergency transportation funds	0.0	Not available	Not available		Identification of emergency transport providers and determination of funds needed. Line item budget in village expenditure plan. Identification of funds for the provision of this service.	VHC/VHMCs continue to build capacity, raise awareness and identify avenues of support. Village Councils and VHC/VHMCs are identifying options for the provision of emergency transport funds in local budgets; 6 ambulances are available within the district; identification of most isolated villages to receive “Dawa Donkeys”. Increased enforcement of government policy of free ambulance transport for pregnant women.
% of VHCs with emergency transportation funds that have at least 75% of the original investment available in	0.0	Not available				VHC/VHMCs continue to build capacity, raise awareness and identify avenues of support. Village Councils and VHC/VHMCs are identifying options for the provision of emergency transport funds in local budgets;

cash.						identification of most isolated villages to receive “Dawa Donkeys”. Increased enforcement of government policy of free ambulance transport for pregnant women. The district currently has 6 ambulances stationed at the center and at Health Centers.
3. Community-health facility connections are strengthened.						
% of VHCs that had a staff members from their local health facility attend their meeting in the previous month.	0.0	Not available	100% of villages with a staffed health facility had a HW attend VHC meeting in the previous quarter. HW is secretary of the VHC/ VHMC		Training of VHC members in data collection and use of data in planning. Review of meeting reports. Review of Health Facility reports.	566 VHC members; community members (TBAs, 10-cell leaders) and village and ward leaders trained in data collection. Introduction of village-level Vital Statistics and Pregnancy Monitoring VPR tool currently used in 38/44 villages, Vital Statistics data tool currently used in 17/44 villages . 34 villages provide data collected by C-IMCI trained CORPs. On-going review of VHC and HF reports during quarterly visits.
% of VHCs that review data reports prepared by their local health facility.	0.0	Not available	Not available		Design and production of referral card. Collection of referrals cards monthly/quarterly. Report by Health Facility on referral cards and follow-up by VHC/VHWs on referred patients.	Referrals cards for TBAs, and C-IMCI CORPs designed, approved by CHMT, field testing continues. Referrals cards to be distributed to 50 trained TBAs in 9 pilot villages. Participating C-IMCI CORPs to be determined. HFA to be conducted in 2011 LQAS survey to be conducted in November 2010.

						xx villages utilize HF data for planning purposes.
% of completed referrals made by VHC members and VHWs per referral cards that have been collected at health facilities.	0.0	Not available	Not available		Attendance at a minimum of one VHC meeting by appropriate CHMT member(s) including RCH and/or IMCI Coordinator. Coordinated attendance at meetings by CHMT	VHC meetings currently attended by District Health Officer Referral cards in the pilot/introductory stage.
% of VHC meetings in the previous quarter attended by a CHMT member.	0.0		Not available		Attendance at a minimum of one VHC meeting by appropriate CHMT member(s) including RCH and/or IMCI Coordinator. Coordinated attendance at meetings by CHMT	VHC meetings currently attended by District Health Officer
4. The quality and consistency of health worker supervision is increased.						
% of health workers trained in IMCI who report having received supervisory visit from the CHMT within the previous six months, that a standardized			100%		Training of health workers in IMCI. Support of monitoring and supervision activities through collaboration with	100% of HWs trained in IMCI received at least one supervisory visit by a member of the CHMT within the past 6 months. The District and Regional IMCI Coordinators has raised the priority level of IMCI and C-IMCI within the District. This component is

checklist was used, and that they received supportive feedback.					project and CHMT staff.	part of the comprehensive supervisory visits that are scheduled to take place quarterly by the CHMT. The standardized checklist is long and comprehensive and currently not completed properly. Supportive feedback is a challenge with supervisory skills-building an objective of the project's human resource capacity building plan.
5. CHMT uses HMIS data to inform District Health Reports and Plans.						
% of health facilities submitting monthly reports to the CHMT on time.			See explanation.		<p>Review of submitted monthly report and coordination of data collection with project M&E Coordinator.</p> <p>Training in data collection and HMIS tools.</p> <p>Review of existing reporting tools including streamlining and field testing appropriate, approved tools.</p>	<p>CHMT reports that they are responsible for the collection of quarterly data from health facilities in the district. Quarterly data is collected within the reporting month during supervisory meetings.</p> <p>Although reports are received, both the project and CHMT question the validity of data and note the lack of reliable data collection at the village level, hence the need for the design of a new, user-friendly community-based data collection tool (Pregnancy Monitoring Log and U-5 Morbidity/Mortality Reporting Forms)</p> <p>The CHMT's ability to collect data at each of the District's government facilities is impacted by availability of vehicles, allowances and limited number of CHMT members.</p>
6. A training function is established within the CHMT for IMCI.						
100% of planning and implementation of the Phase III IMCI training is carried out by the CHMT without			See explanation.		Key planning for IMCI training carried out by District IMCI Coordinator.	<p>The District CHMT conducts the IMCI training of all HWs in collaboration with CEDHA.</p> <p>WellShare continues to provides support to Regional and District-level trainers in the</p>

WellShare's direct involvement.					District's IMCI Coordinator works closely with trainers from CEDHA to provide IMCI. District leaders provide funding for IMCI training in District's health budget.	provision of C-IMCI training. Project staff still provide technical and logistical support to the CHMT for the training of CORPs
Sustainability						
<i>1. The quality and consistency of health worker supervision established during the project is maintained.</i>						
% of health workers trained in IMCI who report having received a supervisory visit from the CHMT within the previous six months, that a standardized checklist was used, and that they received supportive feedback after WellShare phased out from the Phase I communities.			Not applicable.		Monitoring and supervision of HWs trained in IMCI conducted by CHMT staff. Use of MoHSW and project developed supervisory checklist. CHMT trained in supervisory skills including the provision of positive feedback.	

Annex 2: Workplan

Tanzania Child Survival Project - Year 5 Detailed Workplan

ACTIVITY	Year 5												RESPONSIBLE PERSONNEL	OUTPUTS	Comments	
	O	N	D	J	F	M	A	M	J	J	A	S				
Result I: Maternal and neonatal mortality and																
IR I: Increased knowledge of newborn, pregnancy and post-partum danger signs by mothers																
Activity 1. Refresher MNC training for community leaders/village health committee (VHC) members during M&S visits	X			X	X	X	X	X	X	X	X	X		WellShare, CHMT	44 VHCs/VHMC receive training.	increased MNC and FP knowledge and support among men; dissemination of BCC messages to encourage men to accompany their partners to the HF.
Activity 2. Refresher Home-based Life Saving Skills (HBLSS) training for TBAs at village level during M&S visits				X	X	X	X	X	X	X	X	X		WellShare	88 HBLSS Trainers, approx. 200 additional TBAs; 234 TBAs receive refresher training	Provide refresher training for TBAs who have been formally trained as TOTs in HBLSS
Activity 3. Additional TBAs identified trained in adult education, group dynamics, and communication of health messages for newly formed STGs	X			X	X	X	X	X	X	X	X	X		WellShare	A minimum of 2 TBAs per village/15 villages	Identification and creation of 15 additional STGs
Activity 4. Continued development of innovative information, education and communication (IEC) materials	<i>on-going</i>												WellShare, CHMT	Video programs, calendars, posters, pamphlets, drama performances, community events	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities	
Activity 5. Distribution of education materials/information to the community	<i>on-going</i>												WellShare	# of materials disseminated	Review BCC messages and dissemination methods; include role models and their stories in project BCC	
Activity 5a. Carry out MNC film shows/drama performances within local communities	X			X		X		X		X		X		WellShare, drama troupe	Minimum of 2 shows/month during training/outreach activities	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities
Activity 5b. Carry out MNC drama/cultural performances at monthly markets	X			X		X		X		X		X		WellShare, drama troupe	Minimum of 1 show/bi-monthly; 5 markets	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities
Activity 5c. Create and distribute educational audio cassettes/cds with key MNC messages to MAISHA transport drivers														WellShare, drama troupe	30 drivers receive orientation and materials	Modify MAISHA activities to provide an alternative to driver initiated education
Activity 5d. Distribute project-produced films/dvds on MNC to local transport companies for viewing during long-haul travel (i.e. Karatu-Arusha, Arusha-DSM)				X		X		X		X		X		WellShare, private transport companies	10 DVD copies of series provided to 2 bus companies; DVD played a minimum of once/week on bus leaving from Karatu	Develop dvd/video on exclusive BF, distribute to additional long-haul bus companies
Activity 5e. Conduct health talks through TBAs/STG members within the community during antenatal care (ANC) clinic days (including mobile outreach)	X	X	X	X	X	X	X	X	X	X	X	X	X	TBAs, WellShare	1 health talk/month, 22 STGs	Pilot the dissemination of BCC messages (including audio cassettes) to a HF in a Phase III village for use during RCH clinics (replicate if successful).

Activity 5f. Support and participate in national and district-wide events (i.e. Day of the African Child, International Womens' Day, World Health Day, Uhuru Torch, etc.)				X			X		X						WellShare, CHMT, Karatu District Council	Participation in a minimum of 3 district-wide/national events.	
Activity 5g. Highlighting of MNC messages within district-wide AFYA 1-2-3 campaign				X			X			X					WellShare	Quarterly inclusion of MNC messages	
IR II. Increased quality of ANC, safe delivery and post-partum care services																	
Activity 6. Continued training of HWs in MNC/ANC/AMSTL/PPC				X			X						X		WellShare, CHMT	25 HWs training in focused ANC (FANC), OB emergencies, PPH, neonate resuscitation	
Activity 7. Continued supervision and monitoring of trained TBAs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	WellShare, CHMT, HF staff	Quarterly visits to all trained TBAs	Identify ways to better support community cadres
Activity 8. Collection of village level MNC and disease surveillance (i.e. pregnancy registers and U5 morbidity/mortality data collection) during quarterly M&S	X	X	X	X	X	X	X	X	X	X	X	X	X	X	WellShare, CHMT, VHC, TBAs	Data collection tool in 38/44 villages	Improve community use of data.
Activity 8a. Joint monitoring/supervision and data collection from TBAs and 10-cell leaders including follow-up training as needed	X		X				X						X		WellShare, CHMT	Increased supervision and capacity building for TBAs and community leaders	Identify 1-3 measurable indicators in collaboration with VEO and HF staff that can be monitored by the community; train village and HF staff on how to monitor and graph data; display progress over time at village office and HF
Activity 8b. Quality assurance of pregnancy registers via interviews with 15-20% of mothers registered with TBAs	<i>on-going</i>													WellShare, CHMT	Confirmation of data validity		
IRIII. Increased access/use of ANC, safe delivery and post-partum care services																	
Activity 9. Enhanced referrals between TBA/community level and health facilities via improved communication and collaboration systems	<i>on-going</i>													WellShare, CHMT, HF staff	TBAs providing referrals, pregnancy registers	Continue to foster increased collaboration between TBAs and HWs at the community level	
IRIV. Improved social environment for use of MNC services																	
Activity 10. Assist CHMT in preparing District Council Comprehensive Health Plan		X	X	X	X	X									WellShare, CHMT	Completed and approved plan with enhanced focus on MNC services.	
Activity 13: Advocate with VHC/VHMCs the provision of a sustainable budget item for emergency transport in village budgets. Further development of alternative transport methods including animal transport ("Dawa Donkey")		X	X	X	X	X	X	X	X	X	X	X	X	X	WellShare, District, Ward and Village government, CHMT	30 VHC/VHMCs advocate for transport funds to their village governments	
Activity 14. Collaboration with collaborating partners to deliver health messages in the community			X		X		X		X		X				WellShare, CHMT, FAME, VWP	Quarterly educational programs during outreach clinics	

Result II: Maternal and neonatal morbidity and mortality are decreased as a result of child spacing/family planning.														
IR I. Increased knowledge and interest in child spacing														
Activity 15. Child spacing (CS)/family planning (FP) refresher training for TBAs during quarterly monitoring and supervision meetings	X	X	X	X	X	X	X	X	X	X	X	WellShare, CHMT	234 TBAs visited	Implement training activities at village level to decrease costs.
Activity 16. Continue to develop innovative information, education and communication materials	ongoing										WellShare, CHMT	Video programs, calendars, posters, pamphlets, dramas, community events	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities; develop BCC messages to encourage men to accompany their partners to the HF	
Activity 17. Distribution of education materials/information to the community	on-going										WellShare	# of materials disseminated	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities	
Activity 17a. Conduct CS/FP film shows/drama performances within local communities	X	X	X	X	X	X	X	X	X	X	X	WellShare	Minimum of 2 shows/month during training/outreach activities	Review BCC messages and dissemination methods; include role models and their stories in project BCC activities; develop BCC messages to encourage men to accompany their partners to the HF
Activity 17b. Carry out CS/FP drama/cultural performances at monthly markets	X	X	X	X	X	X	X	X	X	X	X	WellShare	Minimum of 1 show/bi-monthly; 5 markets	
Activity 17c. Distribute project-produced films on CS/FP to local transport companies for viewing during long-haul travel (i.e. Karatu-Arusha, Arusha-DSM)	X	X	X	X	X	X	X	X	X	X	X	WellShare	10 DVD copies of series provided to 2 bus companies; DVD played a minimum of once/week on bus leaving from Karatu	
Activity 17d. Conduct health talks through TBAs/STG members within the community during antenatal care (ANC) clinic days (including mobile outreach)	X	X	X	X	X	X	X	X	X	X	X	TBAs, WellShare	1 health talk/month, 22 STGs	Pilot the dissemination of BCC messages (including audio cassettes) to a HF in a Phase III village for use during RCH clinics (replicate if successful); develop BCC messages that encourage men to accompany their partners to the HF.
Activity 17e. Support and participate in national and district-wide events (i.e. Day of the African Child, International Womens' Day, World Health Day, Uhuru Torch, etc.)	X	X	X	X	X	X	X	X	X	X	X	WellShare, CHMT, Karatu District Council	Participation in a minimum of 3 district-wide/national events.	Enhance MNC and FP knowledge and support among men; Develop BCC messages to encourage men to accompany their partners to the HF.
Activity 17f. Highlighting of CS/FP messages within district-wide AFYA 1-2-3 campaign specifically targeting male partners	X	X	X	X	X	X	X	X	X	X	X	WellShare, CHMT	Quarterly inclusion of CS/FP messages	Expanding BCC messages to better target men; develop BCC messages to encourage men to accompany partners to HF
Activity 18. Continued collaboration with CPAR in 5 project villages to increase access to SRH education	X	X	X	X	X	X	X	X	X	X	X	WellShare, CPAR staff,	Community meetings with men and women	
Activity 19. Conduct LQAS focused on FP and Child Spacing	X	X	X	X	X	X	X	X	X	X	X	WellShare	Data collected from LQAS	Conduct one LQAS prior to final evaluation; focus data collection on key interventors

IR II. Increased quality of family planning services													
Activity 20. Refresher training of HWs in CS/FP										<i>on going</i>	WellShare, CHMT	25 HWs trained in Focused ANC, CS/FP	
Activity 21. Monitoring and supervision of HWs, review of TBA records during supervisory visits	X			X				X			WellShare, CHMT	Review of clinic records, TBA reports	Identify 1-3 measurable indicators in collaboration with VEO and HF staff that can be monitored by the community; train village and HF staff on how to monitor and graph data; display progress over time at village office and HF.
Activity 22. Health Facility Assessment of FP services	X										WellShare, CHMT	Assesment of 100% of government and NGO health	Assessment will be conducted during LQAS activities
IR III. Increased access/use of modern child spacing methods													
Activity 23. Promotion of FP services through collaboration with community partners				X			X		X		WellShare, CHMT, VWP, CPAR,	Attendance at FP outreach clinics	Pilot the dissemination of BCC messages (including audio cassettes) to a HF in a Phase III village for use during RCH clinics (replicate if successful); develop BCC messages that encourage men to accompany their partners to the HF.
IR IV. Improved social environment for use of modern child spacing methods													
Activity 24. Collaboration with partners to deliver CS messages in the community		X		X		X		X			WellShare, CHMT, FAME, CPAR, VWP	Quarterly educational programs during outreach clinics	Pilot an open discussion about FP at a community meeting in cooperation with VEO, replicate if successful.
Result III: The impact of malaria (M), diarrheal disease (DD), and pneumonia (ARI) on infants and children is diminished as a result of improved prevention, home-based care and facility-based case													
IR I. Increased knowledge of prevention and care-seeking for malaria, diarrheal disease and pneumonia													
Activity 25. C-IMCI training for remaining wards and villages				X		X		X			WellShare, CHMT	3 wards, 10 villages	
Activity 26. Refresher training on M, DD, ARI for VHC/VHMC members and water and sanitation committee members where applicable				X	X		X	X	X		WellShare, CHMT	100% of VHC/VHMC/W&S committees receive information on key project interventions during M&S visits	
Activity 27. Training on M, DD, ARI for TBAs/community leaders and STG members	X		X	X		X	X	X	X		WellShare, CHMT, TBAs	30 additional TBAs trained, 15 STGs	
Activity 28. Continue to develop innovative information, education and communication materials focused on M, DD and ARI										<i>ongoing</i>	WellShare, CHMT	Video programs, calendars, posters, pamphlets, dramas, community events	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials
Activity 29. Distribution of education materials/information to the community										<i>on-going</i>	WellShare	# of materials disseminated	Pilot the dissemination of BCC messages (including audio cassettes) to a HF in a Phase III village for use during RCH clinics (replicate if successful); incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials
Activity 29a. Carry out film shows/drama performances within local communities targeting M, DD, ARI				X		X		X			WellShare	Minimum of 2 shows/month during training/outreach activities	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials; Include role models and their stories (particularly for EBF and ORS) in project BCC activities

Activity 29b. Carry out M, DD, ARI drama/cultural performances at monthly markets	X			X	X	X	X	X			WellShare, Drama troupe	Minimum of 1 show/bi-monthly; 5 markets	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials; Include role models and their stories (particularly for EBF and ORS) in project BCC activities
Activity 29c. Distribute project-produced films on M, DD, ARI to local transport companies for viewing during long-haul travel (i.e. Karatu-Arusha, Arusha-DSM)	X		X								WellShare, private transport companies	10 DVD copies of series provided to 2 bus companies; DVD played a minimum of once/week on bus leaving from Karatu	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials; Include role models and their stories (particularly for EBF and ORS) in project BCC activities
Activity 29d.. Conduct health talks through TBAs/STG members within the community during antenatal care (ANC) clinic days (including mobile outreach)	X	X	X	X	X	X	X	X	X	X	TBAs, WellShare	1 health talk/month, 22 STGs	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials; Include role models and their stories (particularly for EBF and ORS) in project BCC activities
Activity 29e. Support and participate in national and district-wide events (i.e. Day of the African Child, International Womens' Day, World Health Day, Uhuru Torch, etc.)			X		X	X					WellShare, CHMT, Karatu District Council	Participation in a minimum of 3 district-wide/national events.	
Activity 29f. Highlighting of MNC messages within district-wide AFYA 1-2-3 campaign	X		X		X		X				WellShare	Quarterly inclusion of M, DD and ARI messages	Incorporate specific hand-washing before food preparation and after changing the baby into the existing BCC and IEC materials; Include role models and their stories (particularly for EBF and ORS) in project BCC activities
Activity 29g. Ngorongoro Run: The Race Against Malaria, community awareness event held in conjunction with World Malaria Day					X						WellShare, CHMT, private sector	Successful marathon	
IR II. Increased quality of health services for malaria, diarrheal disease and pneumonia													
Activity 30. Refresher training of HWs in facility-based IMCI; inclusion of HF staff in C-IMCI training	<i>on going</i>										CHMT	# of HF staff trained including newly assigned staff.	
Activity 31: Monitoring and supervision of trained individuals at ward and village level, review of reports during supervisory visits			X		X		X				WellShare, CHMT, Village leaders, HF staff	Review of reports, community surveys	Identify 1-3 measurable indicators in collaboration with VEO and HF staff that can be monitored by the community; train village and HF staff on how to monitor and graph data; display progress over time at village office and HF; Discuss 1-day refresher training for CORPs at village level with District's IMCI Coord.; Include VEOs and HF staff in training; Identify ways to better support community cadres.
Activity 32. Conduct LQAS focused on FP and Child Spacing	X										WellShare	Data collected from LQAS	Conduct one LQAS prior to final evaluation; focus data collection on key interventors

IR III. Increased access/use of preventive methods and increased access to health services for malaria, diarrheal disease and pneumonia															
Activity 33. Track referrals of sick children by trained community cadres to health facilities	X	X	X	X	X	X	X	X	X	X	X	X	CHMT, WellShare	HF data review and collection of TBA/CORPs reports on referrals	Identify 1-3 measurable indicators in collaboration with VEO and HF staff that can be monitored by the community; train village and HF staff on how to monitor and graph data; display progress over time at village office and HF
IR IV. Improved social environment to support behavior change on prevention and care seeking															
Administrative/Monitoring & Evaluation Activities															
Activity 34. Collaboration with partners to deliver care-seeking behavior messages in the community	X		X		X		X		X		X		WellShare, CHMT, FAME, CPAR, VWP	Quarterly educational programs during outreach clinics	Pilot an open discussion about FP at a community meeting in cooperation with VEO, replicate if successful.
Activity 35. Monitoring, Supervision and Evaluation Capacity-building of VHC/VHMCs	<i>on-going</i>											WellShare, CHMT	30 VHC/VHMCs trained	Identify 1-3 measurable indicators in collaboration with VEO and HF staff that can be monitored by the community; train village and HF staff on how to monitor and graph data; display progress over time at village office and HF	
Activity 36. Completion of project's final evaluation											X	X	WellShare, Consultant, CHMT, community	LQAS conducted in all villages; collection of qualitative data at the community level.	

KEY: CHMT=Council Health Management Team; HF=health facility, HW=Health Worker, MAISHA=Men Active in Sustaining Health Actions, C-IMCI=Community-Integrated Management of Childhood Illnesses, FAME=Foundation for African Medicine and Education, HF=Health Facility, CPAR=Canadian Physicians for Aid and Relief, VWP=Village Wellness Project

Note: Limited October 2010 activities due to national elections.

Annex 3: Papers or Presentations about the Project

WellShare International was invited to present an oral presentation on their submitted abstract “Village-Level Pregnancy Register: Improving pregnancy and post-partum data collection in rural Tanzania” to the annual conference of the American Public Health Association (APHA). The conference was held in Philadelphia, PA from November 7-11, 2009. Innocent Augustino, M&E Coordinator, and Laura Ehrlich, International Program Director, represented the organization at the conference.

The Tanzania Public Health Association (TPHA) also accepted a submitted abstract “Village-Level Pregnancy Register: Improving pregnancy and post-partum data collection in rural Tanzania” which was presented in poster form by Mr. Abdullah Iddi during the annual meeting held in Dodoma, Tanzania November 2-5, 2010.

WellShare also presented on the Tanzania Child Survival Project to local organizations, University of Minnesota students and other groups in Minnesota.

Annex 4: Results Highlight

1. *Promising practice*

A. **Simple and appropriate data collection tools**

Internationally, the validity of health data at the district and community level is in question. The forms designed for the collection of data are repetitive, cumbersome and difficult to complete. There is a gap between the data collected at health facilities and the actual health situation at the community and household level because many people do not access care through the structured system. The need for village level surveillance data has led the project to design and implement two data collection forms targeting two different community cadres.

1. **Village Vital Statistics Register:** In Tanzania, each 10 households are supervised by a ‘ten-cell leader.’ These individuals are close enough to the household level and responsible for a manageable number of households so that the collection of valid data on the morbidity/mortality of under 5s and the tracking of pregnant women and delivery is possible.
2. **Village Pregnancy Register.** TBAs are required to complete government forms on their interaction with pregnant women, delivery and referral services. These forms are difficult and confusing for women with varying levels of formal education. The project has developed and is currently implementing this simple, comprehensive village register that is providing all the information the MoHSW requires plus additional information helpful to the community, CHMT and the project.

The Village Pregnancy Register is now implemented in 38 of 44 Karatu villages and has met with great acceptance and success. The Regional Medical Officer has shared the design and data collected with the MoHSW and bi-lateral agencies. The data collected is key to tracking project activities in the area of MNC.

The Village Vital Statistics Register is currently being piloted in 9 villages. The data collected will be used as one tool to track the effectiveness of C-IMCI activities at the community level.

B. **Training of Tribal “Health Advocates”**

The Hadzabe tribe of Tanzania is the last remaining hunting and gathering society in East Africa. The dwindling number of tribal members in the project area (estimated at approximately 5,000) have been negatively impacted by climate change, encroachment on their hunting grounds by pastoralists and developers, introduction of new diseases (including HIV), high infant and maternal mortality rates, limited access to health and education services, as well as being irreparably effected by tourism and anthropological studies. The Hadzabe have been thrust into the 21st century while trying to continue to live by their traditions.

And it is their traditions that have made them most vulnerable. Tourists visiting Hadzabe living areas have been known to request that children run naked making them more susceptible to pneumonia and malaria. Adults receive money from the tourists and use it for the purchase of alcohol and marijuana placing them at increased risk of STIs, HIV and other chronic illnesses. There are no trained TBAs or midwives within the Hadzabe tribe; woman assist each other in the delivery of their babies and therefore obstetric emergencies usually result in death. The tribal families are scattered having limited access to health care. Children are taken vast distances to be housed in a government school catering to the Hadzabe children. As a result, parents do not see their children for long periods and therefore are reluctant to send their children to school.

It is with this background that WellShare began cultivating a relationship with the Hadzabe. Since the project's inception in 2007, staff has made periodic visits to tribal leaders and assisted in the creation and capacity building of the Datoga and Hadzabe Development Association (DAHA). The Datoga tribe, a pastoralist society, co-exist with the Hadzabe and have for years competed with them for lands and resources. In 2008 these two tribes began to identify areas of mutual cooperation, including the area of tourism, and decided to join together to form DAHA. By 2009, WellShare was asked to assist DAHA in the development of an administrative structure, technical training and participation in quarterly meetings to address any health issues raised.

After two years, the members of DAHA identified health and education as key needs for their communities and requested training from WellShare for an initial 15 identified "health advocates." During tribal meetings, the members determined their greatest health problems: malaria, diarrheal disease, pneumonia, HIV/STIs, MNC and substance abuse. Culturally-specific and low-literacy training materials were produced for distribution to the trainees. The training, held August 8-14, 2010, was conducted in both the Hadzabe and Datoga languages.

WellShare has also worked closely with FAME and the CHMT in the planning of outreach mobile medical clinics to be held monthly for the Hadzabe and Datoga, scheduled to begin in November 2010.

It is anticipated that community education and access to healthcare services will have a positive impact on the morbidity and mortality of this fragile society. It must also be noted that the recognition of health as a key need for their community is a major step forward in the survival of the Hadzabe people.

2. *Innovative idea*

A. "Dawa Donkeys"

The availability of reliable and affordable transportation in an emergency situation is an international challenge. Women die at the community level when obstetric emergencies occur and they cannot reach the nearest health facility in time. Sick children and family members die in their homes because there is no way to reach medical help. Each of Karatu's villages exist in a unique environment, with its own transportation challenges. Since 99% of the District does not have paved roads, and the vast majority of villages are

isolated by rough and/or impassible roads (in rainy season), the design of an appropriate and sustainable method of transporting patients is key to survival.

The project, in collaboration with the District Veterinary Officer, has designed and is currently piloting the “Dawa Donkey” cart. *Dawa* is the Kiswahili word for medicine. The “Dawa Donkey” is an emergency ambulance which utilizes existing animal power with a newly designed cart and harnessing system. The cart is lightweight, strong, and provides a mattress for the patient and sitting room for an attendant and/or family members. The cart is designed with a suspension system to ensure the most comfortable ride possible on difficult roads. The donkeys are locally available and need minimal upkeep.

A hardy, indigenous animal, donkeys are susceptible to one disease (vaccines are available) and can haul heavy loads. Traditionally, donkeys are not utilized for heavy work in the project area, but on-going training and sensitization of community members has resulted in their increased use. The harnessing system provides an “animal friendly” connection to the cart and allows for the incorporation of two donkeys if necessary. Donkeys can traverse rough roads at a pace close to a bicycle (10kph) and are much faster than walking or carrying a stretcher.

The initial cost and maintenance of the “Dawa Donkey” is much less than the purchase of a motorcycle, and does not require the recurring costs of fuel and spare parts. This conveyance method has the potential of providing sustainable village level transportation with the introduction of a more humane system of animal harnessing.

The pilot project, currently implemented in the village of Laja, had a start-up cost of USD 1,000 provided by individual donor funding. Start-up costs included training of community members in the care of donkeys and work on the initial cart design. It is proposed that project-trained TBAs will oversee the use and upkeep of the donkey cart and that 5 remote villages will receive “Dawa Donkey” carts as part of WellShare’s objective of working with communities to identify emergency transport options.

Annex 5: CSHGP Project Data Form

See attached.