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

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Submitted to:
Susan Monaghan
United States Agency for International Development

For further information, please contact:
Dr. Eric van Praag
evanpraag@fhi.org

Table of Contents

I. OVERVIEW ……. 1

II. OBJECTIVES AND ACTIVITIES ……. 2

A. Objective 1. ……. 2

B. Objective 2. ……. 5

C. Objective 3. ……. 9

III. ACTIVITIES PLANNED FOR QUARTER TWO……. 13

IV. TARGETS……. 15

V. APPENDIX …….. 16

A. Positive Prevention Numbers Reached …….. 16

ACRONYMS

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

I. OVERVIEW

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

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

Key highlights of the quarter included the team building retreat for all NACP staff in October 2009, and the NACP-led partners meeting in December 2009. Additionally, for the roll-out of the newly-developed national HBC recording and reporting system, a five-day TOT was conducted to 30 district HBC trainers in November 2009. Finally, FHI worked in collaboration with TACAIDS (through the Impact Mitigation Technical Working Group) to facilitate finalization of planning and budgeting guidelines that include NCPA integration into district plans, which will be used by councils to develop council-specific plans for MVC services.

Below is the quarterly progress report, which covers the period October to December 2009.

II. OBJECTIVES AND ACTIVITIES

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

Activity 1.1: Strengthen leadership and management capacity of NACP

a) FHI's seconded planner to the NACP management unit, Ms. Tuku Bangwe was able to expand her duties due to the replacement of her supervisor, the NACP administrator, by Mr. Erasto Edward. After a briefing with Mr. Edward on the seconded planner position, he better understands the role of a planner in harmonizing the multiple donor project inputs to strengthen NACP functioning, and he supports her in fulfilling the mandate of her role.

   A very successful team building retreat, which was coordinated by the seconded planner and facilitated by TRACE, was held on 19-22 October 2009. The retreat brought all staff from all units in the NACP together and resulted in a first-ever recognition among staff of attitudes about their work environment and issues/weaknesses that are hindering progress in their work. Team action plans were drafted at the retreat, and TRACE developed several recommendations for improving NACP teamwork. Implementation of the plans and follow-up on the recommendations will be facilitated by the planner/FHI over the coming months.

   Important progress was made by the planner in managing NACP donor funds. For example, CDC funds utilization increased approximately 80% over last quarter due to improved and timely planning and coordination of activities. The planner also led the CDC 2010 project writing team and substantially improved the MOHSW standardized reporting system among all units in the NACP by coordinating and following up with the heads of units. The improved reporting avoided queries from the auditors for the first time this year.

b) FHI, in an effort to support coordination by the NACP of all treatment partners' roles, facilitated the NACP-led partners meeting on 15 December 2009. The theme chosen was roll-out to peripheral sites without increasing costs. NACP chaired the meeting and provided an update on national progress and challenges so far. Several partners presented on their outreach successes and methodologies. One conclusion arrived at during the one-day meeting was that prioritization of need as determined by district health authorities will allow phasing of roll-out to peripheral sites. Additionally, it was determined that better analysis of the cost consequences from a commodity and a health systems point of view and cost savings have not as yet been fully explored such as: peripheral refill only sites, three monthly prescriptions for stable patients; task shifting; strengthening zonal Medical Stores Department (MSD) with Supply Chain Management System (SCMS); use of zonal health

resource centres for all training; involvement of public/private sites; strengthening Council Health Management Teams (CHMTs) to prioritize health centre/dispensary choices for expansion; slowing down the rate of growth; etc. The ART M&E update was presented by Bonita Kilama of the NACP in a very candid and analytical way highlighting the current shortfalls in implementing one central monitoring system for ART, shifting M&E responsibilities from partners to District AIDS Coordinators (DACs) and Regional AIDS Coordinators (RACs), and the need for clear SOPs to reflect roles and responsibilities of CTC staff, DACs and partners. Attendance at this NACP-led meeting was high and clearly exhibited NACP ownership of its programs. FHI will continue to advocate for NACP-led partner meetings.

c) FHI supported integration of program by working with the NACP to liaise with other groups, in particular the National Tuberculosis and Leprosy Program (NTLP) and the reproductive health (RH) division to jointly plan integrate TB//HIV activities and FP/HIV activities. NACP co-chaired the working group on FP/HIV integration twice during the quarter, and a feasibility study is underway through other FHI funding. Integration with the NTLP is more complex. Meetings on TB/HIV integration were held this quarter on the joint strategy, working groups, training materials, etc., but they were not jointly led and guided. On the 3Is (Improve screening, IMM prophylaxis, Infection control of airborne diseases), CDC through the NTLP with ICAP, are leading efforts, but they do not ensure joint ownership. Next quarter a new attempt will be made to have the NACP lead the integration efforts and take charge of strengthening the roles of CTCs to screen for TB, pilot INH Preventive Therapy (IPT) and promote disease control efforts.

Activity 1.2: Maximize the use of human resources in health

a) FHI actively participated in the recently-formed human resources (HR) working group chaired by the department of HR MOHSW, which met almost fortnightly during the quarter. Together with the WHO and the CDC, the HR working group is tasked with preparing the background paper and presentation on task shifting (TS). It will be presented to the Senior Management Committee of the MOHSW to advocate for TS in an evidence-based manner, sensitize members and clarify the advantages and requirements to use TS to alleviate immediate pressures on the health workforce within the legalities of the country. The presentation was discussed and approved by the working group, and in early 2010, it will be presented to the Permanent Secretary and her management team. Additionally, FHI participated actively with Mkapa Foundation Capacity project in a small task force to address workforce deployment, utilization and retention procedures for health staff at the district level and to design a workplan on improvements and efficiencies in productivity.

b) Addressing staff retention at health facilities was discussed this quarter among all treatment partners as well as ways to harmonize support to staff working on HIV care and treatment beyond the training, mentoring and career development that treatment partners are providing. FHI solicited this information to inform the HR working group about field realities in order to

plan better for staff retention. Currently, over time, performance-based team bonuses, hospital fixed bonuses, allowances for supervisory visits and outreach are some of the ways partners support staff in the absence of specific national guidance.

c) The roles and potential of the Zonal Health Resource Centres (ZHRCs) were discussed at the annual ZHRC meeting in Morogoro in November with active FHI participation to advocate for the NACP to promote closer collaboration and use of the ZHRCs as training facilities and possible use of their faculty in HIV-related activities to assure updated training skills in prevention, treatment care and support. The role of ZHRC to control and guide training facilities in their respective zones and the role partners and the NACP play in planning trainings remained unresolved. FHI will continue to facilitate discussions about the potential role of the ZHRC.

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

a) Despite regular and joint pressure from FHI and the Mkapa Foundation, the secretariat of the NSCTHR was not able to call a meeting during the quarter. The evaluation and adaptation of the integrated management of adult illnesses (IMAI) training course led by WHO/I-TECH has been ongoing, and FHI reviewed/commented on earlier drafts of an IMAI course for staff at the peripheral levels. FHI participated in the preparation of a field test of the WHO clinical pocket guide for mid-level hospitals together with Pharmaccess and have requested ICAP and FHI/Tunajali to work with four hospitals to run an actual field test of the guide in January 2010 to be applied by MO/AMO/COs at site.

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

a) During several workshops this quarter, FHI briefed NACP staff working on finalizing a number of national materials on field experiences and the latest evidence on the National Framework, the Manual on Supportive Supervision and Clinical Mentoring and the TB/HIV proposal for piloting Intensified Screening and IPT.

b) FHI supported NACP CTU staff to inform partners during the NACP partner meeting on national policies with regards to peripheral health facility selection for care and treatment provision or refill by council health authorities and current guidance on eligibility and treatment as national guidance is pending results of a feasibility study to apply changes in CD4 eligibility and choice of first line drugs.

c) FHI assisted TACAIDS and the NACP in clarification of roles for a new TACAIDS-led working group on the multi-sectoral approach in HIV care

chaired by Dr. Kaushik of Hindu Mandal vis-à-vis the clinical subcommittee of the MOHSW chaired by Dr. Sam Kalluvya of Bugando Medical Centre.

d) The clinical subcommittee met on 14 December 2009 for the fourth time in 2009. FHI initiated discussions on progress on IPT with a conclusion that extensive pilot testing may take too long to complete before the recommended WHO policy can be implemented as most countries in the region are already embarking on national implementation. With EGPAF, FHI made a strong plea to elevate the paediatric working group to a full subcommittee. A focal point in the NACP on paediatric matters was urgently requested as well as revision of the paediatric training curriculum in early 2010 with the inclusion of a specific adolescent chapter. The WHO and the MOHSW will soon finalize the essential prevention and care intervention package, and a request was made for contributions from all partners.

Activity 1.5: To ensure quality of care, FHI will facilitate and provide TA to the NACP to finalize, print, and disseminate SOPs for CTCs and an operational manual on TB/HIV for peripheral clinics and promote its utilization

a) The Standard Operating Procedures (SOPs) for CTCs in Tanzania were finally submitted to the Program Manager NACP for clearance by the Permanent Secretary of the MOHSW and subsequent printing. Formatting was done by FHI headquarters and hopefully printing and dissemination can be finalized in quarter two of FY10.

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

a) Together with other FHI programs, the Systems Strengthening project supported a pilot exercise to implement a full continuum of care approach (CoC) in one district in order to inform the MOHSW about the feasibility of wide-scale implementation of this nationally-approved approach. This quarter in Mvomero, the council and all active partners in prevention, care, treatment and support agreed on a formal meeting and networking mechanisms to identify PLHIV and families early and refer them to appropriate programs/institutions to meet their needs. Please also see objective 3, activity 3.9 for related information.

Objective 2.2 Increased capacity of the Counseling and Social Support Unit (CSSU) of the NACP to lead, coordinate and monitor the provision of quality palliative care services and strengthened Home-based Care Coordinator.

Activity 2.1: Strengthen the coordination and management capacity of the NACP Care and Social Support Unit (CSSU)

a) FHI continued to support the CSSU of the National AIDS Control Program (NACP) in strengthening coordination and management capacity. During this reporting period, FHI facilitated one care and support sub-committee meeting. The meeting was conducted in December 2009 and the main issue discussed was the plan to roll out the newly-developed national HBC recording and reporting system. During the meeting, the NACP requested that HBC implementing partners support the roll-out process, which involves dissemination of the tools to the Regional Health Management Team (RHMT) and the Council Health Management Team (CHMT). The process also includes training of the HBC services providers so that they can report using this system.

Activity 2.2: Provide TA to the CSSU to improve the quality of palliative home based care services

a) At the request of the NACP, FHI provided technical and financial support for the review of the national guidelines for home based care services. The key HBC implementers took the lead in reviewing the guidelines, which is now finalized. The logistics for printing the guidelines are now underway, and a workshop with the key HBC stakeholders to disseminate the guidelines is planed to take place in February 2010. The process for reviewing the national HBC training materials to ensure that they are in line with the reviewed guidelines is also underway and the initial steps to identify the consultant who will assist in this exercise have been taken. Next steps include dissemination of the national HBC guidelines, review of the national HBC training materials and development of a job aid or leaflets for implementers.

Activity 2.3: Strengthen the NACP health information system, in particular to roll out the developed national HBC recording and reporting system and institutionalize it for data collection and analysis for use (Data Management and Monitoring System).

a) As reported in the previous quarterly report, with financial and technical support from FHI, the NACP of the MOHSW, in collaboration with other key HBC stakeholders, finalized the national HBC recording and reporting system (RRS). A technical working group from the key HBC stakeholders worked together and finalized the system. During the quarter, as mentioned above, FHI facilitated a care and support sub-committee meeting in which roll-out of the RRS was discussed. Additionally, FHI supported the NACP in printing related tools to be distributed to the implementing partners. The tools include a notebook for patient registration and follow up, a summary form for the volunteers/HBC providers, a summary form for the HBC supervisor and district HBC coordinator and the referral form. (See attached national HBC recording and reporting system tools).

b) For the roll-out of the newly-developed national HBC RRS in the country a five-day TOT was conducted to 30 district HBC trainers in November 2009. The trainees were from the regions of Mwanza, Singida, Dodoma, Iringa, Coast, Morogoro, Mbeya and Zanzibar. A training to M&E staff and one program staff member from each key HBC partner will be conducted next quarter. In the same quarter, the data clerks from the implementing partners

and the HBC coordinators will also be trained on both paper based and electronic part of the system. The two cadres are expected to work together to produce the HBC reports in their respective districts. The trainings are expected to be conducted in February 2010, and FHI will provide technical and financial support.

c) FHI provided technical facilitation at the HBC RRS dissemination meetings for the RHMTs (Regional Medical Officer, Regional Nursing Officer, Regional AIDS Control Coordinator, Regional Health Management Information System Officer) and CHMTs (Municipal Medical Officer of Health, Municipal AIDS Control Coordinator, Municipal Nursing Officer, District Medical Officer, District AIDS Control Coordinator, District HBC Coordinator, District Nursing Officer, District Health Information Management Coordinator). Two meetings were held during the quarter. The first meeting was held in December, 2009 and it included the regions of Iringa, Mbeya and Ruvuma with 106 participants. The second meeting pulled 95 participants from Arusha and Manyara regions and was also held in December 2009. At the meetings, it was decided that the RHMTs and CHMTs will meet with the implementing partners to develop regional roll-out plans. In the next quarter, FHI will provide financial and technical facilitation at the HBC RRS dissemination meetings for the RHMTs and CHMTs in the Dodoma and Morogoro regions. The meeting will be conducted by the end of January, 2010

d) The electronic DMS component of the system has been developed by University Computing Centre (UCC). The system received some inputs from the technical working group, including FHI staff. FHI, through the TUNAJALI program, intends to immediately adopt the system for reporting HBC activities. In the next quarter, FHI will collaborate with UCC to train the district HBC coordinators and HBC implementing partners data clerks on the DMS to enable electronic data capturing. While UCC will support these training in the regions of Dodoma and Morogoro, FHI will financially and technically facilitate the same training in the regions of Mwanza, Iringa, Coast, Singida and Zanzibar. FHI under TUNAJALI will be the first program to pilot the HBC electronic DMS, and therefore, lessons learned from this experience will be shared for review of the system. The DMS is located at the following website: http://www.nacp.go.tz/databases/homebasedcare_db.php

Activity 2.5: Provide TA to the MOHSW through the NACP to expand integration of Community-Based Positive Prevention into existing programs

a) The MOHSW, through the NACP IEC unit in collaboration with the WHO and FHI, held a meeting in October with partners and stakeholders, including PLHIV support groups, and agreed on the need for a national strategy on Positive Prevention for country-wide implementation and called for a small task force to develop necessary standards for implementation of PP at facility and community level based on lessons learned from the pilot.

b) A component of Positive Prevention has successfully been integrated into the national guidelines for home-based care and approved by the MOHSW through the NACP. The national guidelines are now at the printing stage and

will then be disseminated. Additionally, FHI prepared an outline of a phased approach for incorporating Positive Prevention in the national guidelines for PMTCT, HIV/ART and HBC in Tanzania.

c) Positive Prevention indicators have been utilized since the start of the program. However, there is a need to revise the indicators to incorporate PEPFAR indicators. FHI continued to work on the revision of the indicators this quarter. Draft M&E indicators were reviewed and revised to ensure that the three components of Positive Prevention are addressed. The indicators will be field tested with the 2,000 CBPP clients who will be recruited effective January 2010. When M&E data are available, areas for improvement in the delivery of CBPP services will be identified and a plan for addressing selected gaps will be developed. Draft M&E indicators developed for the CBPP project were reviewed and revisedto ensure that the three components of Positive Prevention are addressed. The indicators will be field tested with the 2,000 CBPP clients who will be recruited effective January 2010. When M&E data are available, areas for improvement in the delivery of CBPP services will be identified and a plan for addressing selected gaps will be developed. Once the indicators are finalized, they will be shared with the MOHSW through the NACP for approval and adoption.

Activity 2.6: Finalize the scope and content of national community-based Positive Prevention

a) FHI continued to work with the NACP on finalization of training materials for community HBC providers and PLHIV support group members. FHI reviewed the draft materials and identified areas in need of revision, notably: (1) expand content on TB/HIV co-infection, (2) expand content on male circumcision, and (3) add a module on Family Planning. These revisions will be completed in the next quarter. FHI will also continue to liaise with AED on the expansion of content relative to WASH, per request of USAID. Once finalized, national trainers (Positive Prevention TOTs) will be utilized to finalize training material (for input) before the USG partners meeting and dissemination.

Activity 2.7: Revise the HBC reporting and monitoring tools to include Positive Prevention as one of the standard activities

a) The MOHSW, through the NACP, has approved new HBC reporting and monitoring tools. Positive Prevention was not incorporated, because the process of developing HBC reporting and monitoring tools was initiated before the start of the Positive Prevention program. FHI will continue to liaise with NACP to incorporate Positive Prevention into the HBC reporting and monitoring tools. So far four tools have been developed by the program (P1 client identification form, P2 client follow up form - assessing client condition at home, P3 monthly report form, P4 distribution form).

Activity 2.9: Conclude the community-based Positive Prevention (CBPP) pilot including surveying the CHBC providers and PLHIV support group members delivering CBPP-related services and the beneficiaries of these services to identify successes, challenges and areas for improvement

a) During the quarter, FHI enrolled a total of 348 PLHIV (M 126, F 217) among them, 22% were PLHIV HIV+ youth (M 25, F 49). Please see Appendix A for further details on numbers reached.

Activity 2.10: Prepare and disseminate report on the results of the community-based Positive Prevention pilot and determine next steps.

a) FHI began drafting the results of the mid-pilot assessment.

b) A workplan was drafted to prepare for the final assessment of the CBPP project. Included were specific provisions for revision of the mid-pilot survey assessment tools and development of guides and instruments for focus groups and in-depth interviews with beneficiaries of the project.

c) A QI tool has been developed and will be finalized in the next quarter.

Objective 3. Strengthened national systems for OVC in Mainland and Zanzibar
Section 1: Technical assistance to DSW and PMORALG in Mainland Tanzania

Activity 3.1: Strengthen the capacity of the DSW of the MOHSW to plan and catalyze implementation of OVC policies, strategies, guidelines, plans and standards

a) In this reporting period, FHI continued to provide technical and financial assistance to the new DSW management team to ensure it is capable of rolling out, monitoring and evaluating implementation of the NPCA, Data Management System (DMS) and national guidelines for improving quality of MVC services.

b) FHI continued to support the DSW by maintaining two staff (a Senior Technical Officer – Monitoring and Evaluation and a Data Management Specialist) seconded to the DSW Family and Child Welfare unit to provide support in monitoring the roll-out of the NCPA and DMS. The data management specialist also continued to provide IT technical support to DSW staff.

c) FHI supported the DSW to prepare a meeting of the national steering committee, which was going to take place in December, but was unfortunately postponed a day before by the Permanent Secretary. FHI will continue to liaise with the MOHSW to organize this important meeting.

d) FHI supported the DSW to procure furniture for the MVC resource facility/library within the DSW office.

Activity 3.2: Strengthen the capacity of the DLG of the PMORALG to catalyze integration of the NCPA into council plans and monitor MVC care and support activities by councils

a) FHI worked in collaboration with TACAIDS (through the Impact Mitigation Technical Working Group) to facilitate finalization of planning and budgeting guidelines that include NCPA integration into district plans, which will be used by councils to develop council-specific plans for MVC services.

b) FHI supported PMORALG to organize one workshop to orient regional IT officers and council statisticians/ planning officers on DMS use and data analysis to assist implementers. Twenty-three officers from all councils of Morogoro, Coast and Iringa regions (2 regional IT specialists, and 21 Council planners/statisticians) were trained on DMS use and data analysis. They will be available to support councils to use data in the DMS.

Activity 3.3: Pilot and roll out national quality improvement guidelines for MVC services

a) In this reporting period, FHI supported the MOHSW to print and distribute 5,000 copies of the national QI guidelines.

b) FHI started the process of developing a user-friendly, pocket-size QI job aid and poster that will aid volunteers and MVCC members to achieve QI at the point of service delivery.

c) FHI continued to co-chair monthly meetings of the QI Taskforce.

d) FHI participated in facilitating a workshop organized by the MOHSW (with support from URC) to develop a QI training manual for training users of the national QI guidelines. This workshop was held in Tanga for three days and was attended by selected members of the QI Taskforce. URC is facilitating finalization of the QI training manual.

Activity 3.5: Provide TA to MOHSW to finalize national training guidelines

a) In this reporting period, FHI initiated the process of developing national guidelines for establishing and managing children's clubs. FHI supported engagement of a consultant who will work with DSW and FHI to develop the guidelines.

Activity 3.6: Provide technical assistance to MVC implementing partners to ensure MVC care, support and protection services are standardized, and enhance linkages with other key stakeholders such as TACAIDS and sector ministries

a) FHI continued to participate in IPG meetings, to share information and provide input on national MVC programming and service provision guidance.

Activity 3.7: Strengthen OVC monitoring and information systems of the DLG and DSW, and in particular build the capacity of the DLG and DSW to analyze and use data for decision making

a) FHI continued to maintain staff seconded to the DSW to strengthen its M&E function (Senior Technical Officer for M&E and the Data Management Specialist).

b) FHI supported the MOHSW to engage a consultant and organize a national workshop to review the national M&E plan and related tools. The draft reviewed tools will be finalized in Q2.

c) Through the Senior Technical Officer - M&E and the Data Management Specialist, FHI continued to provide TA to the MOHSW and PMORALG to monitor, analyze, report and use MVC data. An update on the implementation of the NCPA and roll-out of the DMS (as of the end of December 2009) is available separately. However, it is worth noting that by the end of December 2009 the following was achieved:
   - The national DMS for MVC had been rolled out to a cumulative total of 78 (92%) out 85 councils, which had conducted MVC identification
   - 65 (83%) out of the 78 councils had sent reports to the DSW
   - Reports generated from the DMS sent to 52 (80%) out of the 65 councils. These reports are to be used for planning and decision making. Data from the remaining councils were recently received and are being analyzed, while other reports had serious data quality issues
   - 344,569 (46%) out of 746,183 MVC are registered in the DMS

Factors hampering rapid implementation included lack of regular electricity and internet connectivity in most districts. Rapid turnover of government staff necessitates continuous training and supportive supervision. FHI will endeavor to support LGAs, building their capacity to enable the councils to use the data for planning and decision making. So far, the DMS has proved useful in some districts as follows:

- The MOHSW is able to provide monthly updates on number of MVC in the country.

- Mtwara Rural District Council found it easier "to go into the DMS" to identify most vulnerable children who completed standard seven and passed their examination in 2009. The council is soliciting funds to support their secondary education.

  "*Before training on DMS in our council, it was hard to plan for the MVC. After being trained to use the DMS, I can now generate simple reports from it, and it has became easy to plan for MVC," Mtwara Rural District Council Social Welfare Officer, Ms. Sauda Goha had this to say.*

- Magu District Council has been able to coordinate provision of support based on individual needs of MVC.

- Kilosa District Council has been able to analyze MVC data disaggregated by ward and village and shared the information with respective MVCCs to inform planning.

- For most councils, the number of MVC in their areas is now easy to obtain.

- There has been an improvement in MVC data collection in terms of data quality.

Activity 3.8: Provide financial and technical support to HelpAge to develop a MVC service providers' manual on supporting elderly caregivers of MVC

a) FHI has entered into discussions with HelpAge International (Tanzania) to lead the process of developing a service providers' manual on supporting elderly caregivers of MVC.

Activity 3.9: Contribute to strengthening the Mvomero Umoja continuum of care learning district

a) In this reporting period, the Systems Strengthening project participated in facilitating a quarterly CoC Network Coordinating Committee meeting, during which FHI's initiative to strengthen a functional CoC network to pilot for national-level implementation was introduced to the committee, and baseline service mapping was planned for Q2.

Section 2: Technical assistance to the Department of Social Welfare Zanzibar

Activity 3.10: Strengthen the capacity of DSW Zanzibar in planning, developing and managing implementation of MVC policies, strategies, guidelines and standards for MVC

a) FHI ccontinued to support two staff seconded to the DSW Zanzibar (Psychosocial Support Counselor and Data Management Specialist) to strengthen the department's capacity for MVC program and data management.

b) The consultant engaged to lead development of the Zanzibar MVC action plan continued to gather technical inputs from key stakeholders. First draft of the action plan due in Q2.

c) FHI supported Zanzibar to conduct a four-day training for 40 social workers, (including 12 TOTs) on psychosocial care and support, caretaking skills and community participation.

Activity 3.11: Strengthen DSW Zanzibar monitoring and information system for tracking MVC/OVC identification, service providers and service provision

a) FHI continued to support the Data Management Specialist seconded to DSW Zanzibar to provide overall management of Zanzibar DMS. He also provided technical support in the identification of MVC in two districts of Mjini Magharibi and Wete whereby 50 Shehia were covered.

III. ACTIVITIES PLANNED FOR QUARTER TWO (JANUARY-MARCH 2010):

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

1. Facilitate implementation of recommendations resulting from October 2009 NACP team building retreat, including strengthening planner's role in harmonizing planning for all donor-supported NACP treatment activities.

2. Participate in the meeting with the Senior Management Committee of the MOHSW to present and advocate for TS.

3. Print the SOPs for CTCs after clearance by the Permanent Secretary of the MOHSW is received, and seek printing support from other donors supporting the NACP.

4. Brief the NACP/NTLP on the WHO expert meeting on developing guidance for ICF/IPT implementation, and facilitate piloting and phased implementation by partners

5. Prepare for next subcommittee meetings of the NSCTHR, advocate for paediatric subcommittee and follow up on earlier action points.

Objective 2. Increased capacity of the Counseling and Social Support Unit of the NACP to lead, coordinate and monitor the provision of quality palliative care services and strengthened Home-based Care Coordinator

1. Print revised national HBC guidelines.
2. Conduct a workshop to disseminate the revised guidelines to key HBC stakeholders.
3. Engage a consultant to develop user-friendly leaflets on the national HBC guidelines for field workers.
4. Identify a consultant to review and update the HBC training materials according to national guidelines.
5. Engage a consultant to document the effectiveness of HBC and OVC service integration to inform decision-makers for future policy direction and to share with USAID.
6. Support a TOT on the HBC RRS for one M&E staff member and one program staff member from each key HBC partner.
7. Ensure that RHMTs and CHMTS share HBC RRS roll-out plans, which include details on who is responsible for what, with HBC partners.
8. Train government officers in the use of the HBC RRS in February 2010.

9. Collaborate with UCC to train district HBC coordinators and partner data clerks on the DMS.
10. Schedule a visit with the PMORALG to discuss its role in District HBC Coordinator positions.
11. Strengthen functioning of the HBC Coordinators checklist to assess client needs.
12. Support printing of the national guidelines for integrating Positive Prevention into HBC, and work towards integrating Positive Prevention into national guidelines for care and treatment, PMTCT and other HIV-prevention programs.
13. Support the MOHSW to train 16 TOTs in expanded CBPP.
14. Support MOHSW to train 40 national Positive Prevention TOTs on CBPP integration within HBC service delivery.
15. Finalize revision of PP indicators to incorporate PEPFAR indicators
16. Complete revisions to training materials for community HBC providers and PLHIV support group members.
17. Liaise with the NACP to incorporate PP monitoring tools into national HBC reporting and monitoring tools.
18. Continue to implement the CBPP pilot.

Objective 3: Strengthened national systems for OVC in Mainland and Zanzibar

1. Continue to liaise with the MOHSW to organize a meeting of the national steering committee.
2. Train additional council statisticians/ planning officers on DMS use and data analysis.
3. Work with the MOHSW to finalize the national M&E tools.
4. Coordinate baseline service mapping for the Mvomero CoC learning district.
5. Finalize first draft of the Zanzibar MVC action plan.
6. Test the DMS in Zanzibar if electricity supply is restored.

IV. COP TARGETS

FY 2010 (October 1, 2009 to September 30, 2010)

	INDICATOR	FY10 TARGET	Q1
Objective 1: Strengthened capacity of the National AIDS Control Program to lead and coordinate the scale-up of national care and treatment services through effective policies, manpower and management of the program			
1	No. of MPH students taught in health systems strengthening	20	0
2	No. of government national health officials from NACP/MOH trained in team building and management	35	32
3	No. of TOT trained in national QI guidelines	40	0
4	No. of healthcare providers from small private clinics trained in clinical care and management	40	0
Objective 2: Increased capacity of the Counseling and Social Support Unit of the NACP to lead, coordinate and monitor the provision of quality palliative care services and strengthened Home-based Care Coordinator			
5	No. of government officers trained to use the DMS	50	0
6	No. of data clerks trained on the DMS in collaboration with UCC	30	0
7	No. of TOT trained in HBCT	40	0
8	No. of TOTs on the HBC RRS to HBC implementing partners, M&E and HBC technical officers and national HBC facilitators	40	30
9	No. of individuals reached through the pilot in four sites with CBPP services	2,000	343
10	No. of TOT trained in CBPP integration within HBC service delivery	40	0
11	No. of TOT trained in expanded CBPP (e.g., for WASH, TB and FP)	16	0
Objective 3: Strengthened national systems for OVC in Mainland and Zanzibar			
12	No. of government officers trained to use the DMS	50	23
13	No. of IPs trained to use national M&E tools	50	0
14	No. of national facilitators/trainers trained on national MVC program/ NCPA facilitation, MVC identification, QI training, establishing and managing children clubs	100	0
15	No. of CSWOs trained in MVC program guidelines and tools	50	0
16	No. of social workers in Zanzibar trained including TOT on psychosocial support, caretaking skills and community participation	40	40

A. Positive Prevention Numbers Reached During the Quarter

Table 1: Total number of clients enrolled this quarter

Age Category	Male	Female	Total
0 – 9	14	34	48
10 – 24	11	15	26
25 – 35	16	40	56
36 – 45	61	68	129
46 and above	24	60	84
Total	**126**	**217**	**343**

Table 2: Total number of clients/partners tested this quarter

Age Category	Male	Female	Positive	Negative	Total tested
15 - 35	75	93	29	9	168
36 and above	53	69	51	10	122
Total	**128**	**162**	**80**	**19**	**290**

Table 3: Total number of clients who disclosed status to partner/family members this quarter

Age Category	Male	Female	Total
15 – 35	111	125	236
36 and above	102	210	312
Total	**213**	**335**	**548**

Table 4: Number of clients taking medication – ARV & Septrine (clients enrolled this quarter)

Age Category	0 - 9		10 - 24		25 - 35		36 – 45		46 and above	
Sex	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
ARVs	7	8	15	9	30	63	53	107	32	43
Septrine	10	20	6	11	33	39	29	82	35	28
Total	**17**	**28**	**21**	**20**	**63**	**102**	**82**	**189**	**67**	**71**

Table 5: Number of clients practicing health living (clients enrolled this quarter)

Age Category	0 - 5		6 - 18		19 - 35		36 - 45		46 and above	
Sex	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Use safe water	22	18	42	35	43	64	91	109	41	49
Use bed net daily	22	15	46	33	48	71	60	77	56	23
Consistently use condom	0	0	0	0	39	64	61	81	37	12
Total	**44**	**33**	**88**	**68**	**130**	**199**	**212**	**267**	**134**	**84**

Table 6: Number of clients who missed doses (this quarter)

Age category	0 - 5		6 - 18		19 - 35		36 – 45		46 and above	
Sex	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
ARVs	1	-	-	1	-	-	2	1	-	0
Septrine	-	1	-	-	-	-	1	1	1	0
TB Drugs	-	-	-	-	-	-	-	-	-	-
Total	**1**	**1**	**0**	**1**	**0**	**0**	**3**	**2**	**1**	**0**

Challenges:

- Stigma and discrimination is still a challenge in some communities which results in poor response for HIV testing, disclosure of HIV status, joining of support groups and utilization of CTCs for care and support.
- Poverty persists in the households of our clients resulting in lack of adequate food for PLHIV.
- Clients complained about poor services from health personnel at CTCs.
- Delayed results of CD4 count.

Successes that have been mentioned during supportive supervision were:

- The Positive Prevention program facilitates/encourages clients to live positively/healthily.
- The supplied water guard reduced water borne diseases such as typhoid and diarrhea.
- Protective gear (condom) has been used effectively by partners living with HIV/AIDS aiming to prevent onward transmission.
- Skin diseases reportedly were reduced/disappeared due to the use of medicated soap.
- The rate of condom use by clients is high (evidenced by request of condoms by clients). We are hoping the rate of onward transmission is reduced.
- The Positive Prevention program promotes testing and disclosure to partners and families.
- It has been reported that clients adhere to ARV treatments.
- Male condom use has been accepted positively.
- PLHIV group member numbers have increased and some have been able to start small enterprise activities.
- The Positive Prevention program facilitates provision of care and support to PLHIV, and government authorities recognize the positive-benefits of the program.
- The Positive Prevention program is helping clients to live healthier lives, especially in regards to adherence to ARVs. This is evidenced by the low number of clients that missed doses (ARVs and Septrine) this quarter.