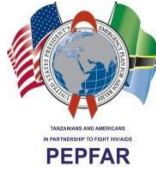

Community Health and Social Welfare Systems Strengthening Program (CHSSP)

Quarter 1 Report
Program Year 2

Reporting Period: October 1, 2015 – December 31, 2015

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Tanzania Community Health and Social Welfare Systems Strengthening Program (CHSSP)

Quarterly Report (October- December 2015)

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Acronym List

AIDS	Acquired immunodeficiency syndrome
AIHA	American International Health Alliance
ART	Antiretroviral therapy
AGYW	Adolescent girls and young women
CBO	Community-based organization
CCHP	Comprehensive Council Health Plan
CHACC	Council HIV/AIDS Control Coordinator
CHMT	Council Health Management Team
CHSB	Council Health Service Board
CHSSP	Strengthening Community Health and Social Welfare Systems Program
CHW	Community health worker
CHW TF	Community Health Workers' Taskforce
CSO	Civil society organization
CS	Civil society
CMAC	Council Multi-sectoral AIDS Committee
CPT	Child Protection Team
DACC	District AIDS Control Coordinator
DSW	Department of Social Welfare
DSWO	District Social Welfare Officer
GBV	Gender-based violence
GOT	Government of Tanzania
HFGC	Health Facility Governing Committee
HIV	Human immunodeficiency virus
HPS	Health Promotion Services
HRH	Human resources for health
HSS	Health systems strengthening
IPG	Implementing Partners Group
ISW	Institute of Social Work
JSI	JSI Research & Training Institute, Inc.
LGA	Local Government Authority
KP	Key population
MACs	Multi-sectoral AIDS Committees
MCDGC	Ministry of Community Development Gender and Children
MOHSW	Ministry of Health and Social Welfare
MVC	Most vulnerable children
MVCC	Most Vulnerable Children Committee
NACOPHA	National Council of People Living with HIV/AIDS
NACP	National AIDS Control Program
NGO	Non - government organization
PEPFAR	President's Emergency Plan for AIDS Relief
PD	Program description
PLHIV	People living with HIV
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PP	Priority population
PSW	Para-social worker
PY	Program year
RHMT	Regional Health Management Team
RAC	Regional AIDS Coordinator

SW	Social welfare
SW&SP-TWG	Social Welfare and Social Protection Technical Working Group
TACAIDS	Tanzania Commission for AIDS
TOMSHA	Tanzania Output Monitoring System for HIV/AIDS

Executive Summary

During October-December 2015, Community Health and Social Welfare Systems Strengthening Program (CHSSP) made significant progress in realignment to PEPFAR 3.0. This process entailed an extensive re-design of the project description (PD) that involved several consultations with USAID and with the Government of Tanzania (GOT). Due to this process, the Program's work plan for PY2 became redundant and could not be reworked until completion and approval of the revised PD. However, in consultation with USAID and GOT, the Program identified a select number of activities that could still be implemented during this transition phase. This quarterly report covers the progress of the identified priority activities while the revised PD and full PY2 work plan were under review.

In selecting the priority activities, CHSSP took into account the comments received following submission of the PD and at the presentation of the PY 2 work plan. These priority activities are detailed in Annex 1. Throughout the period of PD revision, the Program continued to implement activities both at national and local government authority (LGA) levels. At the national level, the Program continued to actively support the GOT with foundational coordination and policy development activities, including:

- Supporting three coordination meetings for the Social Welfare/Social Protection Technical Working Group;
- Supporting action plan development for the National Civil Society Organization (CSO) Steering Committee under the Tanzania Commission for AIDS (TACAIDS);
- In coordination with the Ministry of Health's (MOH's) Community Health Worker Taskforce (CHW TF), developing a selection criteria to identify participants for the CHW training program from saturation and aggressive scale up districts. This process was designed to increase accountability of the sponsorship program for CHW candidates that CHSSP will provide in Q2. The Program also conducted consultations to design the disbursement mechanisms for the CHW sponsorships. These mechanisms will be finalized at the beginning of Q2. These activities are within the broader support CHSSP has been providing to the CHW TF for the design of the new CHW program. In this context, CHSSP also supported the TF to advance the development of a *District CHW Program Implementation Plan.* Moreover, CHSSP supported the TF in the development of training materials that will be used in the new CHW program. This involved significant technical and financial support as these materials include 14 training modules requiring input by a number of experts.
- Revisions to the entry level qualification for para social worker (PSW) training, including facilitating policy dialogue to remove age restrictions that have impeded the retention of PSWs at community level and contributed to attrition of social welfare human resources.
- Development of service models. CHSSP supported a delegation of MOH senior officials from the Department of Social Welfare (DSW) and the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) to travel to Zimbabwe on a study tour of the case management model for most vulnerable children (MVC). This delegation was an important activity to obtain buy-in to adapt case management in Tanzania. CHSSP produced a summary report that will be used to drive planning in Q2.

At the LGA level, the Program continued to actively support strengthening coordination and capacity development of key structures and systems through the following activities:

- CHSSP's district introductory meetings: CHSSP regional offices developed a package of presentations to explain the objectives of the program and engage districts. By end of Q1, the Program had been introduced in 11 districts out of the 22 planned for this fiscal year.

- Council Multi-sectoral AIDS Committee (CMAC) Guidelines Printing and Dissemination: 154 CMAC members received an orientation on the new guidelines. CHSSP liaised with TACAIDS to facilitate printing of the guidelines and these will be available in the next quarter.

Cross-Cutting Activities

Government Official Consultations

A consultation meeting with government officials from Ministry of Health and Social Welfare (MOHSW[1]), PMO-RALG[2], MOHSW-DSW, TACAIDS, Non-Governmental Organization (NGO) Coordination Division- Ministry of Community Development, Gender and Children (MCDG) and USAID took place on December 2, 2015 to highlight the revised program objectives in alignment with PEPFAR 3.0 and continue soliciting inputs from the government to guide the implementation of program activities. The group suggested structures and systems (Table 1) the program can work to support.

A consultation meeting was also conducted with Community Development Officers, Social Welfare Officers, Council HIV/AIDS Control Coordinator (CHACC) and District AIDS Control Coordinator (DACC) in Kinondoni MC and Ilala MC districts. The CHSSP team covered the program objectives and also requested for information that will inform the PY2 workplan.

Table 1: Suggested Structures and Systems

National/Central Government Level		
Structures/Systems	**Intervention**	**Rationale**
National Council for NGOs	Support the National Council for NGOs to implement the NGO Code of Conduct	Facilitates coordination and networking of Tanzanian NGOs and CBOs working on HIV for a common and harmonized goal of influencing policies and major decisions on HIV for priority and key populations
DSW- IPG (Implementing Partners Group)	Support DSW to effectively coordinate the IPG	Coordinates implementing partners and offers an important forum where partners share information
MOHSW/PMO-RALG District Health Service Unit	Support the functionality of the MOHSW/PMO-RALG District Health Service Unit	Oversees the coordination of health policies and guidelines of health services at the LGAs and community level.
Regional Level		
Regional Secretariat and RHMT (Regional Health Management Team)	Support the Regional Secretariat to perform supervisory role to LGAs with regard to priority and key populations	Facilitate linkages between central government and LGAs; Provide supportive supervision on implementation of the priority and key populations interventions

[1] Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) as of January 2016

[2] President's Office Regional Administration and Local Government (PO-RALG)

LGA/Community Level		
NGO Ethical Committees	Support establishment of the NGO Ethical Committees at LGAs and community level	Self-regulation of NGOs/CSOs for effective implementation of priority and key population interventions at council and community levels
LGA Health Governance structures Council Health Services Board and Health Facility Governing Committee	Strengthening the functionality of the CHSB and HFGC	Endorses the Comprehensive Council Health Plan (CCHP) and facility plans focusing on the priority and key populations
Community Development Department at LGA and Community level	Support the Community Development Department at LGA to effectively coordinate CSOs/NGOs focusing on priority and key populations	NGOs/CSOs that work with priority and key populations are not well coordinated

CHSSP Staff Orientation

The staff orientation which took place in Iringa from December 9-12, 2015 was designed to foster reflective thinking to help strengthen problem-solving with our stakeholders to advance solutions for system strengthening. The objective of the orientation was to build the understanding and skills of CHSSP personnel, especially at the regional level in order to better implement the changes to CHSSP's project design.

Implications of the PEPFAR 3.0 Pivot and Communicating with Stakeholders

The first day of the staff orientation meeting focused on discussing the main changes to the design of CHSSP and PEPFAR 3.0 strategies. Participants worked in groups to fully articulate the implications of the PEPFAR pivot for CHSSP. The sessions also included realistic scenarios to help participants sharpen their skills in clearly communicating the PEPFAR pivot, explaining the structures and systems CHSSP focuses on, and the background rationale for interventions. The team engaged in critical discussion and reflection after each role play.

Monitoring, Evaluation and Reporting

The focus of the second day of orientation meetings was on monitoring, evaluation, and reporting. Three major topics were discussed:

- The CHSSP District Monitoring System;
- Reporting;
- Findings from the CHSSP Baseline Landscape Assessment.

CHSSP's monitoring and evaluation (M&E) efforts aim to ensure that relevant, up-to-date data is in the hands of users – particularly program and district staff – presented in a way that is easy to understand and to use to help guide programming and prioritization. The CHSSP M&E team facilitated an overview, demonstration and practice session of its on- and off- line data system, including practice in using one of the data entry tools. The system enables creation and use of up-to-date dashboards with data collected through simple data collection tools during program staff field visits. As new activities are implemented, new data will be collected, automatically updating the online dashboards, providing current information to guide program decision-making, compare progress across districts and regions, and to motivate staff. Data collection tools will be further refined based on the final changes to the

CHSSP PD. Subsequently, additional training will be provided to regional program staff so they can begin using the system.

A second area of discussion and learning was on timely, accurate and meaningful reporting. Reporting templates, roles and responsibilities, and timelines for activity reporting, monthly, quarterly, and annual reports were reviewed, followed by a learning and practice session on answering the "so what?" of reporting. The purpose of this session was improve reporting to capture critical learning from activities that highlight how CHSSP is achieving its objectives in alignment with PEPFAR 3.0 priorities.

Finally, a presentation and discussion of the findings from the (pre-pivot) CHSSP baseline that was conducted in July 2015 was provided by the M&E team. The focus of the discussion was on ensuring relevant findings will be used to guide future programming, as well as addressing any information gaps that needs to be filled now that the project's geographical and technical focus has shifted. Summary sheets and a brief presentation will be shared and discussed with key ministries, donor, regional and district officials.

Summary of Session on CHWs and the Community Improvement Collaborative Approach
Through Objectives 2 and 3, CHSSP is working to assist the Government of Tanzania to expand and better equip the community health and social welfare workforce and to improve referrals and linkages among community cadres and other providers or service levels. CHSSP is contributing to these aims by supporting the Government of Tanzania to roll-out a national CHW cadre and through implementing a collaborative approach to validate and expand effective models to strengthen linkages and referrals.

On day three of the workshop included a presentation aimed at orienting regional staff to current progress of the CHW program. The presentation provided staff an overview of the CHW policy and strategy and provided a detailed update on what had been achieved to-date and what is expected to be completed with support of CHSSP and other partners in the near future. The discussion closed with next steps that regional offices need to carry out in order to facilitate the identification of CHWs for scholarship and coordination with MOHSW at national and regional levels for orientation of districts to the CHW program.

Finally, staff reviewed and discussed a collaborative case study and used an interactive exercise to apply basic concepts of developing, implementing and measuring change with an improvement aim. The project's objectives, approach and timeline for implementing community collaboratives were reviewed in plenary.

District Monitoring System

CHSSP is excited to be developing the District Monitoring System described above. As mentioned, the system will accommodate new data sets as new program areas are implemented. The initial data collection tools that CHSSP is currently developing are designed to:

- Assess the current status of health and social welfare systems in the districts in collaboration with district officials and other local stakeholders;
- Identify key stakeholders' priority areas within CHSSP's mandate; and
- Collect additional baseline data against which change can be measured.

Initial questionnaires were developed by the CHSSP M&E technical and M&E teams, and created in KoBo Toolbox for data entry. Data will be imported into JSI's Salesforce database for analysis to share district performance indicators on a dashboard for rapid decision-making. These initial questionnaires were piloted in Ilala district and results from the pilot were shared during the program staff orientation in Iringa. The tools are being revised to reflect changes from the recently approved program

description. Ongoing work is also being conducted by the team to develop and refine the data storage and presentation aspects of the system.

Introductory Meetings

The success of CHSSP's planned interventions depends heavily on the engagement of stakeholders at every level of the health system. As such, CHSSP regional directors have developed a package of presentations to be used during introductory meetings to new districts to discuss the objectives of the program. Districts were selected from the PEPFAR COP 2015 geographic pivot list based on location and HIV prevalence rate.

The Mbeya team presented to a group of stakeholders from Mbozi and Rungwe districts. Meetings in Sumbawanga MC and Sumbawanga DC in Rukwa region are planned to take place at the beginning of the next quarter. In Dar es Salaam, members of the Council Health Management Team (CHMT) and other district officials (DMO, DCDO, DPLO, DSWO, DAC and CHAC) in Ilala and Kinondoni districts were interviewed during the piloting of the district monitoring tool after an introduction of the CHSS program's objectives. These meetings served as the forum for advocating health system strengthening at the council level and clarifying the mandate of CHSSP as a partner to create linkages between service providing implementing partners and key populations rather than providing service training, equipment supplies, medical supplies and infrastructure development.

In Songea MC, Mbinga MC and Wanging'ombe DC in Ruvuma and Njombe regions, the introductory meetings are planned to take place at the end of January 2016 along with the orientation and dissemination of the Multi-sectoral AIDS Committee (MAC) guidelines.

Coordination with Implementing Partners and Other Stakeholders

The Mbeya CHSSP team visited implementing partners (Jhpiego, Baylor International Pediatric AIDS Initiative and Walter Reed) working in the region. The teams discussed key systemic/operational/policy challenges being faced in Tanzania in implementing HIV counseling and testing, prevention of mother-to-child transmission, voluntary medical male circumcision, and OVC programs all government levels (national, regional, district, health facility and community). The main challenges experienced by implementing partners include a breakdown in linkages, closing the service loop from the community to facility level and interfacing with the government. Some of the solutions identified to strengthen collaboration are holding quarterly implementing partner/RHMT meetings, engaging CSOs in government systems (i.e. reporting, planning and financing), building CSO internal capacity in program and financial management, and working with community systems to address loss to follow-up among antiretroviral therapy (ART) clients.

The CHSSP Regional Director participated in the Iringa USAID supported implementing partners' meeting on December 4th, 2015. The purpose of the meeting was to improve coordination among IPs and increase opportunities for learning and cross-fertilization. Thematic groups have been constituted to address key implementation and coordination challenges. Each group is chaired by an officer from the Iringa Regional Government and supported by an IP. CHSSP will provide support to the newly proposed thematic group on community-based cadres. To further enhance collaboration and reduce duplication of efforts, implementing partners are to submit a summary fact sheet of their activities down to the ward level. In the future, activity mapping will involve GIS and the AIDSFree GIS mapping template has been identified as a starting point. Similarly, partners will share the quarterly and annual reports for the region, as well as activity work plans with the Regional Administrative Secretariat. With regards to the data collected in the region, partners were encouraged to work with the councils, the Regional Secretariat, and their management teams to facilitate integration of selected indicators into the district management information system.

Objective 1: Improved Environment for Community Health and Social Welfare Services (For Comprehensive, Sustainable and Quality HIV and Other Services)

MAC Guidelines: Printing and Dissemination

A total of 154 CMAC members in 6 district councils received an orientation on the MAC guidelines because of the 2014 revision of the guidelines and appointment of new CMAC members due to the 2015 elections. The orientation involved presentations of CHSSP's goal and objectives, presentations of the guidelines, and discussions with participants on their roles and responsibilities to better coordinate HIV services in the district councils. In addition, the CMACs developed action plans to improve coordination of HIV and AIDS services in the councils. Table 2 below indicates the number of CMAC members oriented in each focus district.

Table 2: Number of CMAC members oriented on MAC guidelines

District Council	Number of CMAC members	Female	Male
Mbozi	26	8	18
Rungwe	29	9	20
Chunya	27	7	20
Wanging'ombe	28	9	19
Njombe TC	27	10	17
Ilala MC	17	9	8
Total*	**154**	**52**	**102**

Orientations are planned in Songea MC, Mbinga DC, and Temeke MC for the next quarter.

National SW/SP TWG and Link to Most Vulnerable Children Implementing Partners Group

The IPG is a forum of partners who implement programs focusing on provision of care and support to MVC coordinated by the DSW. CHSSP was represented at the annual IPG meeting in Dar es Salaam on Nov 26, 2015. PACT and UNICEF have been supporting the DSW to coordinate the IPG. That responsibility has now shifted to CHSSP to continue ensuring more functional, better coordinated community structures and systems in serving priority and key populations. The forum will also be used to revive technical committees such as National Child Protection Committees. The program was advised to have an official meeting with DSW Commissioner to discuss this transition. CHSSP will continue its supportive role but the actual facilitation of the IPG meetings should be handled by the DSW in collaboration with PMO-RALG to ensure sustainability.

CHSSP will contribute towards ensuring more coordinated and functional community structures and systems in serving priority and key populations by supporting the IPG form. Strengthening of the IPG forum will also help to link with National SW/SP TWG.

MVC Identification Guidelines

Before MVC are registered for support, they are identified through a national MVC identification process that is carried out by national facilitators in collaboration with MVC Committees (MVCCs) at ward and village levels. The MVC identification process is guided by the National MVC Identification

Guideline which explains necessary steps involved and stipulates a timeframe for each step. The guideline was developed by DSW and has been in use for more than ten years.

CHSSP received a request from DSW to support revision of the guidelines. Subsequently, CHSSP conducted a consensus meeting with DSW and agreed on the process for revising the guideline. It will involve assessment of gaps in the guideline through involvement of implementing partners and stakeholders for MVC programs, formation of a technical task force that will review and revise the guidelines, and addressing identified issues and gaps. The process of the National MVC Identification Guidelines revision will provide stakeholders with an opportunity to include HIV issues that were not addressed in the current guidelines. Inclusion of HIV issues will contribute towards improving HIV testing among children, ART uptake and retention of children on ART.

Support to the National CSO Steering Committee

In collaboration with TACAIDS, CHSSP supported the quarterly CSO National Steering Committee (CSONC) meeting which included members of the technical working group and board members. The participants discussed the challenge of implementing the CSO guidelines and ways to engage CSOs in district planning and budgeting whereby they will advocate for budget prioritization to better provide HIV/AIDS services to key populations. The meeting culminated in the development of an action plan that will be the basis for follow-up in subsequent meetings. The plan included:

- Documentation and sharing of success stories;
- Identifying areas for support in the coordination of HIV interventions;
- Sharing HIV/AIDs guidelines and policies with CSOs;
- Building capacity of CSONSC in documentation and information sharing;
- CSOs participating in the development of the National Development Plan Development Plan for 2016-202;
- Providing M&E technical assistance; and
- CSOs using the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA), a routine, nation-wide system that collects and reports data on non-medical HIV activities all over Tanzania.

Objective 2: Higher Performing Human Resources for Community Health and Social Services - A workforce who is able to support MVC, AGYW and PLHIV to know their status, improve retention and adherence, and achieve viral suppression and overall well-being

Finalization of CHW Program Design

Preparation for the CHW Program Implementation Plan Workshop

CHSSP assisted the Assistant Director of the MOHSW Health Promotion Section to plan for of an advisory group that will prepare a zero draft outline of the District CHW program implementation plan. The process for preparing the implementation plan will be a bottom-up approach where inputs from the district level workshop will be used to update the implementation plan during the national level workshop. In December, CHSSP and Advancing Partners & Communities (APC) collaborated to plan a participatory workshop to bring together stakeholders at the community level to seek their opinions and inputs into the CHW program. Prior to the workshop at the district level, APC and CHSSP will conduct preparatory field visits to ensure an appropriate workshop design.

CHW Training Materials Development

CHSSP supported MOHSW in coordinating three workshops to develop a CHW training Facilitators' Guide which will be used in training the new formal CHW cadre. A total of 47 participants, including facilitators, designers, and content experts from MOHSW services departments, health institutions, social welfare institutes, and the department of food and nutrition contributed the development of the training materials. The planning was conducted prior to the workshop with a select number of experts. A 10-day workshop was conducted to develop the Facilitators' Guide which comprises of the 14 modules including time for field practice. The last six days of the workshop focused on editing and formatting the document. The 14 modules included in the guide are:

1. Fundamentals of Communication & Customer Service
2. Infection Prevention and Control
3. Management of Health Care Facility Environment
4. Basic Computer Application
5. Basics of Citizenship & Gender
6. Basics of Management Information System
7. Basic Life Support
8. Fundamentals of Social Work Practice
9. Prevention & Control of Diseases
10. Community Based Reproductive Maternal and Child Health Services
11. Community Based Health Promotion
12. Home Based Care
13. Basics of Entrepreneurship & Life Skills
14. Managing the Deceased at the Health Facility & Community

The document is in the final stage of development. Additional training materials will be developed between February and May 2016 and include student's manuals and assessment plans, the practicum guides, a practical procedure book, and job aids.

Expansion of HRH for Community HIV Service Delivery

Support through the CHW Taskforce

To contribute to a higher performing human resources for community health and social services in Tanzania, CHSSP works with a number of national bodies, taskforces and working groups. In its support to MOHSW for the rollout of the national CHW cadre, CHSSP collaborates with the MOHSW Health Promotion Services (HPS) Unit and the CHW Taskforce, which is made of up of representatives from a number of MOHSW departments, PMO-RALG, universities, and implementing partners.

CHSSP participated in and supported two meetings of the CHW Taskforce (hereafter, the Taskforce). They presented two key agenda items to the Taskforce; the presentation of the draft zero of the CHW Supervision Guidelines and the terms of reference for the consultant who will assist the Taskforce in the development of the CHW program design.

CHSSP provided financial and technical support to assist the working group to draft the CHW Supervision Guidelines and reviewed progress with the Taskforce. A critical issue impeding the completion of the guidelines was the fact that the CHW training content had not yet been completed. The Taskforce agreed that the draft structure and content of the Supervision Guidelines were in-line with expectations and that completion of the draft required input from the CHW training documents. In

subsequent quarters, CHSSP will continue to support the completion, field review, and revision of the CHW Supervision Guidelines to meet the deadline for printing in early Quarter 4 of PY2.

CHSSP also presented the consultant terms of reference for its support to the CHW program design activity. The Taskforce reviewed and approved these terms of reference. CHSSP further continued preparations for the program design activity, including consultant recruitment and activity planning.

The Assistant Director of the MOHSW Health Promotion Section called an ad-hoc Taskforce meeting of the CHW in November 2015 to discuss the process of selecting candidates for CHW Training. CHSSP participated in this meeting and provided an update and highlighted important issues regarding the selection of candidates for CHW training program. The meeting brought together the MOHSW Human Resources and Training Department and other stakeholders to discuss progress in candidate recruitment and selections and to troubleshoot challenges. During this meeting, it was noted that the recruitment process had not required that candidates have letters of recommendation from their villages or CHMTs. The involvement of communities in the selection of CHWs that will serve them is an international best practice for CHW selection. At the national level, the issue remains unresolved, but the Clinton Health Access Initiative and CHSSP agreed with the Taskforce that they would work with districts to ensure that the candidates they sponsor have appropriate recommendations from their villages and from CHMTs.

Support through CHW Scholarship Offer

The baseline findings showed that there is a lack of a sustainable community health workforce with standardized training, consistent funding, and clear linkages to the national health system. The GOT is in the process of establishing a new CHW cadre. These "formal" CHWs will be integrated into the civil service establishment, recruited by communities, trained for nine months, and deployed back to local communities.

The program in Y2 plans to offer scholarships to selected 200 CHW trainees from target districts to increase human resources for health (HRH) where HIV prevalence is high and ratios of providers to population is low (PEPFAR HRH strategy). The program used the circular issued by the MOH Director of Human Resources and Training that provides instructions for how CHW candidates can join the program.

Through discussions with HPS, RHMTs, and CHMTs, CHSSP has identified a process for identifying candidates for this program year. That process includes select potential candidates for sponsorship from the CHWs who are either already enrolled in the CHW training, but without support, or have already been selected by National Council for Technical Education (NACTE), but not yet enrolled in training. In total, fifteen institutions were identified, three in Njombe, five in Iringa and seven in Mbeya. This distribution accounts for about 45% (301) of the total number of CHWs enrolled from PEPFAR "saturation and aggressive" scale up districts. The list of the 301 CHWs from these focus districts is being reviewed to identify those that meet the criteria for CHSSP sponsorship. A template for selecting candidates has been prepared to ensure that verification and recommendation for sponsorship for each candidate are documented, including approval and recommendations from their communities. A consultation meeting with the regional offices and PMO-RALG was conducted to define the costing criteria and clearly define what the scholarship should cover.

CHW Assessment and Orientation

To gather information on active CHWs and CHVs, identify qualified CHW candidates for sponsorship for formal trainings, and set a foundation for districts to have better information on the community cadres serving in their areas, the program developed a tool for use by the program's regional offices.

CHSSP regional offices conducted an orientation workshop on the CHW assessment tool for 112 community level officials in 5 districts:

- 22 CHMT members from two district of Mbeya city and Chunya district council (Mbeya city 10, Chunya 12);
- 20 CHMT members from Njombe (10) and Wanging'ombe (10) districts; and
- 35 CHMT members from Dar and 35 health facility community care focal persons from Ilala municipal wards.

The assessment uses a slightly adapted version of the national CHW mapping tool developed by Muhimbili University of Health and Allied Sciences (MUHAS) and in use by the Clinton Health Access Initiative. CHSS has consulted with CHMTs to review the tool and design a data collection process that is integrated into CHMT's existing reporting and data gathering systems to make it cost effective and sustainable. The aim is that the tools will be adapted for sustained use to enhance human resource information with data on community cadres enabling CHMTs to better assess and manage their community health and social welfare workforce.

Assessment forms were distributed to all CHMTs and, in Ilala district, to facility staff responsible for community cadres. CHMT members will orient health facility in charges in wards and villages on data collection, supervise data collection, and together with regional CHSSP staff, enter data into the database and conduct analysis. As of the end of December 2015, 1,358 tools were distributed to the districts. Regional offices are following up with focal persons to ensure the forms are distributed and returned for analysis, which is planned to take place between mid-January and March.

Improving Awareness and Understanding of CBHP Policies and Strategies

The successful dissemination of national policies to the district and particularly to the sub-district level will require the availability of documents in Swahili. Subsequent to the approval of the terms of reference by the CHW Taskforce, CHSSP recruited for a qualified translator to translate the Community-Based Health Program Policy Guidelines. Translation is expected to be completed early in Quarter 2.

Strengthening the Roll-Out of the Para Social Worker System

CHSSP is committed to supporting the Council of Social Workers as a regulatory body for professional social workers in Tanzania. Currently the DSW with support from American Health Alliance (AIHA) has drafted a bill that would officially create a Council of Social Workers in Tanzania. The draft bill has not yet been presented to the parliament. The process to pass the bill continues in this financial year. Once the bill is passed, CHSSP will work closely to build the newly-formed Council to build their capacity to fill their mandate

The PSW model (introduced in Tanzania in 2008 by the Institute of Social Work [ISW] and the Tanzania Human Resource Capacity Project) fills a critical social welfare human resource gap at the village level. Retention of PSWs is a challenge. Data from the Tanzania Human Resource Capacity Project on PSW retention showed very high levels of attrition. After only two years, 36%-45% of

trained PSWs had left their posts. The attrition was largely associated with PSWs being young and mobile and leaving to seek to seek paid employment and/or migrate to urban areas. The fact that one of the requirements of the PSW model was that PSWs must be under 35 years of age contributed to the young and mobile PSW cadres. Program data from current Pamoja Tuwalee implementing partners indicate that recruiting older PSW volunteers has a positive effect on retention.

During this quarter, CHSSP worked with ISW to explore possibilities for changing the age criteria for PSW trainees so that the model can incorporate older and more stable individuals. The meeting to discuss age changes was held in Dar es Salaam on December 16, 2015 and was attended by representatives from DSW and ISW. A decision was taken to raise the age limit for volunteers who join PSW from 35 to 60 years. The next steps for ISW are to share the new age limit, revise the training manual, and communicate the change in various stakeholder forums.

Objective 3: Expanded and Improved Health and Social Welfare Coordination and Service Models (To enable improved case finding and HIV testing and counseling, increase active identification, enrollment and treatment of clients, and improve retention and adherence)

Development of a Case Management Model

Despite the favorable policy environment for MVC and the existence of numerous social welfare and protection community structures and service models, there is no comprehensive referral and linkages system in Tanzania that connects all these community structures and actors to ensure that most vulnerable children and their families receive the range of social welfare, protection, and health services they need. As a step to support MOHSW and PMO-RALG to strengthen referrals and linkages using case management by building on existing systems (national child protection system and MVCC referral protocols), CHSSP organized a study visit to Zimbabwe in October 2015 for senior officials from DSW and the PMO-RALG, as well as WEI/Bantwana staff from CHSSP and Pamoja Tuwalee. Visits were conducted the national, provincial, district, village and ward levels. Table 3 provides a snapshot summary of the visit.

Table 3: Field Visits in Zimbabwe and Discussion Themes from the Visits

Level	Institution and Date	Presentation and Discussion Themes
National	WEI/Bantwana Office, Harare - October 19, 2015	Overview of Zimbabwe's National Case Management Model and how WEI/Bantwana contributed to its development
	Ministry of Public Service, Labour and Social Welfare; Department of Child Welfare and Protection Services, UNICEF, – October 19, 2015	Department of Child Welfare and Protection Services functions National Action Plan for Orphans and Vulnerable Children II Overview of the National Case Management System Case Management Information System (CMIS)
	Council of Social Workers – October 22, 2015	Overview of the Council of Social Workers Leadership and responsibilities
Province	Department of Child Welfare and Protection Services: Provincial Office, Masvingo Province – October 20, 2015	Contextual background of Masvingo Province Role of the National Case Management System in addressing social welfare and protection issues at the provincial level Linkages with other stakeholders
District	Chivi Rural District, District Child Welfare and Protection Services Office - October 21, 2015	Contextual background of Chivi district Selection and recruitment of Child Care Workers (CCWs) and Lead CCWs (LCCWS) Linkages with other national programs CCW motivation

		Community places of safety
	Chivi District Administrator's Office – October 21, 2015	Courtesy Call
Ward & Village	Ward 2 of Chivi District: Meeting with Community Childcare Workers and Child Protection Committee Members	Case management from the community volunteer perspective CCW motivation

Building on existing systems to strengthen referral and linkages using the case management approach with a focus on community facility linkages could be the "glue" that binds existing actors and structures at the village, ward, and district levels, ensuring that vulnerable children and families have better access to core services. This will directly contribute to controlling the HIV epidemic by preventing new HIV infections, increasing ART enrollment, and supporting adherence and retention for those on ART.

The lessons learned from the visit were that an effective referral and linkages system for Tanzania must have the following characteristics:

1. Referrals should be multi-sectoral – encompassing the full range of services listed in Tanzania's National Costed Plan of Action II, including social welfare, protection, health, economic strengthening, education, nutrition, psychosocial support, and basic needs.

2. Linkages and referrals must be bi-directional – linking community based service providers with facility based service providers, including both clinical HIV service providers as well as clinics responding to gender based violence.

3. The DSW and PMO-RALG should have full ownership of a unified referral and linakges system which should eventually be scaled up as a national model. In Zimbabwe, WEI/Bantwana spearheaded the initial case management pilot but the success of the model as a national system would not be possible without the commitment of the Government of Zimbabwe.

4. Referral and linages systems must be responsive. When cases are referred "up" to the district level, a timely and appropriate response is critical to the functioning of the system, and the motivation of the volunteers and para-professionals at the community level. In Zimbabwe, the response from the district level child protection officers made the Community Childcare Workers feel that their work was important and appreciated, thus contributing to their satisfaction and retention.

5. There must be a mechanism for retaining para-professionals at the community level. The retention rate of child case care workers in Chivi District after two years was 98%. Tanzania's Para-Social Worker model suffers from high attrition rates: in some districts more than 40% of trained para-social workers have "moved on" one year after being trained.

6. Multiple mechanisms for non-monetary incentives for community volunteers should be built into the system. The Zimbabwe model provides some very compelling examples, including: 1) work tools; 2) training; 3) opportunities for peer support and support supervision; 4) public recognition and responsiveness from the district cadres; 5) participation in savings groups.

Following the study visit, CHSSP, in collaboration with DSW, PMO-RALG, and WEI/Bantwana Pamoja Tuwalee, will organize a stakeholder meeting to identify priority issues to strengthen multisectoral and bi-directional referrals in Tanzania; unpack key roles within case management process; and identify

current bottlenecks in the referral process. This stakeholder meeting will inform the conceptual framework for the referrals and linkages service model that will be piloted in two districts in Y2.

Strengthening Service Access and Quality for PLHIV, AGYW, and MVC

CHSSP is initiating a community improvement collaborative approach to validate and expand service models for improving community based service delivery and linkages for priority and key populations. Collaboratives will focus on addressing key HIV service challenges directly related to PEPFAR's core objectives, such as low uptake of HIV counseling and testing, insufficient treatment initiation, or poor ART adherence among others. CHSSP will work with CHMTs and communities to established community collaborative teams comprised of community, facility, CSO and health systems actors. In Quarter 1, CHSSP completed the collaborative concept design, oriented staff to the collaborative process, and conducted consultative meetings. In December, CHSSP conducted a field visit to Goba ward in Kinondoni to discuss the collaborative process with key health systems structure representatives and stakeholders. The objective of the trip was to identify the most effective stakeholders to participate in collaboratives as well as a locus for teams. In Quarter 2, tools for implementing the collaborative process will be finalized and the collaborative will be initiated in one district.

Way Forward: Key Activities for Q2

In Q2, CHSSP will continue activities initiated in Q1. The program will also:

- Conduct quarterly updates with key government officials and IPs for effective implementation of program activities.
- Revise, finalize and implement the district data entry monitoring tool.
- Support the Government in the finalization of the CHW program design.
- Support MOHSW to develop CHW training materials.
- Conduct assessment at village level to identify existing CHW/Vs to be sponsored by CHSSP for formal CHW training.
- Disburse 200 scholarships to CHWs.
- Translate CBHP policy from English to Kiswahili for use at ward and village level.
- Start implementation of the community improvement collaborative approach.
- Support TACAIDS to coordinate and guide policy and programming on impact mitigation.
- Support Impact Mitigation Technical Working Group quarterly meetings.
- Support National CSOs Steering Committee quarterly meetings.
- Continue orienting CMACs on their roles and responsibilities to better coordinate HIV services to priority and key populations.
- Facilitate joint planning and budgeting meetings between CSOs and local government to address priority population needs.
- Support the DSW to coordinate the National MVC Implementing Partners Group for the implementation of NCPA II.
- Achieve national consensus on way forward with National MVC Identification Guideline.
- Support CHMT (DMO) in 15 districts to better coordinate implementing partner provision of services for MVC, AGYW and PLHIV.
- Support Councils to establish and/or revitalize CMVCC, WMCC in selected districts to better advocate for health and social welfare services to priority and key populations.
- In collaboration with DSW, finalize the Guidelines for Early Identification and Intervention for Children with Disability to ensure that guidelines reflect HIV and child protection linkages.

- Support ISW to revise the PSW training program to improve retention and performance.
- Strengthen multi-sectoral and bi-directional social welfare and protection referrals and linkages using a case management approach.

Administrative and Financial Progress

The first quarter of PY2 saw progress in the administrative and financial activities of CHSSP. Importantly, the Program continued build the operational capacity of regional offices in Mbeya and Njombe, ensuring all necessary systems were in place to support the Program's technical implementation. The following key operational activities were either initiated or accomplished during Quarter 1 of PY 2:

Administration

IT System: Permanent internet connectivity in the Mbeya and Njombe regional offices. An internet service provider (ISP) was contracted to provide internet services and installation of a local area network was completed. The connectivity will support communications, storage and sharing of resources for all staff in the Mbeya and Njombe offices. In the Dar es Salaam central office, two servers were procured, delivered and installed to provide for better sharing of resources and backup of data generated by the Program.

Procurement: Procurement during this quarter continued to focus on core items to operationalize the regional and central offices. This included the initiation of competitive procurements for generators for the regional offices and finalization of office furnishings for Mbeya and Njombe offices.

Mobile Money: CHSSP signed an agreement with Vodacom to supplement Selcom for the provision of mobile money payment services in order to ensure CHSSP compliance with the Electronic Payments provision of the Cooperative Agreement. Mobile payments for workshop/training/meeting participants are being done through the Vodacom system on a pilot basis, with positive results. CHSSP expects to phase out Selcom during Q2.

Compliance: As part of day-to-day internal controls, the finance team continues to provide training to all new staff on policies and procedures to ensure understanding and accountability. The finance team, with support from the home office, conducted trainings on JSI Management Accountability and Cost Share Regulations for all three CHSSP offices. We also continued to refine the systems developed to ensure internal controls and donor compliance of the Program. These systems include the Program Finance Manual, Regional Office Finance Manual, Local Hire Employee Manual, and Operations Manual.

Human Resources

Recruitment: CHSSP underwent a significant process of restructuring in order to bring its staffing in to alignment with the new PD. Based on these changes, the Human Resources Manager, with support from the Home Office and Senior Management, began drafting 27 job descriptions, including two key positions (Director of M&E and Deputy Chief of Party) and the newly created role of Technical Director, as well as multiple F&A and program positions. These changes were necessary to bring in the new skills required for implementation of the revised PD. During Q1, the recruitment of the permanent Director of Finance and Administration commenced and initial interviews were conducted. CHSSP expects to conclude recruitment for this position early in Q2.

Finance

The financial summary of Quarter 1 of Program Year 2 is provided in the table below.

Budget Realignment: In December of PY2, CHSSP submitted a realigned program budget to USAID in response to significant programmatic changes as a result of the PEPFAR 3.0 pivot. These changes included a comprehensive reorganization of staffing, changes to the distribution of program costs across objectives, as well as an update to JSI's approved Negotiated Indirect Cost Rate Agreement and the holiday, sick leave, and vacation (HSV) rate. USAID approval of the realigned budget is pending.

Cost Share: With respect to cost share, JSI's ability to generate cost share is directly linked to program implementation. The program has begun to seek out opportunities through the work thus far and expect to begin recording cost share in the coming quarters. With the approval of the redesigned PD late in December, CHSSP plans to hold a cost share strategic planning session early in Q2 to align with the PY2 work planning. During this time the most appropriate type of cost share will be redefined and a concise plan will be generated for USAID's input and review. In anticipation of this planning session, cost share trainings were held in all CHSSP offices in December.

Deliverables

Reporting: CHSSP submitted the SF425 and Quarterly Accruals Report to the CHSSP USAID AOR.

Tanzania Community Health and Social Welfare Systems Strengthening (CHSS)
Cooperative Agreement No. AID-621-A-14-00004
JSI Research & Training Institute, Inc.

Quarterly Financial Report
October - December 2015

LINE ITEM	TOTAL APPROVED BUDGET	PREVIOUS CUMULATIVE EXPENDITURES	Quarterly Expenses for Reporting Period Oct - Dec 2015 (Q1) *				TOTAL TO DATE *
			OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	TOTAL	
SALARIES	$15,725,249	$454,491	$ 87,520.55	$ 77,422.07	$ 79,768.26	$ 244,710.88	$699,202
CONSULTANTS	$260,058	$32,717	$ 15,348.33	$ 15,348.33	$ 15,813.42	$ 46,510.08	$79,227
TRAVEL, TRANSPORTATION AND PER DIEM	$487,630	$139,579	$ 17,980.77	$ 14,245.02	$ 14,676.70	$ 46,902.49	$186,482
ALLOWANCES	$319,567	$174,739	$ 3,100.23	$ 933.46	$ 961.74	$ 4,995.43	$179,734
EQUIPMENT, MATERIALS AND SUPPLIES	$1,436,710	$478,479	$ 15,292.82	$ 15,292.82	$ 15,756.24	$ 46,341.88	$524,821
OTHER DIRECT COSTS	$2,119,123	$171,118	$ 24,652.76	$ 24,217.13	$ 24,945.51	$ 73,815.40	$244,934
PROGRAM COSTS	$4,508,749	$98,902	$ 6,202.39	$ 40,153.07	$ 5,385.83	$ 51,741.29	$150,644
GRANTS	$2,000,000	$0	$ 43,408.38	$ 43,408.37	$ 10,965.89	$ 97,782.64	$97,783
SUBRECIPIENTS / SUBCONTRACTS	$8,147,604	$424,505	$ 31,963.57	$ 128,442.60	$ 8,658.09	$ 169,064.26	$593,569
TOTAL DIRECT COSTS	$35,004,689	$1,974,530	$ 245,469.80	$ 359,462.87	$ 176,931.68	$ 781,864.35	$2,756,394
INDIRECT COSTS / OVERHEAD	$991,996	$215,066	$ 23,041.39	$ 23,041.42	$ 23,739.70	$69,823	$284,889
TOTAL COSTS	**$35,996,685**	**$2,189,596**	**$268,511**	**$382,504**	**$200,671**	**$851,687**	**$3,041,283**

* JSI's field office accounting system operates with a 1-month lag. Therefore, this report does not yet include expenses recorded in the field during June, as they have not yet been actualized in the Home Office accounting system.