USAID Kizazi Kipya

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Presented to:

Ms. Elizabeth Lema
Agreement Officer's Representative
USAID/Tanzania
686 Old Bagamoyo Road, Msasani
P.O. Box 9130
Dar es Salaam, Tanzania
elema@usaid.gov

Presented by:

Elizabeth Jere
Chief of Party
Pact Tanzania
Plot No. 74 Uporoto Street
Victoria Ursino South P.O. Box 63
Dar es Salaam, Tanzania
+255-222761933
ejere@pactworld.org

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pact building local promise.

USAID Kizazi Kipya aims to enable more Tanzanian orphans and vulnerable children (OVC)—children, adolescents, and young people orphaned and made vulnerable by HIV and other adversities—to use age-appropriate HIV and AIDS-related and other services for improved care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing.

Pact is a promise of a better tomorrow for all those who are poor and marginalized. Working in partnership to develop local solutions that enable people to own their own future, Pact helps people and communities build their own capacity to generate income, improve access to quality health services, and gain lasting benefit from the sustainable use of the natural resources around them. At work in more than 30 countries, Pact is building local promise with an integrated, adaptive approach that is shaping the future of international development. Visit us at www.pactworld.org.

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Cover photo: Members of USAID, Kizazi Kipya and Sauti project on a joint field visit in Arusha, Tanzania. Photo credit: Allison Ficht (USAID Washington)

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Abbreviations and Acronyms

AGPAHI	Ariel Glaser Pediatric AIDS Healthcare Initiative
AGYW	adolescent girls and young women
AIDS	acquired immune deficiency syndrome
AKF	Aga Khan Foundation
AMCOS	Association of Agricultural Marketing Cooperative Society in Southern
ART	anti-retroviral therapy
CBO	community-based organization
CC	community council
CCD	Care for Child Development
CCW	community case worker
CDCS	Country Development Coordination Strategy
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSSP	Community Health and Social Welfare System Strengthening program
CHW	community health worker
CLWS	children living or working on the streets
COP	chief of party
CPE	Community Peer Educator
CPT	Child Protection Team
CRMC	Community Resources Mobilization Committee
CSO	civil society organization
CTC	care and treatment clinic
CUAMM	Universitaires Apirants et Medecins
DC	district council
DCOP	deputy chief of party
DFID	U.K. Department for International Development
DIT	district implementation team
DHIS2	District Health Information Software version 2
DSW	Department of Social Welfare
DSWO	District Social Welfare Officer
ECD	early childhood development
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMMP	Environmental Mitigation and Monitoring Plan
ES	economic strengthening
ESSP	Economic Strengthening Service Provider
EW	empowerment worker (economic)
FY	fiscal year
GOT	Government of Tanzania
HBC	home-based care
HTS	HIV Testing Services
HES	household economic strengthening
HIV	human immunodeficiency virus
IHI	Ifakara Health Institute
ILO	International Labour Organization

IMA	Interchurch Medical Assistance
IP	implementing partner
IR	Intermediate Result
ISW	Institute of Social Work
LGA	local government authority
LCW	Lead Community Case Worker
LTFU	loss to follow-up
M&E	monitoring and evaluation
MC	municipal council
MDH	Management and Development for Health
MECPZ	Madrasa Early Childhood Programme Zanzibar
MGIT	Maryland Global Initiative Tanzania
MNCH	maternal, newborn, and child health
MOHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
MOU	memorandum of understanding
MTH	*Mabinti Tushike Hatamu* (Girls Let's Be Leaders)
MUAC	mid-upper arm circumference
MUHAS	Muhimbili University of Health and Allied Sciences
MVC	most vulnerable children
MVCC	Most Vulnerable Children Committee
NACOPHA	National Council of People Living with HIV and AIDS in Tanzania
NACP	National AIDS Control Program
NACS	Nutrition Assessment, Counselling, and Support
NGO	non-governmental organization
NIMR	National Institute for Medical Research
NPE	National Peer Educator
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMP	performance monitoring plan
PMTCT	prevention of mother-to-child transmission of HIV
PO-RALG	President's Office – Regional Administration and Local Government
PPP	Public-Private Partnership
PSW	para-social worker
Q	quarter
RAS	Regional Administrative Secretary
RCA	Railway Children of Africa
SAGCOT	Southern Agriculture Growth Corridor of Tanzania
SDP	School Development Plans
SIYB	Start and Improve Your Business
SNU	sub-national unit
SOP	standard operating procedure
SRH	sexual and reproductive health
SWO	social welfare officer
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
THPS	Tanzania Health Promotion Support

TOR	terms of reference
TOT	training of trainers
TSC	technical service coordinator
TSC-CM	Technical Service Coordinator – Case Management
TSC-ES	Technical Service Coordinator – Economic Strengthening
TZS	Tanzania shilling
UPS	Uninterrupted Power Supply
USAID	United States Agency for International Development
USSD	Unstructured Supplementary Service Data
VEO	Village Executive Officer
VSLG	village savings and loan group
WDC	Ward Development Committee
WEO	Ward Executive Officer
WSA	Whole School Approach
$	United States dollar

Executive Summary

USAID Kizazi Kipya is a five-year project (July 2016 to June 2021) funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). The project is implemented by Pact in partnership with Aga Khan Foundation (AKF), Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Ifakara Health Institute (IHI), Railway Children of Africa (RCA), and Restless Development. The project aims to enable one million Tanzanian orphans and vulnerable children (OVC) and young people affected by HIV and their caregivers to utilize age-appropriate HIV-related and other services for improved care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing.

To achieve its goal of ensuring children and youth thrive and survive through sustainable improvements in health and social wellbeing, Kizazi Kipya collaborates with civil society organizations (CSOs), the Government of Tanzania (GOT) at national, regional and district levels, the communities and other stakeholders. In its first year, FY 17, the project covers 130 councils (68 scale up, 62 sustained) across 28 regions of Tanzania Mainland and Zanzibar.

This report covers Q3 of FY 17 (April to June 2017) of project implementation. It presents the progress made in implementing the planned activities, achievements, success stories, challenges, and lessons learned.

Major achievements in Q3 of FY 17 are:

Technical, including service delivery to OVC, youth and their families:

- The project, through CSO community volunteers, provided services to 418,152 OVC, youth and their caregivers (181,254 male and 236,898 female) (OVC_SERV). These represent 72% of the USAID Kizazi Kipya project FY 17 target in the scale-up councils.

- Out of 418,152 OVC and their caregivers who received at least one core service, a total of 88,182 (55%) of the targeted 80% (159,077) of adolescent OVC and caregivers received economic strengthening (ES) services, while 170,151 (56%) of the targeted 80% (305,122) of OVC_SERV under 18 years received nutrition assessment, counselling and support (NACS).

- Pact began to pilot the HIV Risk, Services, and Adherence Assessment tool in Zanzibar. By the end of Q3, 32 OVC were assessed. Results will be presented in Pact's FY 17 annual progress report, along with results from other pilot sites.

- Through its technical partner, RCA, for children living and working in the street (CLWS), the project has concluded the CLWS headcount exercise in ten councils within the six major cities in Tanzania.

- National Institute for Medical Research (NIMRI) approved the protocol that enabled IHI to conduct the formative research on children working in mining.

- Pact, CSOs staff and district coordinators have used the intensive monitoring tools developed in Q2 to monitor progress of OVC and caregivers transitioned in the sustained councils to follow-up on the progress of those OVC and their caregivers; and have learnt that most of them have continued to receive services from the stakeholders who committed to continue to provide them with services.

- The project completed a number of Standard Operation Procedures (SOPs) and training materials to guide the project implementation. The completed SOPs and training packages include: OVC and caregivers Case management; identifying and reporting cases of abused, neglected and exploited children; bidirectional referral and linkage system; and the 90-90-90 strategy. Others in the final stage are: Absorbing village saving and lending groups (VSLG); whole school approach (WSA); teen clubs; and CLWS case management.

Partnership with government and care and treatment partners:

- Pact held a meeting with all care and treatment partners, as well as USAID representatives, and discussed, among other things, Enrollment of HIV+ OVC and caregivers into Kizazi Kipya at CTCs; Case identification using the HIV Risk, Services, and Adherence assessment tool; and rolling out the bi-directional referrals and linkages system with CTCs.

- Pact, at the request of the President's Office – Regional Administration and Local Government (PO-RALG), has procured 67 computers, printers, Uninterrupted Power Supply (UPS) and modems for use by District Social Welfare Officers (DSWOs) in the 67 scale-up councils where Pact is implementing Kizazi Kipya activities. The computers will be handed over to the PO-RALG officially in Q4 and then distributed to all the 67 councils.

Finance, contracts and grants:

- Pact signed sub-awards with all 48 CSOs which were approved by USAID in Q2 and these CSOs have started project implementation, including service provision to OVC, youth and their households.

- Pact received the incremental funding on May 4, 2017. At the end of the quarter Pact's total obligation stood at $32,806,939 (50.47%) of Pact's 5-year budget funding for Kizazi Kipya. Pact has adequate funding available to support escalated spending in Q4.

- Total expenditure reported in Pact's financial system for Q3 FY17 is US$ 3,689,028 compared to US$4,108,236 spent in Q2. The decrease is associated with delayed incremental funding from USAID. Due to this delay, Pact had to delay signing the sub-agreements with CSOs selected through RFA from the original date, April 1, to June 1, 2017. This delay in the start date pushed back the start date for some key council-level activities in scale-up councils

Monitoring, Learning and Evaluation

- Pact worked with EGPAF and its consultant - Digital Brain Tanzania Limited to develop the e-referral system. In this quarter, the team integrated the USSD short code with the top three mobile network operators in the country and is finalizing the technical testing of the Unstructured Supplementary Service Data) (USSD) data collection for the bi-directional referral tracking system.

- Pact finalized the technical set-up of the DHIS2 software for data entry and data management. District Health Information Software version 2 (DHIS2) will primarily be used for housing and management of household level services delivery data and data from community based interventions.

Project Introduction and Background

The government and people of Tanzania have achieved major gains in human development, including a 7% economic growth rate over the past decade. HIV prevalence declined from 7% in 2004 to 5.1% in 2012, and the number of people living with HIV (PLHIV) on treatment has steadily increased since 2010.[1] Despite these gains, deep inequities and vulnerabilities persist. HIV prevalence rates vary across geographic regions, reaching as high as 14.8% in Njombe.[2] The estimated number of orphans and vulnerable children (OVC) is 3.2 million,[3] and 25% of children ages 5–14 years are working, some in the worst forms of child labor.[4] Family is the foremost protective asset for children, but the linked forces of poverty and disease undermine families' capacity to care for children. Children under five years of age experience high rates of preventable illness, stunting, and other developmental delays. Despite persistent missed opportunities for testing infants and children for HIV and linking them to care, great strides in initiating children on anti-retroviral therapy (ART) have been made, and by March 2016, 44,817 children out of the estimated 91,000 children living with HIV were on treatment.

School access declines sharply from primary school to secondary school.[5] By age 18 years, 27% of girls in Tanzania have given birth,[6] 31.1% are married,[7] and 25.8% have experienced sexual violence.[8] HIV prevalence among young women is higher than among young men and spikes from 1.1% at age 15 to 6.6% by age 24.[9]

Supporting the Government of Tanzania (GOT) to measurably advance the global 90-90-90 goals, the Third National Multi-sectoral Strategic Framework for HIV and AIDS, the Country Development Coordination Strategy (CDCS), the Second National Costed Plan of Action for Most Vulnerable Children, and the National Action Plan to End Violence against Women and Children in Tanzania, USAID Kizazi Kipya delivers rapid scale-up of proven family-centered impact mitigation efforts for OVC, reinforced with cross-sectoral, evidence-driven interventions to reduce HIV incidence while improving performance across the continuum of care.

Program Goals and Results Framework

The overall goal of USAID Kizazi Kipya is to ensure children and youth thrive and survive through sustainable improvements in health and social wellbeing. To achieve this goal, the project works to achieve four results as indicated in the results framework presented in Figure 1.

Kizazi Kipya interventions are specifically designed to contribute to all three 90-90-90 goals:

- **First 90:** HIV screening to identify child, youth, and adult beneficiaries with higher HIV risk factors and unknown status and linking them for testing and counseling services
- **Second 90:** Ensuring HIV-positive children, youth, and caregivers access ART initiation services
- **Third 90:** Strengthening the role of community case-managers to support HIV-positive beneficiaries to receive the support they need to sustain long-term adherence to treatment and retention in ART care, contributing to viral suppression

Details will be provided accordingly in each relevant result area.

1 United Republic of Tanzania, Global AIDS Response Country Report, March 2014

2 Tanzania HIV/AIDS and Malaria Indicator Survey 2011/12

3 Measure Evaluation Working Paper, February 2015

4 Understanding Children's Work Project's analysis of statistics from National Panel Survey, 2010-2011

5 UNICEF, State of The World's Children 2015

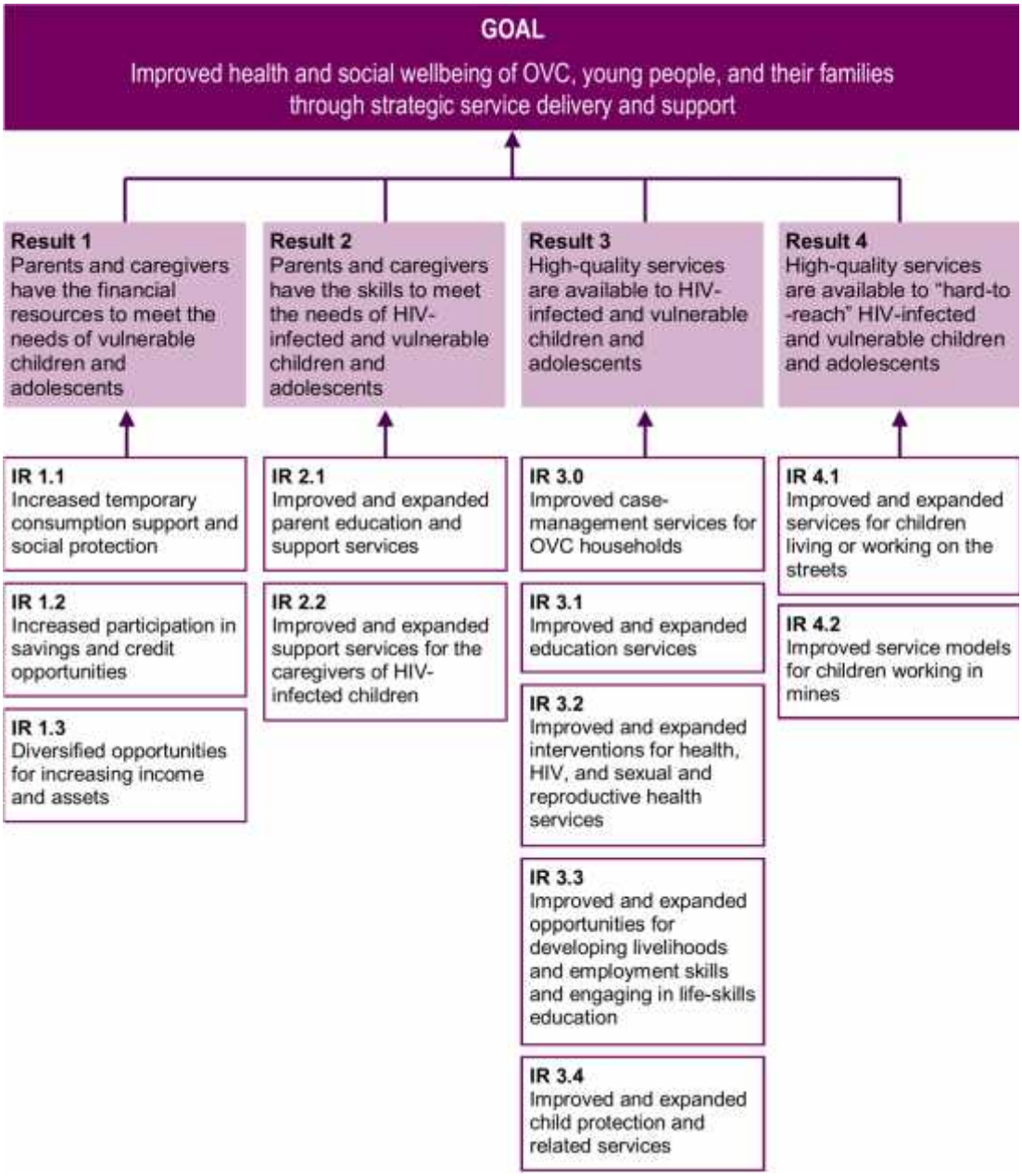
6 Tanzania Demographic and Health Survey 2010

7 THMIS 2011/12

8 Violence Against Children in Tanzania Findings from a National Survey 2009, UNICEF, U.S. Centers for Disease Control and Prevention, MUHAS, United Republic of Tanzania, August 2011

9 THMIS 2011/12

Figure 1: USAID Kizazi Kipya results framework



Geographic Coverage and Targets

In FY 17, USAID Kizazi Kipya covers 130 councils/sub-national units (SNUs), which includes 35 scale-up saturation councils, 33 scale-up aggressive councils, and 62 sustained councils. Across these SNUs, the project's overall FY 17 target is 618,684 OVC, adolescents, and caregivers. Table 1 provides details of project geographic coverage and targets.

Table 1: SNUs by categorization and target

Categorization	SNU/ councils	Under 18 total OVC_SERV target	18+ total OVC_SERV target	Total OVC_SERV target all ages
Scale-up aggressive	35	120,530	40,153	160,683
Scale-up saturation	33	315,359	105,000	420,359
Sustained	62	28,342	9,300	37,642
Total	**130**	**464,231**	**154,453**	**618,684**

Progress toward Project Goal and Target

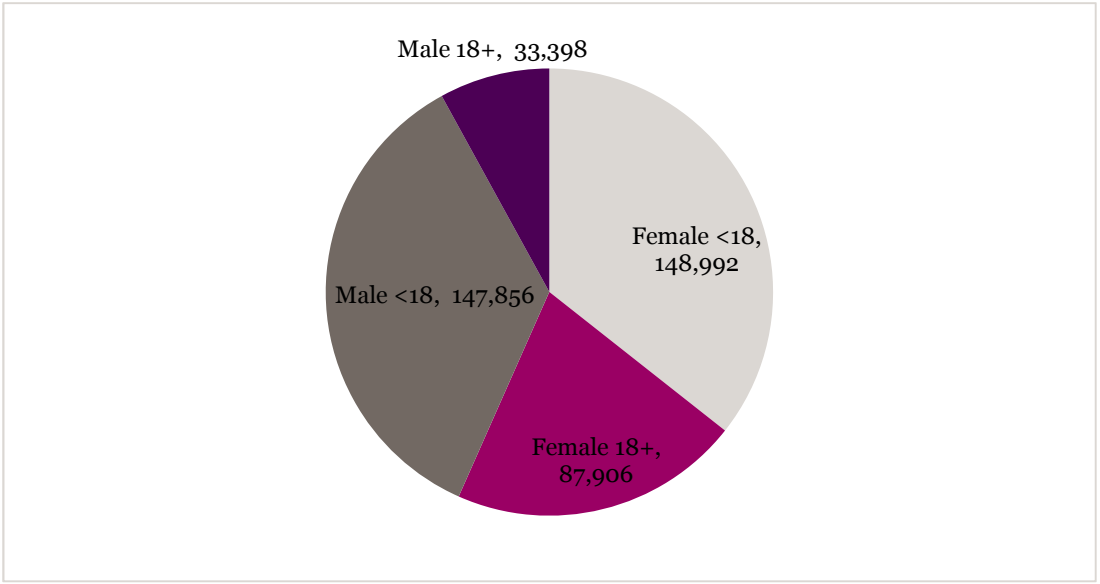
Number of OVC, Adolescents, and Caregivers served

USAID Kizazi Kipya's target for FY 17 is 618,684 OVC, adolescents, and caregivers served (OVC_SERV). This includes 160,683 in scale-up aggressive councils, 420,359 in scale-up saturated councils, and 37,642 in sustained councils. Through civil society organization (CSO) community volunteers in Q3, the project provided core services to 418,152 OVC, adolescents, and caregivers, equal to 72% of the annual target in the scale-up councils. Furthermore, female beneficiaries made up 57% of the total. See Table 2 and Figure 2 for more details.

Table 2: Progress against target per categorization

Councils category	Target	Achievement in Q3	Q2 Performance %	Q3 Performance %
Scale-up aggressive	160,683	107,844	65%	67%
Scale-up saturated	420,359	298,032	68%	71%
Sustained	37,642	N/A	172%	N/A
Not defined[10]	–	12,276		–
Total	**618,684**	**418,152**	**76%**	**72%**

Figure 2: Number of OVC, adolescents, and caregivers served in Q3 disaggregated by age categories and sex



In Q2, the project transitioned 57,065 OVC and their caregivers (81,821 total) in the sustained councils. In Q3 the project, through the CSOs staff, conducted follow-up to the service providers who committed to continue providing support to those OVC and their households in the sustained councils. Kizazi Kipya did not provide direct services to these beneficiaries in the sustained councils hence they are not reported under OVC_SERV in Q3.

The project provided services to 418,152 (72%) out of 581,042 targeted in the scale-up councils, compared to 67% supported in Q2 in the respective councils. To ensure the project reaches its target by

[10] The new councils are councils that were split from the existing scale-up councils. These are Madaba DC – new council split from Songea DC, Malinyi DC – new council split from Movomero DC, Chalinze DC – new council split from Bagamoyo DC, Buchosha DC – new council split from Sengerema DC.

end of FY 17, the project has developed a guide on how to enroll new beneficiaries in the scale-up councils with the focus being on OVC and families receiving HIV services at CTCs.

Unlike in Q2 where OVC caregivers and older adolescents formed 39% of OVC_SERV, in Q3 OVC and caregivers form 29%, while OVC under 18 form 71%. This shift is normal because the data does not include beneficiaries in the sustained councils which might have contributed to the age category difference.

The project served more female (57%) beneficiaries than male (43%), the same as Q2, aligning with the reality that women play more of a caretaking role than men.

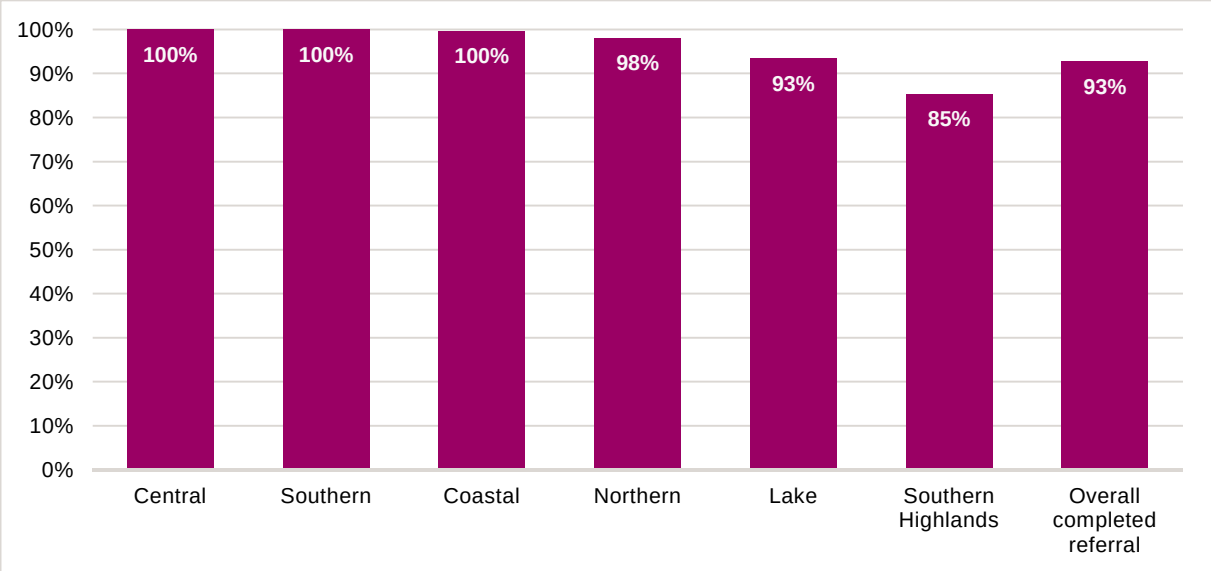
Completed Referrals

To ensure continuum of care to its beneficiaries, Kizazi Kipya works with the government and other service providers through referral and networking. In Q3, the project referred 4,802 OVC and caregivers to service providers, including to health facilities, social welfare officers (SWOs), and community groups. Of 4,802 issued referrals, 1,976 (41%) were referred for HIV Testing Services (HTS), of which 1,832 (93%) were complete referrals, whereby the project, through its community volunteers and CSOs, received verification of services provided from care and treatment clinics (CTCs) and health facilities. Table 3 and Figure 3 provide further details.

Table 3: Q3 FY17: HTS Referrals and Linkages for OVC by Cluster

Cluster	# of HTC referrals issued	# of HTC referrals completed	% of completed referrals
Central	212	212	100 %
Costal	470	468	100 %
Lake zone	274	256	93 %
Northern	107	105	98 %
Southern	82	82	100 %
Southern Highlands	831	709	85 %
Total	1,976	1,832	93 %

Figure 3: Percentage of HTS completed referrals in Q3 FY17



In Q1 and Q2, the project had to use 4 different referral systems inherited from Pamoja Tuwalee project. In Q3, Kizazi Kipya began rolling out an improved paper based referral system which resulted in increased HTS referral completion rates compared to 75% in Q2. The improvement includes Developing

SOP and job aid, and begin training of TSCs and CSOs on these SOP and job aids. The project is waiting for the newly approved National MVC Referral tool to be printed into a book by JSI for distribution to Lead Community Case Workers/ Community Case Workers (LCWs/CCWs), which will increase the number of referrals issued across the project.

In future quarters, Pact aims to have data on HIV testing yield. Currently there is not a process at HTS sites for tracking test results of the OVC referred for testing, nor are there policies in place that allow testing sites to disclose results to community programs. Pact continues to take steps to resolve these issues. In Q3, Pact met with care and treatment partners to discuss issues of shared confidentiality and the bidirectional referral and linkages for Kizazi Kipya project, and the care and treatment beneficiaries. Pact is still making follow-ups with National AIDS Control Program (NACP) to secure a meeting to discuss issues of shared confidentiality, and bidirectional referrals, among other things. Once this is agreed, it will be cascaded to the Local Government Authorities (LGAs) and health facilities and the project expects to improve its performance for both HTS services and completion of referrals. In future quarters, Pact aims to have data on HIV testing yield. Currently there is no process at HTS sites for tracking test results of the OVC referred for testing, nor are there policies in place that allow testing sites to disclose results to community programs. Pact continues to take steps to resolve these issues.

Beneficiary Identification and Enrollment

In Q1, Kizazi Kipya screened Pamoja Tuwalee beneficiaries to determine if they met the project's enrollment criteria. This was a critical step because beneficiaries served under Pamoja Tuwalee used the national most vulnerable children (MVC) identification process until FY 15, meaning that these beneficiaries may not have any HIV- or AIDS-related vulnerabilities. In Q2 no new enrollment was conducted because bridge funding was ending and CSOs for the remainder of the project were not yet selected. In Q3, the project developed the tool to guide the Kizazi Kipya project field staff and CSOs on how to smooth transition OVC and caregivers who did not meet the project enrollment criteria. These beneficiaries continued to receive services in Q3 and will be transitioned in Q4.

In Q3, the project met with care and treatment partners to strategize on how to work with CTCs to identify new beneficiaries at CTCs. Kizazi Kipya then developed a guide on how to enroll beneficiaries at the CTC and selected high volume facilities in councils that are expected to enroll more beneficiaries to reach FY 18 OVC targets. The staff have been oriented on the tool and are expected to start the enrollment at CTCs in Q4 FY 17.

Beneficiaries Transition, Graduate, or Exit the Project

Because PEPFAR will transition out of sustained councils by the end of FY 17, Kizazi Kipya began preparing to transition beneficiaries in Q1 to appropriate stakeholders. Preparations included developing standard operating procedures (SOPs), incorporating comments from the Department of Social Welfare (DSW) into the SOPs, training cluster technical service coordinators (TSCs), and cascading down the training to sustained council CSO staff and Pact's District Coordinators.[11] In Q2, CSOs and Pact's District Coordinators successfully transitioned all active Kizazi Kipya beneficiaries who were previously Pamoja Tuwalee beneficiaries in all 62 sustained councils across 550 wards.

As indicated in Table 4, in Q2, 81,821 beneficiaries in sustained councils who were inherited from Pamoja Tuwalee were transitioned to local stakeholders. The majority of families were transitioned to MVCCs (55%), followed by VSLGs (28%), and other stakeholders, such as programs operating in the council. Two percent of beneficiaries with HIV and/or malnutrition were transitioned to CTCs to ensure continuity of clinical services.

Table 4: Progress of and stakeholders to whom sustained council beneficiaries were transitioned in Q2

Cluster	% of Pamoja Tuwalee beneficiaries transitioned to local stake-holders under Kizazi Kipya	# of beneficiaries transitioned		# and % of beneficiaries transitioned by stakeholders			
		Care-givers	OVC	MVCC	Health facilities/ CTCs	VSLGs	Other
Central	14,381 (100%)	5,710	8,671	6,513 (45%)	335 (2%)	594 (4%)	6,939 (48%)
Costal	6,342 (100%)	1,809	4,533	2,675 (42%)	20 (0%)	1,090 (17%)	2,557 (40%)
Lake zone	33,684 (100%)	7,629	26,055	14,339 (43%)	740 (2%)	17,349 (52%)	1,256 (4%)
Northern	18,971 (100%)	7,181	11,790	14,596 (77%)	140 (1%)	3,110 (16%)	1,125 (6%)
Southern	6,513 (100%)	1,935	4,578	5,265 (81%)	0 (0%)	478 (7%)	770 (12%)
Southern Highlands	1,930 (100%)	492	1,438	1,477 (77%)	21 (1%)	300 (16%)	132 (7%)
Total	81,821 (100%)	24,756	57,065	4,865 (55%)	1,256 (2%)	22,921 (28%)	16 (16%)

In Q3, Kizazi Kipya continued to monitor the progress of the OVC and their families transitioned in the sustained districts through either costed extensions to CSOs that received bridge funding in the sustained councils and through District Coordinators where Pact has been implementing the project directly.[12] CSO staff and District Coordinators operating in sustained councils used a standardized supportive supervision checklist to guide engagement with LGAs, wards, and villages, as well as to conduct follow-up visits with VSLGs, former project volunteers, and beneficiaries who were transitioned during the previous quarter.

In the Coastal Cluster, for example, CSOs staff in sustained councils conducted 316 households visits to observe continuity in service delivery through other service providers. Most households confirmed to have continued receiving services and support (e.g. shelter, food and financial support for education) from local community structures and other service providers such as SILC groups, MVCCs, and LGAs.

[12] In sustained councils where there is no CSO operating under USAID Kizazi Kipya, Pact hired District Coordinators to oversee transition activities.

Progress toward Achieving Project Results

Result 1: Parents and caregivers have the financial resources to meet the needs of vulnerable children and adolescents

HIV reduces economic security and families' ability to meet children's needs by disrupting income streams, depleting assets, and increasing dependency ratios. Under Result 1 and in line with PEPFAR guidance, USAID Kizazi Kipya couple savings-led asset management with parenting skills for proven impact. The project tailors its interventions following *GOT National Guidelines for Economic Strengthening of MVC Households*. Creating family safety nets via VSLGs is an entry point and referral link for HIV services, as well as a platform for caregiver skills-building on health/HIV and positive parenting. Savings provides security for behavior change, enabling investments in health, food security, education, and uptake of HIV services and other essential services. Household economic strengthening (HES) activities within this result area are planned for consideration across the household's needs and continuum of care, with child wellbeing considerations throughout, and contribute to PEPFAR 3.0 and all three 90s of the 90-90-90 goal by reducing economic barriers to care-seeking and retention behaviors.

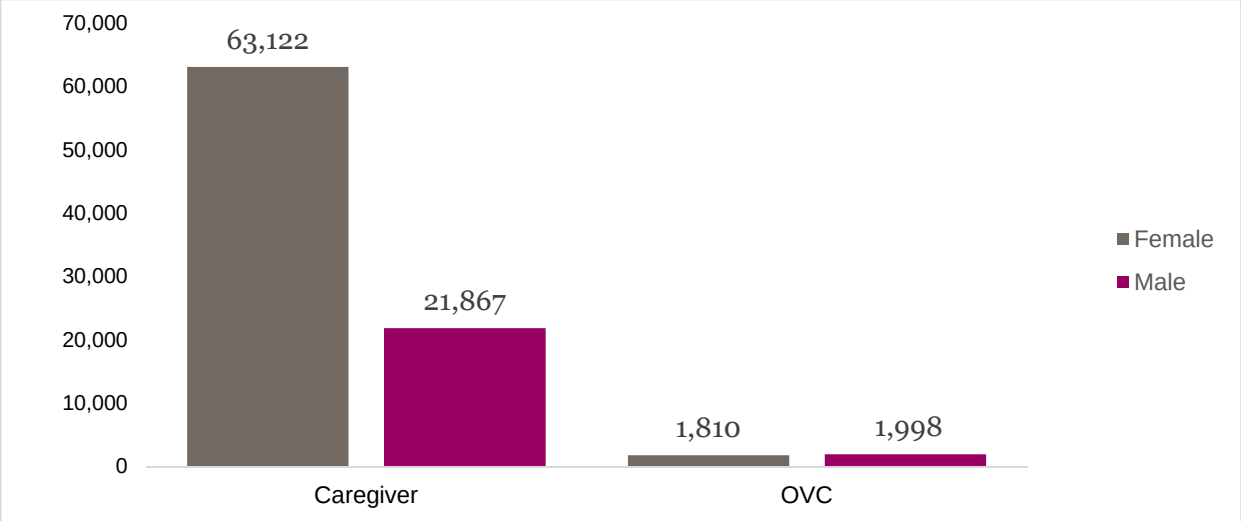
Result 1 contributes directly to the TZ_ECON indicator. As shown in Table 5, overall, Pact achieved progress against FY 17 TZ_ECON targets in both Q2 and Q3. Cluster fluctuation from Q2 to Q3 are a result of possible underreporting which will be rectified in Q4 through mentoring and coaching.

Table 5: TZ_ECON actuals against FY 17 targets in Q3 and year to date, disaggregated by cluster

Cluster	Target	Q3 Achievement	Q2 % Achieved	Q3 % Achieved
Central	22,136	7,311	43%	33%
Costal	43,968	30,999	61%	71%
Lake	34,710	17,763	71%	51%
Northern	12,734	3,075	35%	24%
Southern	8,725	8,994	63%	103%
Southern Highlands	36,804	20,655	52%	56%
Total	**159,077**	**88,797**	**54%**	**56%**

Of the 88,789 caregivers that were reach with ES services in Q3, 74% were female and 26% were male. These percentages are expected given VSLGs have focused on ensuring participation of women, who are typically the primary OVC caregivers. For children reached with ES services, the gender split is more balanced, with 48% female and 52% male OVC reached in Q3. Figure 4 shows these numbers as they relate to one another.

Figure 4: TZ_ECON actuals in Q3, disaggregated by caregiver vs. OVC and by gender



Categorize OVC households per the Child and Family Assets Assessment

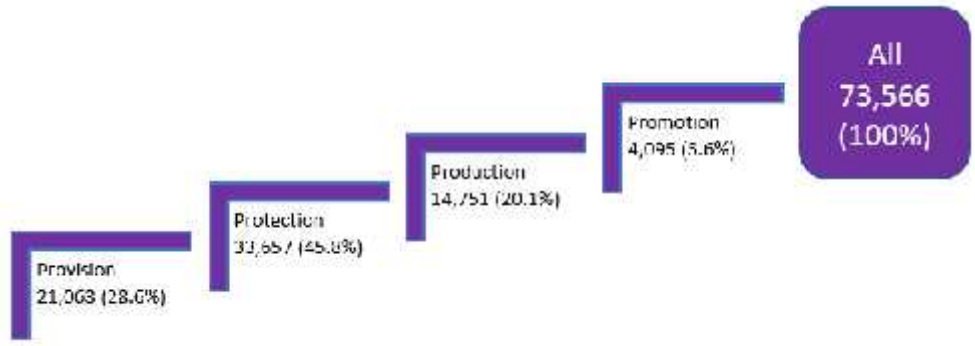
In Q2, Pact conducted seven focus group discussions, four from urban areas and three from rural areas, to collect beneficiary feedback on the proposed criteria for household economic wellbeing categorizations. In Q3, benchmarks for these categories were further refined and finalized (Table 6), and Pact categorized households across "provision," "protection," "production," and "promotion" categories using data from the family and child asset assessment administered to caregivers enrolled in Kizazi Kipya (Figure 5).

Table 6: Criteria for household economic wellbeing categorizations

Criteria for household economic wellbeing categorizations
Provision: Household is categorized as "provision" if one or more of the following are selected
Household has no dwelling
Household has difficulty having two meals per day
Household has no income stream beyond TASAF
Protection: Household is categorized as "protection" if all the following are met
Household has a dwelling
Household does not have difficulty having two meals per day
Household has at least one income stream (beyond TASAF)
Production: Household is categorized as "production" if all the criteria for "protection" are met plus
Household owns one or more of the following assets: bicycle and/or radio
Household has at least one adult member who has worked in the last month
Promotion: Household is categorized as "promotion" if all the criteria for "production" are met plus
Household from rural area reports owns goats, cows, and or/tractor(s)

Household from urban area owns one or more of the following assets: charcoal stove, solar panel, chairs, bajaji, blenders, sewing machines, hair driers, or gas cookers, freezer, refrigerator, and/or ovens

Figure 5: Household Economic Wellbeing Categorization based on Q3 Family and Child Asset Assessment Data



As shown in Figure 5, 28.6% of households enrolled in Kizazi Kipya were categorized as provision, 45.8% as protection, 20.1% as production, and 5.6% as promotion.

IR 1.1: Increase temporary consumption support and social protection

Pact will increase temporary consumption support and social protection, linking destitute OVC households (those needing provision) to immediate basic support while integrating them into early-stage HES interventions to build greater security.

Activity 1.1.1: Link destitute households to consumption support and early stage HES interventions

To ensure that *provision* households participate in savings groups, Pact facilitates linkages using social-inclusion awareness methodology to help groups set targets for and prioritize inclusion of both HIV-positive and destitute households. In Q2, as part of WORTH Yetu, Pact included social responsibility and inclusion principles in the model's materials and developed procedures for WORTH Yetu groups to establish Community Resource Mobilization Committees.

In Q3, Pact delivered its WORTH Yetu ("Our WORTH") training, with support from Pact Headquarters' Livelihoods Director, to all TSCs-ES and staff from 12 CSOs from scale-up councils in Coastal, Northern, and Southern clusters. The WORTH Yetu training included sessions on ensuring each WORTH Yetu group has an OVC fund, social fund, and Community Resource Mobilization Committee to help support destitute households. The new WORTH constitution also includes provisions to help groups set bylaws to include destitute households in groups.

In Q4, Pact will accomplish the following:

- TSCs will deliver the WORTH Yetu training, which includes social responsibility topics and inclusion principles, to CSO staff from scale-up councils in Central, Lake, and Southern Highlands clusters.
- CSOs, with support from TSCs, will deliver WORTH Yetu training to Livelihood Volunteers (LVs).

Activity 1.1.2: In USAID Kizazi Kipya project TASAF districts, work with TASAF ES staff and mobilizers to align and strengthen activities

In Q2, Kizazi Kipya, through TSCs-ES, met with Tanzania Social Action Fund (TASAF) council coordinators to strengthen the working relationship between Pact, CSOs and TASAF council coordinators. In Q3, TSCs-ES and CSOs continued meeting with TASAF at the council level. For example, in Central cluster, CSOs conducted meetings with TASAF Coordinators in 7 scale-up councils. These meetings aimed at strengthening collaboration and ensuring TASAF beneficiaries who are enrolled in Kizazi Kipya will be mobilized to join Worth Yetu groups. During these meetings, CSOs and TASAF shared council level work plans and coverage, and begin to schedule join supportive supervision visits.

Activity 1.1.3: Develop strategy on how to mobilize resources from public and private sectors

In Q1, Pact signed a Memorandum of Understanding (MOU) with President's Office Regional Administration and Local Government (PO-RALG) that defines the mutual responsibilities for USAID Kizazi Kipya's successful implementation. In Q2 and Q3, 64 out of 67 councils signed a tripartite MOU between Pact, CSO and the LGA. Among other things, the MOU set commitment to engage the public sector with regards to resource mobilization throughout the life of the project. For example, the project through its CSO partner (NEWNGONET) in Newala council used the project approach to advocate for public and private partners to support OVC. Based on that, one of the councilors in Makote Ward-Newala DC collaborated with AMCOS (Agricultural Marketing Cooperative Society in Southern Tanzania) and provided Community Health Fund (CHF) cards to 15 households of Kizazi Kipya beneficiaries affected by HIV for them to access prepaid health services in all health facilities across the council

In Q2, Pact developed Terms of Reference (TOR) for a Private-Public Partnership (PPP) consultant to work with the project team to identify key gaps in resources to support OVC, youth, and their caregivers. In Q3, Pact recruited the consultant. The consultant developed the questionnaire to assess the CSOs PPP capacity. Pact approved the questionnaire and linked the consultant with Kizazi Kipya CSOs to start data collection. In Q4, the consultant will finalize the CSOs capacity assessment, develop the training materials and develop the strategy to help the CSOs to develop the plan on how to engage PPP to mobilize resources for OVC support.

IR 1.2: Increased participation in savings and credit opportunities

Pact will build household financial safety nets through savings, using industry-recognized best-practices and approaches to savings and lending. Creating family safety nets via savings and lending groups is an entry point and referral link for HIV services as well as a platform for caregiver skills-building on positive parenting. Savings provides security for behavior change,[13] enabling investments in health, food security, and education[14] and uptake of HIV and other essential health services.

Activity 1.2.1: Create, strengthen, and/or engage VSLGs

In Q2, Kizazi Kipya's ES Advisor finalized the SOP for Supporting VSLGs inherited from Pamoja Tuwalee in Scale-Up Councils, which includes a standard supportive supervision tool to identify VSLG gaps, recommendations to address gaps, and allows for actions to be tracked throughout the quarter. Additionally, Pact's ES Advisor, in collaboration with Pact's HQ Director of Livelihoods reviewed and improved Pact's WORTH model, now called WORTH Yetu "Our WORTH." During Q2, CSOs and Empowerment Workers (EWs), with the support from Pact's TSC-ESs, continued providing technical support to absorbed VSLGs in both scale-up and sustained councils in various areas such as record keeping, loan management, cash out/dividend calculation, groups management and OVC/Social funds.

[13] "Effects of Savings on Consumption, Production, and Food Security: Evidence from Rural Malawi: IRIS Center, University of Maryland, Shaw, A. and Nagarajan, G., 2011.
[14] "The Evidence-Based Story of Savings Groups: A Synthesis of Seven Randomized Control Trials" The SEEP Network, Gash, M. and Odell, K. 2013.

As mentioned in 1.1.1., Pact trained all TSCs and 12 CSOs from scale-up councils in Coastal, Northern, and Southern clusters during Q3. In Q4, the remaining CSOs will be trained, and CSOs will cascade training to LVs, who will begin to mobilize and establish new WORTH Yetu groups in Q4.

Table 7 below presents VSLG statistics from Q3 and year to date.

Table 7: VSLG Statistics in Q3 and Year to Date, Disaggregated by Cluster

Cluster	Y1 VSLG targets	# of VSLG supported in Q3	# of WORTH Yetu groups needed to meet TZ_ECON FY 17 Target	Cumulative total savings from supported VLSGs (Tsh)		# of VSLGs with OVC or Social Fund in Q3	Total value of MVC and Social funds (Tsh)	
				Q3	Year to date		Q3	Year to date
Central	1220	361	859	185,274,200	864,633,158	137	4,764,617	18,747,485
Coastal	2217	256	1961	197,441,209	1,148,342,499	86	4,377,100	15,022,100
Lake	1,922	2748	0	474,049,818	6,488,125,101	904	46,507,571	154,492,571
Northern	667	87	580	39,063,200	339,955,000	27	2,442,300	3,247,900
Southern	456	662	0	81,835,714	833,386,128	225	9,773,998	49,798,135
Southern Highlands	1,982	1800	182	348,134,157	2,933,243,158	609	26,312,230	111,115,238
Total	**8,464**	**5,914**	**3,582**	**1,325,798,298**	**12,607,685,044**	**1,988**	**94,177,816**	**352,423,429**

Activity 1.2.2: Capacitate households with money management skills

Kizazi Kipya strengthens household financial literacy and money management abilities to help households use scarce resources more effectively, shift from reactive to proactive decision-making on household budgetary issues, and responsibly choose the financial services and products that best meet their needs. In Q2, the project developed criteria for selecting an appropriate Household Financial Literacy and Money Management curriculum with a focus on the evidence base, appropriate topics, and teaching methods.

In Q3, Pact begin to review evidence-based curriculums based on ASPIRE's draft literature review of money management curriculums, and will hire a consultant in Q4 to assist with the final selection and adaptation of the curriculum.

IR 1.3: Diversified opportunities for increasing income and assets

Pact will first conduct council-level assessments of local markets and opportunities and then pilot learning and sharing cohorts among VSLGs and link cohorts to enterprise, market and production development trainings. Additionally, Pact will facilitate external-credit linkages with pro-poor financial institutions for mature VSLGs.

Activity 1.3.1: Assess economic opportunities and resources that are available

In FY 17, Pact will conduct council-level assessments of local markets and opportunities. In alignment with the work plan, this activity was slated to start in Q2. To begin this activity, the ES Advisor has started preparations to draft a tool to map local market opportunities. In Q3, CSOs begin developing/updating service directories, which include economic strengthening opportunities. Based on this mapping exercise, in Q4, Kizazi Kipya will select 6 councils (one from each cluster) to begin to conduct deeper council-level assessments of local markets and opportunities for OVC households to enter or strengthen their position within promising value chains.

Activity 1.3.2: Provide trade and/or industry specific economic strengthening services

As indicated in the work plan, this activity will start in Q4.

Activity 1.3.3: Create external credit linkages for mature groups

While this activity is slated to begin in Q4, the project staff are oriented to use every opportunity to support WORTH groups to expand their saving and business. For example, in Q3, in Nanyumbu DC, the project field staff with CSOs staff, collaborated with TASAF coordinators and District Community Development Officers to advocate to the council leaders to use development fund (10%) of council revenue to support WORTH groups as it comprises most of destitute families. Because of this advocacy, four WORTH groups qualified to get loan of Tsh 6,000,000 from Nanyumbu District council. With this support, members of these groups are able to get a substantial loan from their groups and expand their group business. Likewise, in Newala DC, the project staff supported two WORTH groups to develop a strategic business plan and linked them to the District Community Development Department. Based on the business plan presented, each VSLG acquired Tsh 3,000,000 from Newala DC. The loan acquired will partly be used to buy the cashew nut processing machine as planned. Pact will take lessons from Southern cluster field staff to enrich other WORTH groups in other project geographic areas.

Result 2: Parents and caregivers have the skills to meet the needs of HIV-infected and vulnerable children and adolescents

Evidence shows that the impact of HIV on children's long-term development depends heavily on family capacity and coping skills. USAID Kizazi Kipya's proposed parenting interventions across result 2 contribute to the 90-90-90 goal. The activities aim to identify OVC in need of referral for HIV testing services and activities to support OVC caregivers to develop skills to support HIV-positive children and adolescents to initiate and continue ART over time. While interventions to support caregivers of HIV-positive children and adolescents are integrated across all of Kizazi Kipya's results areas (e.g., economic support under Result 1, health services under Result 3), Result 2 focuses on specific parenting skills related to the HIV-specific needs of caregivers.

In Q3, Pact continued to provide nutrition related services, reaching 170,151 OVC under 18 years, 56% of the FY 17 TZ_NUT target. In Q3, 2,108 OVC and caregivers were linked to HIV testing, ART initiation, and ART adherence support.

IR 2.1: Improved and expanded parent education and support services

The Kizazi Kipya project strives to improve caregiver health, socio-emotional well-being, and parenting skills via home visits for individualized case management; care groups to reinforce parenting messages; and through linkages and referrals.

Activity 2.1.1: Strengthen the capacity of caregivers' skills in positive parenting for children (0–19 years)

Community Case Workers are expected to deliver parenting messaging and basic skills-building for caregivers of children and adolescents ages 0–19 years through routine household case management visits, including information on development milestones of children from 0 to 18 years. Under this activity, USAID Kizazi Kipya's Child Protection and Case Management Advisor works with Community Health and Social Welfare System Strengthening program (CHSSP), UNICEF, and Department of Social Welfare (DSW) to review approved government training curricula to identify messages for delivery by LCW/CCW to OVC households.

In Q1, Kizazi Kipya met with UNICEF to understand how UNICEF is supporting the Ministry of Health Community Development Gender Elderly and Children (MOHCDGEC) in developing a national parenting framework and in preventing violence, abuse, and harmful social practices against children and its operationalization at the LGAs and community level. In Q2, Pact also reviewed the ISW PSW training and identified gaps, including caregiver communication with adolescents/youth, to foster openness and discussion around HIV-related behaviors and participated in the National Parenting Task Force Technical Working Group meeting that reviewed the National Parenting Education Manual for Families.

In Q3, Kizazi Kipya participated in the National Parenting Taskforce one-day meeting to review the National Framework for Support to Family Care and Upbringing and the National Parenting Manual for Families. Kizazi Kipya has developed a parenting messages job aid, adopted from the National Parenting Manual for families, which will help CCWs to educate parents during home visits on positive parenting and non-violent discipline techniques.

In Q4, Pact will:

- Pilot and refine parenting messages job aid
- Work with the Department of Community Development and trainers in Kibaha TC and Kilolo DC to train CSOs' Case Management Officers on the National Parenting Education Manual for Families.

Activity 2.1.2: Work with maternal, newborn, and child health (MNCH) workers and other health professionals and nutritionists to address the health and nutritional status of children under five

Kizazi Kipya recognizes that child health and nutrition form a central part of the Early Childhood Development (ECD) of children under five, particularly for HIV-positive children. Child health depends heavily on the availability of and access to immunization, quality management of childhood illness, and proper nutrition. In Q2, Pact began meeting with nutrition and food security program partners to identify ways the project can link beneficiaries to available nutrition services and developed a mid-upper arm circumference (MUAC) job aid that has been incorporated in the Practical Handbook for CCWs in preparation for orienting CSOs' Health and HIV Officers on measuring MUAC.

Kizazi Kipya's current community volunteers, who were trained under Pamoja Tuwalee in Nutrition Assessment, Counseling, and Support (NACS), continue to provide nutrition-related assessments using MUAC tapes and nutrition counseling and referrals to enrolled beneficiaries. Of 43,319- 72% out of 60,186 children under five targeted in FY 2017 who were nutritionally assessed with MUAC tapes, 2,699 (7%) had severe malnutrition, 3,226 (8%) had moderate malnutrition, and 37,394 (90%) had no malnutrition. Table 8 summarizes the number and percentage of children under five who were assessed using MUAC tapes by cluster.

Table 8: Number and percentage of children under five with specific nutritional status per cluster in Q3

	Number and percentage of children under five nutritional status		
Cluster	No malnutrition	Moderate malnutrition	Severe malnutrition
Central	3,224 (89%)	350 (10%)	205 (6%)
Coast	7,886 (95%)	476 (6%)	198 (2%)
Lake zone	12,484 (87%)	1,166 (8%)	1,181 (8%)
Northern	373 (69%)	175 (33%)	29 (5%)
Southern	4,193 (95%)	292 (7%)	186 (4%)
Southern Highlands	9,234 (90%)	767 (7%)	900 (9%)
Total	37,394 (90%)	3,226 (8%)	2,699 (7%)

Overall, in Q3 Pact reached 170,151 OVC and caregivers with NACS (TZ_NUT). This was mainly done through household visits, where community volunteers encouraged OVC households to produce

sufficient food to meet their needs and conducted nutritional assessments, counselling, and referrals/linkages for further support. As presented in Table 9, Pact's achievement in Q3 for TZ NUT represents 56% of the 80% targeted OVC_SERV under 18 years and is a 2% increase from Q2.

Table 9: TZ_NUT Actuals against FY 17 Targets in Q3 and Year to Date, Disaggregated by Cluster

Cluster	Target TZ _NUT	Q2 TZ_NUT	Q3 TZ_NUT	Q2 % Achieved	Q3 % Achieved
Central	42,356	18,716	21,453	40%	51%
Costal	84,358	34,204	32,187	39%	38%
Lake	66,608	57,911	49,612	82%	74%
Northern	24,395	5,181	1,912	19%	8%
Southern	16,752	13,977	15,410	64%	92%
Southern Highlands	70,653	46,018	49,577	65%	70%
Total	**305,122**	**176,007**	**170,151**	**54%**	**56%**

In Q3, Pact also established communication and partnership with nutrition partners, including: Interchurch Medical Assistance (IMA), Mwanzo Bora Nutrition Program, Universities Aspirants et Medecins (CUAMM), and UNICEF. During these meetings, Pact officially introduced Kizazi Kipya, learned more about partners' nutrition programs, and began to identify areas for future collaboration. Specifically, Kizazi Kipya will be linking beneficiaries to the Mwanzo Bora Nutrition Program for services around agriculture and food security. Pact is exploring the possibility of CUAMM and IMA training CCWs, who are also CHW on NACS. UNICEF is supporting Pact with MUAC tapes in Lake and Southern Highlands Cluster as a stop gap measure while JSI procures MUAC tapes for all CCWs in scale-up councils. During Q3, Pact rolled out a new service directory template for health and social services including nutrition services.

In Q4, Pact will accomplish the following:

- Set up a clear communication and collaboration mechanism with nutrition programs.
- CSOs will finalize council level service directories, which will be compiled into a national level service directory (links with 3.0.2).
- CCWs will continue to provide support to OVC and households by conducting NACS using MUAC and provide referrals where relevant.

Activity 2.1.3: Strengthen capacity of case managers to deliver Care for Child Development (CCD) services

The CCD package is a holistic and evidence-based ECD intervention that addresses the developmental needs of children ages 0–3 years. In Q1, the Aga Kahn Foundation (AKF) attended MOHCDGEC's National CCD Working Group to understand progress and status of Tanzanian adapted CCD materials. In Q2, to ensure all CCD activities are harmonized and delivered sequentially, Pact, Aga Kahn Foundation (AKF) and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) finalized the health centers selection where CCD will be delivered. AKF and EGPAF developed an SOP together to ensure CCD activities are harmonized at the health center and in the community.

In Q3, after several delays, UNICEF, in collaboration with the MOHCDGEC, contracted a consultant to review the current CCD package to adapt it to the Tanzanian context and integrate learning from past CCD implementation from other East African countries. The consultant submitted recommendations on the CCD facilitator guide and other CCD training documents. AKF and EGPAF began addressing recommendations and will meet with the MOHCDGEC to request to use the revised version prior to MOHCDGEC's official approval of the curriculum.

During the reporting period, AKF's ECD Advisor visited sites where AKF implements CCD in partnership with the government in Tanzania. Additionally, in Q3, the AKF ECD Advisor conducted an orientation meeting with the TSCs - Child Protection and Parenting on CCD in the Coast, Lake, and Southern cluster.

In Q4, Kizazi Kipya will:

- Meet with the MOHCDGEC to request to use the revised CCD version prior to MOHCDGEC's official approval of the curriculum.
- Finish addressing recommendations to the CCD package and prepare training materials for CCD.
- Begin CCD trainings with CCWs in targeted councils.

Activity 2.1.4: Formation, support, and supervision of CCD to Care Groups

In Q2, AKF East Africa convened a meeting for organizations implementing CCD in East Africa. AKF's ECD Advisor presented the plan for delivering CCD under Kizazi Kipya, received feedback from experienced practitioners and personnel, incorporated the feedback into the planning, and will use the feedback to influence the materials for CCD group-level counselling. Because this activity is dependent on a finalized CCD package, there was no progress for this activity in Q3 as efforts are focused on addressing recommendations on the CCD package.

Activity 2.1.5: Formalize relationship between the case managers, community health workers (CHWs), and home-based care (HBC) providers to improve caregivers' health and ART adherence and retention

Kizazi Kipya CCWs are responsible for conducting case management of OVC households, identifying and assessing OVC caregivers' household strengths and challenges, and supporting the caregivers to develop a care plan to improve their health, social, and economic wellbeing. During this process, CCWs will support HIV-positive caregivers, including provision of referrals to ensure ART adherence and retention. To do this, it is necessary to formalize the relationship between CCWs, CHWs, and HBC providers.

Building on a meeting between Kizazi Kipya (COP and DCOP) and the Permanent Secretary of the MOHCDGEC conducted in Q1, in Q2 the HIV Integration Advisor held an introductory meeting with NACP's Directorate of Prevention. The HIV Integration Advisor, with EGPAF, initiated discussions with PEPFAR care and treatment IPs Tanzania Health Promotion Support (THPS), Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI), MDH, and Baylor College of Medicine Children's Foundation. The discussion topic included: how to foster relationship between the CCWs, CHWs and CHBC as well as models around ART adherence and retention.

In Q3, Pact continued to meet other PEPFAR care and treatment partners: Deloitte and Walter Reed. Pact also held a meeting with all care and treatment partners, as well as USAID representatives, and discussed, among other topics, roles of LCWs/CCWs in improving caregivers' health and ART adherence and retention. USAID Kizazi Kipya, through its CSOs, has also been encouraging available community volunteers as well as HBCs/CHWs to apply to become CCWs.

In Q4, Pact will accomplish the following:

- Continue encouraging CHWs and HBC volunteers to apply to be CCWs in councils where DSW/JSI is rolling out the National Integrated Case Management training.
- Follow-up with care and treatment partners to define specific areas of collaboration at the implementation level.
- Hold a follow-up meeting with the NACP to present USAID Kizazi Kipya's operational plan.

Activity 2.1.6: Strengthen the capacity of case managers to improve caregivers' socio-emotional wellbeing

This activity was slated to begin in Q3. In preparation, in Q2, Pact met with Muhimbili University of Health and Allied Sciences (MUHAS) to discuss depression detection and screening tools that could be adapted to be used in a community setting. In Q3, Pact developed a Terms of Reference for this work and will hire a consultant in Q4 to complete a literature review of depression detection and screening tools. Kizazi Kipya, in collaboration with MOHCDGEC, will select the councils for piloting the tool and adaption.

IR 2.2: Improved and expanded support services for the caregivers of HIV-infected children

A stable, nurturing family environment is critical to effectively addressing the needs of children living with HIV. CCWs who have background as CHWs/HBCPs before joining the project will conduct weekly case management of families with children and/or youth living with HIV in order to ensure that their unique health, nutrition, protection, and socio-emotional care needs are met and to improve HIV clinical outcomes.

Activity 2.2.1: Strengthen capacity of case managers to provide case management to caregivers of HIV-infected children under 15

Case management is a core USAID Kizazi Kipya intervention for OVC and their caregivers. Capitalizing on EGPAF's technical expertise in addressing the HIV-related needs of HIV-positive children and adolescents, the project works with CHSSP to ensure that trained case managers have the skills and abilities to support the sub-set of HIV-positive OVC and their caregivers.

In Q1 and Q2, Pact reviewed the first and second versions, respectively, of the National Integrated Management Training Manual, a government endorsed curricula for training CCWs on case management, particularly to ensure that it is HIV-sensitive.

In Q3, Pact developed HIV sensitive case management supportive supervision tools for TSCs, CSO staff, and LCWs. Once CCWs are trained by JSI, CSO staff and SWOs will conduct joint supportive supervision visits to LCWs and CCWs to provide on-site mentoring and coaching. In Q3, Technical advisors (HIV and bidirectional and case management and child protection) oriented TSC's, CSOs, and DSWOs on the HIV sensitive case management supportive supervision tools. These TSCs and CSO's staff will use the supportive supervision tool with CCWs starting Q4.

Activity 2.2.2: Strengthen community volunteer cadres' skills to support caregivers of HIV-positive children

Kizazi Kipya recognizes that all CCWs need skills to support caregivers of HIV-positive children. In FY 17, EGPAF is strengthening the capacity of LCWs/CCWs in targeted areas trained by DSW/JSI to be able to support caregivers of HIV-positive children. EGPAF is working with DMO, HBC coordinator, and CTC in-charges to identify the LCWs/CCWs to receive a Supplemental Pediatric HIV Orientation.

In Q1, EGPAF held internal meetings to review national curricula for this Supplemental Pediatric HIV Orientation for LCWs/CCWs. In Q2, EGPAF worked with Pact to identify 144 high-volume CTCs across 30 councils, from which LCWs/CCWs will be selected to receive the Supplemental Pediatric HIV Orientation. Also, in Q2, EGPAF developed the SOP to guide PSWs/CCWs to provide support to caregivers of HIV-positive children and held a five-day meeting with National Pediatric HIV Facilitators to review the contents of the Supplemental Pediatric HIV Orientation for PSWs/CCWs.

In Q3, EGPAF and Pact held a meeting with the NACP's Program Officers - Adolescents and Community Based Health Services (CBHS) to share the orientation package for their review and approval, before commencement of the activity. After the review, NACP shared their recommendations including their concern that the orientation materials should be only for volunteers who have background as CHBC and/or CHW training. As such, in FY 17, Kizazi Kipya will roll out the Supplemental Pediatric HIV Orientation to CCWs who are certified as CHBCs or CHWs. EGPAF will develop an orientation package for CCWs without a CHBC/CHW background in FY 18.

In Q4 EGPAF will accomplish the following:

- Roll out orientation of CCWs who are also CHBCs/CHWs using project developed Supplemental Pediatric HIV Orientation.
- Hold a meeting with DSW/NACP and other relevant stakeholders and review available material (CBHS curriculum, National Essential Services Package for MVCs and Adolescents Living with and

affected by HIV and National Integrated Case Management Curriculum) and see which material suits CCWs who do not have prior training in HIV.

Activity 2.2.3: Facilitate and link OVC households to HIV services (under 15 years)

During home visits, LCWs/CCWs will use an HIV Risk, Services, and Adherence assessment designed by Kizazi Kipya to identify children and adolescents with HIV risk factors and to determine ART status, adherence, and provision of CD4 testing and viral load testing. This assessment will be administered semi-annually to active project beneficiaries to ensure targeted referrals for HIV services. LCWs/CCWs then will follow-up on referrals at subsequent case-management visits to reinforce the importance of any HIV-positive household member to immediately start ART and to ensure referral completion.

As the foundation, in Q1, the HIV Integration Advisor drafted the HIV Risk, Service and Adherence assessment tool. In Q2, Pact's HIV Integration Advisor incorporated feedback from USAID, EGPAF, and staff. USAID Kizazi Kipya also worked with JSI and DSW to include the HIV Risk, Service and Adherence assessment in the National Integrated Case Management training package for PSWs/CCWs.

In Q3, Pact began to pilot the HIV Risk, Services, and Adherence Assessment tool in Zanzibar. By the end of Q3, 32 OVC were assessed. Results will be presented in Pact's FY 17 annual progress report, along with results from other pilot sites.

Kizazi Kipya, through CSOs, continued to issue referrals using existing referral systems and project specific referral tools established under Pamoja Tuwalee while the National Referral System is under development. In Q3, the project referred a total of 2,230 (1,335 OVC and 985 caregivers) to HIV services. The table below indicates the number of issued and completed HIV referrals disaggregated by OVC versus caregiver and by cluster.

Table 10: Number and percentage of OVC and Caregivers issued and completed HIV related referrals in Q3

Cluster	# of HIV related referrals issued to OVC	% of completed HIV related referrals issued to OVC	# of HIV related referrals issued to caregivers	% of completed HIV related referrals issued to caregivers
Central	213	100 %	7	100 %
Coastal	448	99 %	57	100 %
Lake	109	92 %	229	94 %
Northern	114	98 %	4	100 %
Southern	10	90 %	78	100 %
Southern Highlands	441	85 %	520	87 %
Total	1,335	94 %	895	91 %

In Q4, Pact will accomplish the following:

- Complete pilot of the HIV Risk Service and Adherence Assessment in Zanzibar.
- Continue to pilot the HIV Risk Service and Adherence Assessment in areas with moderate and high prevalence: Tabora, Mbeya, Iringa and Arusha.
- Continue providing HIV related referrals using the paper-based Bidirectional Referral and Linkage System.
- Print referral forms as a stop gap measure while waiting for JSI CHSSP to print

Activity 2.2.4: Support children who are HIV-positive to access further support at child/ECD corners and youth Teen Clubs

Community case workers and other volunteers that provide household-level HIV support (see 2.2.2) facilitate linkages of families to HIV-specific child- and youth-friendly services at health facilities. Child- and youth-friendly HIV services include skills-building on access to ART, initiation of anti-retroviral drugs, disclosure support, health status monitoring, and adherence to ART. LCWs/CCWs

also ensure that caregivers of children under five who are HIV-positive access ECD corners (see 3.2.1) and that HIV-positive adolescents are referred to teen clubs (see 3.2.4).

In Q2, USAID Kizazi Kipya:

- Continued holding meetings with other PEPFAR care and treatment IPs (THPS, EGPAF, AGPAHI, MDH, and Baylor College of Medicine Children's Foundation) to establish linkages to project beneficiary access to HIV services
- Developed a Health System Engagement SOP that articulates how to engage the GOT health system, including for the MOHCDGEC, NACP, TACAIDS, Regional Health Management Team, Council Health Management Team, Hospital Management Team, CTCs, and other non-governmental health stakeholders at national, regional, council, and ward levels
- Through EGPAF, developed an SOP on Establishing, Supporting, and Monitoring ECD Corners (see IR 3.2.) that guides the entire project at all levels on how to provide children under 5 year with access to ECD corners
- Through Restless Development, developed an SOP on Establishing, Supporting, and Monitoring Teen Clubs to ensure HIV positive children access Teen Clubs

In Q3, Kizazi Kipya continued to meet with PEPFAR IPs (Henry M. Jackson Foundation and Deloitte) and discussed, among other topics, existing child and adolescent-friendly clinic models implemented by CTCs.

In Q4, Kizazi Kipya will accomplish the following:

- Finalize service directory mapping that will include child and adolescent group-based psycho-social support.
- CSOs continue to meet with CTCs to coordinate linkages of HIV positive OVC to child and adolescent friendly HIV services.
- Conduct supportive supervision with CSOs and community volunteers to ensure HIV positive children and adolescents are referred and linked to appropriate psycho-social support.

Result 3: High-quality services are available to HIV-infected and vulnerable children and adolescents

USAID Kizazi Kipya expands implementation of PEFFAR 3.0 OVC programming, with a focus on HIV services, by working closely with the GOT, CHSSP, Measure Evaluation, and care and treatment partners to strengthen coordination of service delivery, improve completed referrals of beneficiaries to community-level services, and spearhead delivery of child-centered case-management to HIV-positive children, OVC, adolescents, and their caregivers.

Interventions designed under this result contribute to the 90-90-90 goals. For the first 90, Kizazi Kipya uses an HIV screening tool to identify child, youth, and adult beneficiaries with higher HIV-risk factors and unknown status and links them to testing at health facilities, PMTCT sites, outreach services, and home-based testing, where available. For the second 90, the project ensures HIV-positive children, youth, and caregivers access ART initiation services. For the third 90, the project strengthens the role of case managers to support HIV-positive beneficiaries to receive the support they need to sustain long-term adherence to treatment and retention in ART care, contributing to viral suppression.

Activity 3.0.1: Rollout of case management services for OVC households, including assessments

USAID Kizazi Kipya is designed around a standard case management approach used in the social work sector. Case management is "a step-by-step process of identifying, providing support, referring and following up MVC cases."[15] The steps in the typical case management cycle are: 1) case identification, 2)

[15] United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children, Department of Social Welfare, "National Integrated Case Management Training Manual for Community Case Workers." January 2017.

screening and enrollment, 3) needs assessment, 4) care plan development, 5) direct service provision and support, 6) referrals and linkages, 7) care plan monitoring, and 8) graduation and case closure.

In Q1, Pact developed the Family and Child Asset Assessment tool to assess caregivers' and children's needs and strengths in various areas, including education, health, and nutritional status and provided JSI/DSW with feedback on the National Integrated Case Management Training Manual for CCWs. In Q2, Pact piloted DSW and project-specific tools in collaboration with JSI and DSW in Ubungo MC, then further refined the tools and oriented TSCs-CM, TSCs-ES, and M&E Officers on the Family and Child Asset Assessment, who then cascaded the training to CSO staff, who cascaded the training down to community volunteers.

In Q3, community volunteers administered the Family and Child Asset Assessment to 73,566 enrolled households. The table below presents household level statistics from the Family and Child Asset Assessment.

Table 11: Household- and Caregiver-Level Statistics from the Family and Child Asset Assessment Conducted in Q3

Cluster	# of households enrolled in USAID Kizazi Kipya to date	# and % of households enrolled in USAID Kizazi Kipya administered the Family and Child Asset Assessment	# and % of households that are food insecure	# and % of caregivers that report being HIV positive	# and % of caregivers who report being HIV positive, who are on ART	# and % of caregivers on ART who report adhering to ART
Central	14,460	11,443(79%)	1,314 (11%)	1,995(17%)	1,889 (95%)	1,843 (98%)
Costal	18,798	13,815 (73%)	3,850 (27%)	1,422 (10%)	1,178 (83%)	1,178 (100%)
Lake zone	23,833	20,238 (85%)	4,299 (21%)	4,402 (21%)	4,178 (95%)	3,831 (92%)
Northern	6,912	478 (7%)	101 (21%)	61 (12%)	54 (89%)	51 (94%)
Southern	7,307	5,229 (72%)	1,032 (19%)	863 (16%)	828 (96%)	791 (96%)
Southern Highlands	27,723	22,363 (81%)	3,083 (13%)	4,399 (19%)	4,106 (93%)	4,018 (98%)
Total	**99,033**	**73,566 (74%)**	**13,679 (18%)**	**13,142(17%)**	**12,233 (93%)**	**11,712 (96%)**

To date, 73,566 (74%) households enrolled in Kizazi Kipya have been administered through the Family and Child Asset Assessment. Eighteen percent of households reported being food insecure. In terms of HIV related statistics, 18% of caregivers enrolled in the project reported being HIV positive; this demonstrates successful targeting during enrollment given this percent is significantly higher than the national adult HIV prevalence in Tanzania. Of the caregivers who reported being HIV positive, 93% reported being on ART, and of those on ART, 96% reported adhering to ART. In Q4, Kizazi Kipya will work to ensure 100% of enrolled beneficiaries have been administered the Family and Child Asset Assessment.

Table 12: Child-Level Statistics from the Family and Child Asset Assessment Conducted in Q2

Cluster	# of children enrolled in USAID Kizazi Kipya to date	# and % of children enrolled in USAID Kizazi Kipya whose household was administered the Family and Child Asset Assessment	# and % of children age 5-18 enrolled in school	# and % of children enrolled in school who have not missed more than 2 days in the past 30 days	# and % of children who are HIV positive	# and % of children who are HIV positive who are on ART	# and % of children who are on ART who report adhering to ART
Central	30,739	24,439 (80%)	17,326 (71%)	16,504 (95%)	716 (3%)	608 (85%)	232 (96%)
Costal	49,311	34,754 (70%)	23,113 (67%)	20,449 (88%)	716 (2%)	532 (74%)	93 (92%)
Lake zone	77,746	64,571 (83%)	40,338 (62%)	35,259 (87%)	727 (1%)	539 (74%)	102 (92%)
Northern	13,584	1,185 (9%)	769 (65%)	736 (96%)	50 (4%)	26 (52%)	2 (100%)
Southern	17,339	12,485 (72%)	7,435 (60%)	6,828 (92%)	159 (1%)	137 (86%)	25 (81%)
Southern Highlands	62,485	49,112 (79%)	32,474 (66%)	29,381 (90%)	889 (2%)	636 (72%)	69 (85%)
Total	**251,204**	**186,546 (74%)**	**121,455 (65%)**	**109,157 (90%)**	**3,257 (2%)**	**2,478 (76%)**	**523 (92%)**

Based on the Family and Child Asset Assessment, Kizazi Kipya has key data on OVC enrolled in the project. Specifically, 65% of children age 5-18 are enrolled in school and 90% are attending school regularly. 2% of children were reported HIV positive—this aligns with national HIV prevalence estimates for children in Tanzania. Of children who are HIV positive, 76% were reported to be on ART, and 92% were reported to adhere to ART.

Beyond the Family and Child Asset Assessment, during Q3, Pact also collaborated closely with JSI/DSW to develop a Practical Handbook for CCWs that will be used during the National Integrated Case Management Training.

In Q3, Pact continued to work with JSI, particularly around the printing of case management tools and the revised schedule of the National Integrated Case Management Trainings. During the reporting period, Pact trained TSCs on key SOPs, including the project specific case management SOP. The TSC cascaded the training to 384 CSO staff (Case Management Officers, Health and HIV Officers, Case Worker Coordinators and M&E officers) and 42 LGA staff (DSWOs, DCDOs, CHACCs), who will roll out the orientation on case management procedures and job aids in Q4 to LCWs/CCWs.

Activity 3.0.2: Design logical referral system

In FY 17, USAID Kizazi Kipya is collaborating with MOHCDGEC, MEASURE, and JSI to develop an electronic OVC bi-directional referral system platform to support referrals and linkages to HIV clinical services and other clinical and social services. This work is led by EGPAF with support from Pact's HIV Integration Advisor and M&E team. By the end of Q2, DSW approved the National Referral Tool and JSI moved forward with process for printing the tool for LCWs/CCWs.

Additionally, in Q2, EGPAF selected Digital Brain Tanzania Limited to build the electronic bi-directional referrals platform. EGPAF will support the rollout of this electronic bi-directional referrals platform in 30 councils in FY 17. In the remaining scale-up councils, Pact will orient CSOs and LCWs/CCWs on the paper based Bidirectional Referral and Linkages System which included new National MVC Referral form to ensure a standardized system across the project. The Referrals and Linkages SOP, developed in Q2, articulates the processes to issue, complete, and track referrals and outlines the responsibilities of Pact, EGPAF, and CSO staff, along with LCWs/CCWs and service providers to ensure a functional Bi-directional Referral and Linkage System.

In Q3, EGPAF, Digital Brain Tanzania Limited and Pact, completed the development of the USSD, Android, and dashboard applications for the electronic bi-directional referral system. While beta testing was planned for Q3, this has been delayed due to a dispute with Airtel regarding the usage of Pact's USSD shortcode. The issue was reported to Tanzania Communications Regulatory Authority and actions to resolve the issue are underway.

Pact's HIV Integration Advisor oriented TSCs on the paper-based Bi-Directional Referrals and Linkages SOP and the TSCs cascaded the orientation to CSO staff (i.e. Health and HIV Officers, Case Management Officers, Case Workers Coordinators and M&E Officers) as well as LGA officials at the council level. This paper-based bi-directional referrals and linkages system is being rolled out in high volume facilities across Kizazi Kipya scale up councils. The paper-based system is a pre-requisite to then roll out the electronic bi-directional referrals and linkages system.

In Q4, Kizazi Kipya will accomplish the following:

- Conduct user testing to improve the electronic bi-directional referral system.
- Pilot the electronic bi-directional referral platform in selected health facilities in Arusha CC, Tabora MC, Nzega DC, Temeke MC, Kinondoni MC, Ilala MC and Mbeya CC.
- In non-EGPAF sites, CSOs' Health and HIV Officers, Case Management Officers, Case Workers Coordinators and M&E Officers will train LCWs/CCWs on the paper-based bi-directional referral and linkage system and job aids.

IR 3.1: Improved and expanded education services

Through its technical partner AKF, Kizazi Kipya works with CSOs and the government officials in the education system to enhance learning for pre-primary school children through the use of low cost materials and facilitate the communities to challenge existing socio-cultural norms around female education through the WSA. To ensure comprehensive support across multiple levels, Kizazi Kipya implements both low cost materials development and the WSA in the same schools.

Activity 3.1.1: Prepare district implementation teams (DITs) to deliver WSA in target schools

USAID Kizazi Kipya identified the WSA as the best method to support communities to challenge existing socio-cultural norms around female education. WSA facilitates the targeted primary school and surrounding communities to identify challenges and barriers that limit the ability of schools to provide high education. In terms of HIV-prevention efforts for adolescent girls, this intervention is critical because a girl's progression in school decreases her risk of HIV infection.

In Q1 and Q2, the project selected 144 health facilities in the 30 councils and 481 primary schools in 11 AKF councils, respectively, to implement the WSA. Also in Q2, AKF hosted a workshop with AKF field officers experienced in delivering the WSA, education managers from across the East African region (Kenya, Tanzania, and Uganda), and regional and international AKF education advisors to review the WSA materials and develop a supplementary material to ensure that the process of supporting the school and community explicitly focuses on the most marginalized households and children, including those infected or affected by HIV/AIDS.

In Q3, AKF finalized the WSA materials including SOP, Master Trainer Manual and the Facilitator's Manual. The finalization process included adapting and incorporating feedback from Kizazi Kipya's Senior Technical Advisor and Deputy Chief of Party. The feedback provided aimed at ensuring the SOP and training materials will support the schools and communities to reach the ultimate goal of ensuring the expected school development plans produce better results, including reducing girls' dropout, ensuring retention and transitioning to secondary school.

Pact placed TSC-Education in two clusters in Q3, and AKF worked with these field staff to prepare for the delivery of the WSA trainings. The preparation included identification of Master Trainers who will deliver the trainings to District implementing teams. AKF identified the Master Trainers from Southern Tanzania (Lindi and Mtwara), where it has been delivering the WSA approach through the Global Affairs Canada supported Strengthening Education System in East Africa project.

To enhance government ownership, AKF and the project field staff held meetings with District Education officers in Geita D.C - Geita region; Ilala and Kinondoni Municipal councils - Dar es Salaam region; Nyamagana D.C and Sengerema D.C - Mwanza region and Mbeya D.C, Rungwe D.C, Mbarali D.C, Chunya D.C and Kyela D.C - Mbeya region. The meetings aimed at discussing the training logistics, including the overall objectives of the WSA, the training schedule and selection of the district implementing team, Ward and Schools to implement the WSA.

In Q4, AK will work with Pact to prepare and deliver the WSA trainings to DITs.

Activity 3.1.2: DITs support target schools to develop and implement School Development Plans (SDPs) and block grants through WSA

This activity was meant to start in Q3, however due delays in adapting the materials, the activity will be done in early Q4.

Activity 3.1.3: Support LGA to develop and review a coordinated retention and transition between secondary and primary schools

This activity is contingent on 3.1.1 and 3.1.2 and, as indicated in the work plan, does not begin until Q4.

Activity 3.1.4: District tutors prepare low-cost material package to pre-school teachers and train zonal trainers

As part of AKF's role to deliver low cost material package to pre-primary school teachers, in Q1, AKF met with the Madrasa Early Childhood Programme Zanzibar (MECPZ), an organization that has been working with AKF for the past 30 years and has supported more than 9,000 pre-primary teachers to create age-appropriate low-cost materials (LCM), and agreed on modalities to work together to contextualize the materials for Kizazi Kipya councils in mainland Tanzania. AKF also discussed developing the low-cost materials with Tanzania Institute of Education (TIE), Right to Play, and other pre-primary education stakeholders.

In Q3, AKF contracted the services of MECPZ to deliver the low-cost materials. MECPZ has adapted their early childhood development curriculum to fit Kizazi Kipya's needs in both Tanzania mainland and Zanzibar and connect the low-cost development materials training content to the national Curriculum and Syllabus for Pre-primary education. To ensure consistency with Kizazi Kipya needs, AKF Education and ECD Advisors attended a 3-day workshop at MECPZ to discuss and guide the outline of the two manuals which will be used for the low-cost development materials training.

AKF reviewed the low-cost material development manuals in line with the comments Pact provided. The final SOP has been sent to Pact Senior Technical advisor for Final review and approval

As part of preparation for LCMD, AKF ECD and education advisors visited similar LSM activities delivered by MECP in Zanzibar and in Lindi. The visit aimed to develop an understanding of the process and to discuss related issues with teachers. These exposures have supported the advisors to ensure quality in the development of the SOP and delivery of the low-cost development material component.

With guidance from the ECD and Education Advisors, the TSCs mapped the pre-primary classes where both LCMD and WSA will be implemented. The TSCs are currently working with the Ward Education Coordinators to collect the data on the targeted primary schools which have preprimary classes and assess the characteristics of the classroom (i.e. full time assigned teacher, secured, number of pupils). The mapping exercise will inform the project's final selection of the schools which will be engaged in implementing the LCMD.

In Q4, the project will accomplish the following:

- AKF will work with MECPZ to finalize translation of the manual to Kiswahili and design the manual.
- AKF, with support from MECPZ, will deliver the LCMD trainings to district tutors.
- TSC and AKF will finalize the preprimary classes mapping and select the low-cost development materials DIT.
- AKF will work with MECPZ to deliver the LCMD training to district tutors.

Activity 3.1.5: District tutors deliver low-cost material package to pre-school teachers

This activity is contingent on 3.1.4 and, as indicated in the work plan, does not begin until Q4. In Q4 the district tutors will deliver the low-cost material development package to pre-school teachers.

IR 3.2: Improved and expanded interventions for health, HIV, and sexual and reproductive health services

Kizazi Kipya will strengthen community-level structures that build social capital of OVC, youth and caregivers and expand access to HIV and health information and services. The services provided through these structures are designed to complement the services provided during household-level case management.

Activity 3.2.1: Targeted health facilities provide ECD services and establish ECD corners

USAID Kizazi Kipya is establishing ECD corners, which provide an opportunity for health workers to model interactions between caregivers and children. Early stimulation contributes to early remediation of developmental delays and enables a more effective response to nutrition support.

In Q2, EGPAF developed an SOP to guide the establishment and support of ECD corners, which facilitate referral of HIV-positive and exposed children (activity 2.2.4) to receive early stimulation activities in the ECD corners (activity 3.2.1). In addition, EGPAF and AKF developed a joint SOP on CCD training to help both consortium members facilitate the CCD training to health care workers (HCWs) and LCWs/CCWs, respectively.

In Q3, as mentioned under 3.2.1, EGPAF and AKF are addressing recommendations to improve the CCD package made by the consultant hired by UNICEF in partnership with MOHCDGEC to facilitate the adaptation process of CCD to Tanzania.

In Q4, EGPAF plans to accomplish the following activities:

- Meet with the MOHCDGEC to request to use the revised CCD version prior to MOHCDGEC's official approval of the curriculum.
- Finish addressing recommendations to the CCD package and prepare training materials for CCD.
- Begin conducting CCD trainings to HCWs in selected high-volume health facilities.

Activity 3.2.2: Establish Teen Clubs for adolescent girls and boys (ages 10–14 years and 15–19 years)

A teen club is an organized group that brings young girls and boys together to share and learn about issues that affect them and to develop core life skills through club organization and management. Youth are supported to establish the youth-led clubs and provided with the opportunity to learn and acquire knowledge on HIV, livelihood opportunities, and career choices. The teen clubs aim to improve the youths' situation in their communities while developing organizational, planning, and management skills. Restless Development leads all activities under this activity, including recruiting and training National Peer Educators (NPEs) and Community Peer Educators (CPEs) who are responsible for mobilizing adolescents and establishing the teen clubs. The NPEs are stationed at the ward level and work alongside the CPEs and CSOs.

In Q2, Restless Development developed the Establishing and Supporting Teen Clubs SOP with NPEs and reviewed and updated the Teen Club Toolkit and NPE and CPE training materials. In Q3, Restless Development conducted its foundational training for all 50 recruited NPEs. During the reporting period, Restless Development supported CSOs to recruit CPEs, who will oversee out of school teen clubs for OVC ages 10-14 and 15-19. In Q3, Restless Development developed and adapted materials to deliver trainings on establishing and supporting Teen Clubs to CSOs and CPEs. In Q4, Restless Development will work with the project field staff and the CSOs to prepare CPEs training.

Activity 3.2.3: Implement the adapted "Girls Let's Be Leaders" toolkit with Teen Clubs

In Q2, Restless Development adapted their "Girls Let's Be Leaders" Toolkit to the Kizazi Kipya context. The "Girls Let's Be Leaders" Toolkit was included in the training Restless Development delivered to NPEs and CSOs in Q3.

In Q4, Restless Development will support NPEs to prepare CSOs and CPEs training in establishing and supporting teen clubs, which will include the "Girls Let's Be Leaders" Toolkit

Activity 3.2.4: Roll out the Stepping Stones curriculum to Teen Club participants

Kizazi Kipya plans to use the evidenced-based Stepping Stones curriculum, a gender-transformative HIV-prevention intervention effective in reducing sexual risk-taking and intimate partner violence, which has been adapted to Tanzania's context for adolescent girls and young women (AGYW) and translated into Kiswahili by Jhpiego. In FY 17, in councils where Restless Development is not mobilizing and establishing Teen Clubs, Pact planned to use trained facilitators to deliver Stepping Stones to AGYW enrolled in Kizazi Kipya. Initially, Pact planned to use the Sauti-trained peer educators, however, subsequently learned that these peer educators were too busy with Sauti activities to facilitate groups under Kizazi Kipya. However, because there are no national facilitators that have been trained, Pact is exploring the possibility of supporting the training of national facilitators in FY 18.

Activity 3.2.5: Provide SRH education outreach to Teen Clubs (ages 12–18 years)

In FY 17, NPEs and CSOs, with technical support from EGPAF's Pediatric HIV Officer and Pact's cluster-level Bi-Directional and Referral Coordinators, are engaging HCWs to support SRH educational outreaches to teen clubs on a quarterly basis. Outreach services include HTS referrals and educational sessions on adolescent sexual reproductive health (ASRH). Moreover, Pact and EGPAF are collaborating with the USAID Boresha Afya program (EGPAF) and AGPAHI to ensure coordination on ASRH outreaches, as both USAID Boresha Afya and USAID Kizazi Kipya will conduct this intervention.

In Q2, EGPAF developed an SOP on how HCWs would provide ASRH outreach services to the project-supported teen clubs in councils where Restless Development will implement Kizazi Kipya and in Q3 EGPAF, with support from Pact, included the procedures on delivering ASRH outreach services in councils where Restless Development will not support teen clubs. Additionally, EGPAF identified HCWs from high volume sites who are already trained on ASRH through EGPAF CIFF – Adolescent project. A total of 113 ASRH trained HCWs have been identified to support this activity under Kizazi Kipya.

In Q4, EGPAF will accomplish the following:

- Orient CSO District Reproductive and Child Health Coordinator (DRCHCo), CSO Health and HIV Officers, NPEs/CPEs and other stakeholders on the SOP.
- Continue identification of trained HCWs in other councils and engage them in the facilitation of outreach sessions.
- Rollout the sessions in non-Restless Development supported councils.

Activity 3.2.6: Implement DREAMS interventions to reduce HIV incidence and increase school attendance among AGYW

DREAMS funding under Pact will be included in the upcoming project modification, so there are no major DREAMS activities to report for Q3.

Activity 3.2.7: Link adolescents to MTH/DREAMS drop-in centers

In Q2, given news that Sauti Drop-in-Centers have been closed per MOHCDGEC's request, Pact mapped Restless Development's 26 *Mabinti Tushike Hatamu* (Girls Let's Be Leaders; MTH) drop-ins across Dar es Salaam, Iringa, and Ruvuma regions. These MTHs focus on supporting girls ages 14–19 years through

SRH education, vocational trainings, and sports to help them achieve their goals. The MTH location information will be included in respective CSO's council and ward level service directories, which will be completed in Q4. Once MTHs are included in the service directories, CCWs will refer and link female adolescent beneficiaries to these centers as appropriate.

Activity 3.2.8: Case managers work with high-pediatric-volume CTCs to trace HIV-positive OVC who miss appointments, enroll them in USAID Kizazi Kipya, and link them back to CTCs

In 2015, the GOT adopted the "test and treat" strategy for all HIV-positive children and adolescents under age 15 years, which mandates that all HIV-positive children and adolescents start ART immediately after diagnosis with HIV. Caregivers often are referred to larger health facilities for their children's ART initiation and continued care due to the lack of trained pediatric HIV specialists at lower-level health centers and dispensaries. The geographic distance has cost and time implications, particularly if the caregiver receives his/her own ART at a different facility from the child. These and other barriers put children on ART at risk of missing clinic appointments and defaulting on treatment and threaten their chances of achieving the ultimate goal of durable viral suppression (the third 90 goal) and of preventing HIV-related mortality.

In Q3, Kizazi Kipya continued to discuss with other IPs (THPS, MDH, AGPAHI, EGPAF, and BIPAI) models for pediatrics, adolescents, adult loss to follow-up (LTFU) tracing, shared confidentiality, and other services related to Kizazi Kipya's beneficiaries. At the regional and council levels, in Q3 alone, Kizazi Kipya held meetings with 20% of RHMTs, 35% of CHMTs and 43% of other IPs at council level.

In Q4 Pact will accomplish the following:

- Bi-Directional and Referral Coordinators will continue collaborating with care and treatment IPs and RHMTs at the regional level.
- CSOs will continue to maintain relationships with CHMTs and care and treatment partners at the council level.
- CSOs, with technical support from Bi-Directional and Referral, will coordinate around LTFU issues (e.g. CTC focal person identifies LTFU cases that community volunteers can trace) with targeted 168 CTCs in scale-up councils (links to IR 3.0.2).

I.R. 3.3: Improved and expanded opportunities for developing livelihoods and employment skills and engaging in life skills education

USAID Kizazi Kipya Project strives to meet the developmental needs, protect against exploitation and ensure safety and build life skills and entrepreneurship of youth. Restless Development is the project technical partner with combined youth expert in youth direct capacity building in life skills and entrepreneurship. To ensure sustainability, Restless Development will strengthen the CSOs capacity to address the needs of these youth through capacity assessment and support, training, youth (NPEs), mentoring and coaching.

Activity 3.3.1: Orientation/top-up training of Start and Improve Your Business (SIYB) trainers on policies (gender and child protection), project strategy, and contents of training manuals

Through its partner Restless Development, Kizazi Kipya is strengthening CSOs' knowledge, skills, and opportunities for youth livelihoods development based on the International Labour Organization (ILO) SYIB curriculum. Restless Development implemented this project with ILO and to date has SIYB TOTs and two master trainers who continue to provide skills and awareness on livelihood opportunities and marketing strategies. The TOTs use ILO SIYB training manuals that Restless Development has contextualized to cater to young people with low education levels.

In Q2, Restless Development developed an SOP for rolling out the SIYB model, demonstrating integration with other Kizazi Kipya activities, including education promotion, ES activities with

caregivers, case management, and OVC identification; conducted a refresher training for its TOTs; and selected and trained 10 NPEs (4 females, 6 males) as master trainers for the SIYB packages.

In Q3 Restless Development successfully reviewed a number of curricula including: Girls Let's Be Leaders, *Tuongee kuhusu Elimu ya Afya na uzazi,* the SIYB toolkit and the financial literacy curriculum. Linked to 3.2.2, in Q4, the trained 50 NPEs will start preparation for training CSOs and CPEs in the SIYB Package

Activity 3.3.2: Training of CSOs in youth engagement, life skills, livelihoods, and youth employability

As a project technical partner on youth engagement, life skills, livelihoods, and youth employability, Restless Development is responsible for strengthening the CSOs capacity to work with youth.

In Q2, Restless Development developed an SOP on training CSOs in youth engagement, life skills, livelihoods, and youth employability and started preparation to conduct the CSOs assessment on youth engagement.

In Q3, Restless Development conducted organizational capacity assessments to nine CSOs (WAMATA, KIWWAUTA, ACT- DSH, ADP Mbozi, IRDO, COCODA, Allamano Centre, TAHEA and Afya Women Group). The assessment aimed at identifying the CSOs strengths and gaps in the areas of youth engagement, life skills, financial management, monitoring and evaluation, gender issues, child protection, livelihood and youth employability. Restless Development is compiling and analyzing the data. The report will be shared in Q4 and CSOs will be supported to develop action plans against the gasps identified.

In Q4, Restless Development will work with the project field staff to support CSOs to develop an action plan for addressing the identified gaps.

Activity 3.3.3: Support CSOs in marketing youth products through local- and national-led initiatives organized by government and other partners

As indicated in the work plan, this activity will not begin until Q4.

IR 3.4: Improved and expanded child protection and related services

The Violence Against Children (VAC) study conducted in 2009 found high rates of VAC in Tanzania, including higher vulnerability of orphans to different forms of abuse compared to non-orphans[16]. More than a third of orphaned females reported experiences of childhood sexual violence compared to a quarter of females who were not orphaned[17], which implies a higher risk of orphans to HIV infection.

Activity 3.4.1: Conduct *Sinovuyo Caring Families for Parents and Teens* to reduce risk of violence, neglect, and abuse [this activity is linked with activity 2.1.5 and DREAMS]

Pact is working with Clowns Without Borders to scale-up community-based violence prevention activities using the evidence-based *Sinovuyo Teens* package,[18] an intervention aimed at specifically reducing the risk of violence against adolescents and improving positive parenting. Evidence-based HIV-related modules have also been added to the original *Sinovuyo Teens* by Clowns without Borders for DREAMS programs in other African countries; Pact will use this enhanced curriculum with groups of adolescents, both girls and boys, and their caregivers. In FY 17, the Sinovuyo Caring Families for Parents

[16]UNICEF (2011). Violence Against Children in Tanzania.

[17] Ibid, page 22.

[18] Sinovuyo means "We Have Happiness" in isiXhosa, the predominant language in the Western Cape.

and Teens intervention is being piloted in five councils (Temeke DC, Mbeya CC, Iringa DC, Kyela DC, and Morogoro MC).

In Q2, Kizazi Kipya introduced the Sinovuyo Caring Families for Parents and Teens intervention to the Director for Child Development from the MOHCDGEC, who commented that the intervention has come at the right time given the launch of the National Plan of Action to End Violence against Women and Children (2017/18-2021/22).

In Q3, Pact worked with Clowns Without Borders and in collaboration with MOHCDGEC to adapt the Sinovuyo Caring Families for Parents and Teens curriculum to the Tanzanian context. The curriculum has been renamed Furaha Caring Families for Parents and Teens and has been translated to Kiswahili. During the reporting period, Clowns Without Borders conducted a CSO readiness assessment, held a preparation meeting with CSOs and government representatives, and trained its first wave of Furaha facilitators, who will train the CSO Case Management Officers, CSO Case Management Coordinators, LCW, and CCWs.

In Q4, Pact will:

- Mobilize Kizazi Kipya beneficiaries to take part in Furaha Caring Families for Parents and Teens.
- Conduct Furaha Caring Families for Parents and Teens sessions with approximately 400 OVC, age 10-17, and their caregivers.

Activity 3.4.2: Refer cases of violence, abuse, neglect, and exploitation to DSWOs and Child Protection Teams (CPTs)

Through their case management work, CCWs are positioned to identify cases of violence, abuse, neglect, and exploitation. Identified cases must then be referred to relevant channels according to national reporting structures as per GOT's national child protection regulations. Specifically, CCWs refer child abuse, neglect, and exploitation cases to DSWOs and CPTs who take over the case to ensure survivors receive appropriate services.

In Q1, Pact met with UNICEF and agreed on councils where child protection interventions overlap and identified synergies[19] in the following councils: Iringa MC, Iringa DC, Makete DC, Mbarali CC, Mbeya CC, Mbeya DC, Mufundi DC, Njombe DC, and Temeke MC. As a result, UNICEF will strengthen child protection systems and Kizazi Kipya will ensure CCWs issue referrals into the system and ensure that cases of abuse, neglect, and exploitation are followed up in a timely manner. In Q2, Pact finalized the SOP on Identifying and Responding to Cases of Child Abuse, Neglect and Exploitation, which is aligned with the GOT Law of Child Act (2009), Tanzania's Child Protection Regulations, Child Development Policy Tanzania (2008), and the National Costed Plan II of Action for MVC (2013-2017). Also, in Q2, Pact completed mapping of existing child protection systems at the council level.

In Q3, Kizazi Kipya volunteers referred 796 cases of child abuse, neglect, and exploitation to government child protection systems across project councils. To increase identification and reporting, Pact oriented 15 TSCs and 384 CSO staff on the Identifying and Responding to Cases of Abuse, Neglect and Exploitation SOP. Key topics in this orientation included signs and symptoms to recognize potential cases of abuse and training on a Child Abuse Incident Reporting form that CCWs can use to refer cases of abuse, neglect, and exploitation to DSWOs and CPTs

Additionally, in Q3, Pact in collaboration with UNICEF, conducted a CPT functionality assessment using the National Child Protection Monitoring System Tool in two councils: Kilolo DC and Mufindi DC. These assessments revealed significant gaps, specifically around coordination, referral follow-up and feedback as well as documentation.

In Q4, Kizazi Kipya will accomplish the following:

- Orient LCWs/CCWs on Identifying and Responding to Cases of Abuse, Neglect and Exploitation, Case management and Bi-directional referral and linkages SOPs.

- Continue assessing child protection systems in targeted councils to identify specific training needs using the National Child Protection Monitoring System Tool.

- Meet with the Commissioner for Social Welfare and UNICEF to develop a training plan to address gaps among DSWOs and CPTs.

Activity 3.4.3: Conduct case conferencing and develop care plans with multi-disciplinary panel members if a child is removed from home

In addressing complex child abuse cases, case conferencing is necessary, especially when a child must be removed from the home environment for her or his safety. In Tanzania, while case conferencing is a government-specified child protection intervention, the process is not widely implemented in all councils. In Q2, Pact finalized the SOP on Identifying and Responding to Cases of Child Abuse, Neglect, and Exploitation as mentioned in 3.4.3. Pact operationalized procedures for conducting case conferencing aligned with Tanzania's child protection regulations.

In Q3, as mentioned, above, Pact and UNICEF assessed CPTs in Kilolo DC and Mufindi DC, which included examining the extent to which case conferencing is conducted in adherence with Tanzania's Child Protection Regulations. In Kilolo DC, the DSWO reported that no child protection case conferencing is currently conducted due to lack of human resources and lack of training on how to conduct case conferencing. In Mufindi DC, child protection case conferencing is conducted at the council level, typically with heads of relevant departments, but children and caregivers are not involved in the process.

In Q4, Kizazi Kipya will accomplish the following:

- Continue assessing the extent to which case conferencing is conducted in adherence with Tanzania's Child Protection Regulations in targeted councils.

- Include case conferencing in the training plan to present to the Commissioner for Social Welfare.

Activity 3.4.4: Ensure proper investigations of child abuse, neglect, and exploitation are conducted in partnership with social welfare officers to determine whether more interventions are required

In Tanzania, alleged child abuse perpetrators often are not properly investigated due to a variety of factors. This has allowed many child abusers to remain unpunished and able to continue harming children. In response, as mentioned in 3.4.3 and 3.4.4, Kizazi Kipya finalized an SOP on Identifying and Responding Cases of Child Abuse, Neglect, and Exploitation.

During the CPT functionality assessment in Kilolo DC and Mufindi DC conducted in Q3, the DSWO in Kilolo DC reported that no health facilities in the council have been trained to collect forensic evidence from survivors. In Mufindi DC, the DSWO reported that only 16 out of the 64 health facilities are able to collect forensic evidence from survivors. Given the importance of forensic evidence in prosecuting and convicting child abusers especially rape, this remains a gap in moving forward investigations.

In Q4, Kizazi Kipya will include forensic evidence training in the training plan to present to the Commissioner for Social Welfare

Activity 3.4.5: Strengthen systems for child protection at council and community levels

In FY 17, Kizazi Kipya is working with stakeholders to ensure that OVC and their household members can access available child protection services, including one-stop centers for violence against children and gender-based violence services. Where the systems and/or structures do not exist, the project will

work within the existing framework and ensure DSWOs, police, and other stakeholders have basic skills on addressing child protection issues.

In Q1, Kizazi Kipya mapped councils where UNICEF supports child protection systems (as indicated in 3.4.2) to ensure the project will complement UNICEF efforts by referring abused, neglected, and exploited children to UNICEF-supported district CPTs. In Q2, Pact worked with DSW to map the councils with established child protection systems, apart from those mapped under UNICEF and existing one-stop centers.

In Q3 Kizazi Kipya started initial meetings with district stakeholders specifically with One Stop Centers focal persons. In Ilala, the project CSO partner- WAMATA met with Amana OSC focal person to better understand the functionality of the center. Despite the center being operational, there are still challenges that hinder service providers from responding to cases in a timely manner. Specifically, the center is open only during normal government working hours, while most survivors try to receive services at night.

In Mbeya CC, Kizazi Kipya lead initial discussions with the DSWO about the shutting down of the former OSC located at the Field Force Unit compound, which was not friendly to survivors. HJF is interested in establishing one in a different location preferably in the hospital compound, and discussions with Pact, government, and other stakeholders are underway.

In Q4, Kizazi Kipya will:

- Support the One-Stop Center quarterly meetings for service providers at Amana Regional Referral Hospital to discuss continuation of services after normal government working hours.
- Follow-up with MOHCDGEC and HJF on the plans to re-establish the One Stop Center in a survivor friendly location in Mbeya CC.

Activity 3.4.6: Strengthen networking among district stakeholders, including health facilities and case managers, to ensure victims of violence receive services.

In Q1 and Q2, DSW and CHSSP, with support from Kizazi Kipya, trained 231 CCW trainers, including CSO staff, on how to recognize signs of potential abuse and where to refer these survivors for further support. Also in Q2, Pact finalized the above-mentioned SOP on identifying and responding to cases of abuse.

In Q3 Kizazi Kipya trained TSCs and CSO staff, as mentioned in 3.4.2 on the SOP on identifying and responding to cases of abuse. As part of this orientation, a child protection job aid was rolled out which outlines sign and symptoms of potential abuse for CCWs to easily reference, as well as a one-page guide to record names of DSWOs, CPTs, Police, ASWO, WCDO, OSC, and Hospital/Dispensary/Health facility to know exactly who to contact if a child abuse case has been identified. This guide will be useful to CCWs particularly in areas where there is no CPTs or where other reporting structures are lacking.

In Q4 Pact will provide on-site technical assistance to CSOs and CCWs to ensure the Child Abuse Incident Reporting form is used properly to ensure completed referrals.

Result 4: High-quality services are available to “hard-to-reach” HIV-infected and vulnerable children and adolescents

Children living or working in the street (CLWS) and children in the worst forms of labor, such as children working in mines, are hard to reach. A significant proportion of CLWS and children working in the mines experience higher rates of sexual abuse and sometimes are engaged in high-risk behaviors, including transactional or commercial sex, which places them at an elevated risk of HIV and other sexually transmitted infections. USAID Kizazi Kipya works with RCA and IHI to ensure the needs of hard-to-reach children are well addressed. RCA focuses on IR 4.1, which aims to improve and expand services

for CLWS, while IHI with Pact focuses on IR 4.2, which aims to improve service models for children in the mining sector. IHI is responsible for conducting formative research that will form the basis for Pact to develop the model of serving these children in the mining sector.

IR 4.1: Improved and expanded services for children living or working on the streets (CLWS)

Through technical partner RCA, Kizazi Kipya supports CLWS in 10 urban councils in the six major cities in Tanzania (Dar es Salaam, Mwanza, Arusha, Dodoma, Iringa, and Mbeya). Overall, the project aims to increase access to health, education, and ES services for about 9,700 CLWS over the project's five years.

Activity 4.1.1: Conduct headcount of CLWS in six cities

The headcount of CLWS aims to establish the number of CLWS that live on the streets either part time or full time. It is also meant to establish a baseline and convey evidence on the extent of the issue of CLWS in the six cities. In Q2, RCA and IPSOS carried out the headcount of CLWS in Mwanza (Ilemela MC and Nyamagana MC) and Arusha CC.

In Q3, RCA conducted CLWS headcount exercise in the remaining councils in Dodoma MC, Iringa MC, Mbeya CC, Mbeya DC, Kinondoni MC, Ilala MC (and Ubongo MC), Kinondoni MC and Temeke MC (and Kigamboni MC). While the original plan was to conduct the exercise in the remaining seven councils, the project conducted the exercise in nine councils because the government split Ilala MC and Temeke MC into two MCs each. The exercise included the following activities:

i. Seeking Approval for the headcount of CLWS at the District Level

Following Pact headcount exercise introductory letters to targeted Municipals, the Municipal Directors in nine councils approved the exercise. RCA further held meetings with the District Social Welfare heads in each Council to seek support in planning, mobilizing data collectors and mapping the areas to be included in the exercise. The CSOs implementing the CLWS component, made follow-ups to the Social Welfare Office and Police Gender and Children's Desks to request their participation and support.

ii. Mapping and Zoning of the Headcount sites

With the support from CSOs, RCA staff carried out a mapping exercise in each of the Councils to identify areas where CLWS are found during the day and night time. Since CLWS are engaged in various survival activities, they can be found in specific areas such as markets, busy streets/intersections, dump sites, etc.

Once the areas were identified, the mapping was presented to the local data collectors to get their input and ensure that additional critical areas were included for the headcount.

iii. Mobilization and training of the data collectors

RCA worked with municipal respective Social Welfare offices and CSOs to identify and mobilize Data collector. These data collectors were mainly drawn from para-social workers, Social Welfare officers, Social Welfare students, volunteers and CSO staff.
In each of the cities, RCA conducted a two-day training to familiarize the data collectors on the headcount methodology and on how to fill the data tool. This training was followed by the data collection exercise that took four days in each of the cities. The counting of CLWS was conducted during the day and at night. The main objective of the night count was to establish how many CLWS were sleeping in the streets and also to identify female CLWS that were more hidden in the day compared to the night.

The following table shows a description of data collectors by organization and number of data collectors in each of the districts.

Table 13: Number of data collectors who participated in CLWS headcount exercise

Headcount Site	Number of Participants	Participants Description
Dodoma MC	20	❖ CLWS CSOs staff- (Kisedet, and Safina) ❖ Para-social workers ❖ Social Welfare Officers Dodoma MC ❖ IPSOS staff
Iringa MC	20	❖ CLWS CSO staff- IDYDC ❖ Social Welfare Officers ❖ IPSOS staff
Mbeya MC	25	❖ CSO staff (Caritas) ❖ Social Welfare Officer MC ❖ IPSOS staff
Dar es Salaam (Ilala MC, Kinondoni MC, Kigamboni MC, Temeke MC and Ugumbo MC)	81	❖ CLWS CSO staff- (Baba Watoto, Watoto Wetu Tanzania, and Safin) ❖ Students from The Institute of Social Welfare ❖ Social Welfare Officers from Ilala, Kigamboni, Kinondoni, Temeke and Ugumbo CC) ❖ IPSOS staff

The headcount in the above nine councils plus the three councils where the exercise was conducted in Q2, concluded the headcount of CLWS in the 6 cities where the CLWS component is implemented under the USAID Kizazi Kipya project.

Because the project involved the government at all levels during the headcount exercise, the government is keen and want to own the findings and the implementation including dissemination and publication of the report. The data is being analyzed and the full report will be ready for publication in Q4 with dissemination in Q1 of FY 18.

Activity 4.1.2: Identification of CSO partners to work with in the six target cities

In Q2, Kizazi Kipya selected six CSOs that will implement activities with CLWS and held a workshop to ensure their understanding of how to carry out project activities. In Q3, RCA continued to work with the CLWS CSOs to ensure planned activities are implemented accordingly.

Activity 4.1.3: CSO partner training

As a project technical lead on CLWS interventions, RCA is responsible to ensure CSOs implementing CLWS component understands and integrate HIV prevention and response in CLWS programming. RCA committed to ensure that SOPs, training materials and project guiding documents are aligned with the 90-90-90 project strategy and the overall Kizazi Kipya project goal before commencing any activity.

In Q2, RCA started adapting the training materials to ensure that HIV services to CLWS are well integrated within the training modules. In Q3, the CSOs with RCA support conducted a number of activities elaborated below:

i. Finalizing of the CLWS Training Curriculum

RCA finalized and submitted the SOP on Case Management of CLWS within Street Outreach and Family Reunification. The CLWS SOP is meant to provide step by step guidance to CSOs street, youth and family workers on how to provide case management to CLWS and their families when reunified.

RCA also developed and submitted the Street work and Intensive family work training curriculum to Pact for review. Both RCA and Pact agreed that the curriculum be used to as a pilot to train staff while collecting the feedback on areas of improvement. The feedback will be incorporated in the final street work training curriculum in Q4 to ensure that the Curriculum can be adopted by the Government as a resource for CSOs working in support of CLWS in Tanzania.

While the SOP and training materials are almost final, there is recognition within the program that these will emerge and be developed further as we continue to apply these methodologies and learn from practice across the program.

ii. CSO Training in Street Work and Intensive Family Work Curriculum

RCA conducted the training on street work to four CSOs working in Iringa MC, Mbeya DC, Arusha CC and Dodoma MC. In all the trainings, the project involved the DSWO from the respective council as a participant, and in the Iringa training, two officials from the MOHCDGEC participated in the training. Table 14 below provides a summary of the trainings conducted by RCA to date in this last quarter:

Table 14: Number CSOs staff and government officials trained on street work

Curriculum	Name of Organization	District	Number of Participants Trained	Description of Participants
Street Work Training -Pilot	IDYDC	Iringa MC	8	4 IDYDC staff 2 Municipal Social Welfare Officers 2 MOHCDGEC
	KISEDET	Dodoma MC	4	4 Kisedet Staff
	Amani Center	Arusha CC	8	6 Amani staff 1 DSWO 1 Gender desk police
	Caritas	Mbeya MC and Mbeya DC	9	7 CSO staff 2 SWO
Intensive Family Work Training	Amani Centre	Arusha CC	12	10 Amani staff 1 SWO 1 Gender Police Desk Officer

iii) CSOs Learning Visits

RCA organized visits for four of the CSOs implementing the CLWS component to learn from RCA work in Mwanza. The visits aimed to exposure the CSOs staff on the work of the long-term experience of Cheka Sana in Mwanza that has been receiving funding and technical support from RCA before Kizazi Kipya project started. This learning visit included: i) Kisedet (Dodoma MC). ii) Amani Center (Arusha MC). iii) Caritas (Mbeya MC). iv) IDYDC (Iringa MC). Each CSO had 4 staff members involved in the 3 day visits.

The learning visits provided the CSOs opportunity to see the CLWS interventions in action, at the street and family level. At the street level, CSOs staff were exposed to street outreach activities which included hygiene, one on one with CLWS, mobile school, and life skills sessions with CLWS. In addition, the staff saw the application of the association model by visiting youth groups that are at different stages of the association model. At the family level, CSOs were involved in the pre-planning of family visits, family visit sessions, and evaluation of family visit sessions. In addition, they were taken though the case analysis process and introduced to the process of developing hypothesis and strategies for case management of CLWS.

IR 4.2: Improved service models for one category of hard-to-reach children

IHI's key activities includes to conduct formative research, refine the strategy design for identification of youth miners, and work with Pact to develop the service model for children in the mining sector and test its effectiveness. Based on the formative research findings and stakeholders view during dissemination workshops, Pact will lead the implementation of the service model.

Activity 4.2.1: Develop research question, proposal, tools for data collection, and information and communication forms and submit to institutional review board for approval

In Q2, IHI submitted the protocol to the National Health Research Ethics Committee (NaHREC) of National Institute for Medical Research (NIMR), which is obligated to register, approve, and monitor all health research conducted in Tanzania to ensure that it follows ethical standards. As part of preparation for conducting formative research, IHI also developed several SOPs to be used during field preparation and implementation of informative research.

In Q3, NIMRI approved the protocol that enabled IHI to conduct the formative research. To successfully conduct the research, IHI conducted the below activities.

i. Recruitment of the qualitative field team

IHI hired a team of four experienced qualitative researchers to form part of the IHI formative research for children in the mining team. IHI introduced Kizazi Kipya project to the new field team and oriented them on the data collection tools and guides for use in conducting the formative assessment field activities. To ensure quality of expected work, IHI lead team supported the field research team to pilot test the data collection tools and guides. The pilot exercise provided conceptual clarifications of the research design to the team and made team members better acquitted to the research topic. The pilot experiences provided an opportunity to the research team to identify practical problems with the data collection guides, data collection processes and areas that required adjustments. IHI lead team used the feedback collected during the pilot testing to refine the data collections tools and guides before the actual data collection activities.

ii. Data collection

IHI conducted data collection activities for the formative assessment in both Bukombe, Chunya and Songwe district councils. The data collection exercise included focus group discussions with the community members, in-depth interviews with children/adolescents (both miners and non-miners), parents, teachers, health facility in-charges, mine owners/financiers, district and community leaders as well as influential people in the study sites. A total of 82 interviews were conducted for the three study sites. Table 14 below provides further details.

Table 15: Number of participants who participated

Data collection method & participants	Research sites			
In-depth Interviews	Bukombe	Chunya	Songwe	**Total**
Child miners	6	5	4	15
Child out of mines	6	5	4	15
Miner parents	5	2	2	9
Mine owners	5	2	2	9
Health facility	2	1	2	5
Civil Society Organizations	4			4
Community leaders	4	2	2	8
District officials	2	2	1	5
School teacher	2	1	1	4
Key Informant Interviews				
Influential people	3	1	2	6
Focus group discussions				
Male	2	1	1	4
Female	2	1	1	4
Total number per site	**43**	**23**	**22**	**88**

iii. Data coding and analysis

The data collection exercise has been completed. IHI is has started to develop a code book for the formative assessment. This will be followed by coding of the data, analysis and report writing. The project expects to disseminate the report in Q4.

Activity 4.2.2: Reconnaissance visits to all potential sites for children in the mining sector

Kizazi Kipya initially planned to implement interventions for children in mining in Geita DC and Chunya DC. However, the IHI and Pact visit to Geita DC conducted in Q1 determined that much has been done in Geita DC in supporting children in mining, and stakeholders advised the project to consider Bukombe DC instead. In Q2, IHI and Pact conducted a reconnaissance visit to Bukombe DC and decided to drop Geita DC and replaced it with Bukombe DC

As indicated on activity 4.2.1, a number of visits were made in the three targeted district councils to ensure proper procedure for data collection are followed.

In Q4, IHI will accomplish the following activities:

- Conduct one-day meeting to disseminate research findings.
- Prepare the tools for conducting the qualitative baseline data collection on children working in mining.
- Hire field interviewers and VCT counselors from the local areas where the activities will be carried out.

Progress against Targets and Budget

Table 13 details the progress made on each result, with specific focus on this quarter's indicators and targets against targets for FY 17. The table also shows the expenditures for each result area.

Table 16: Progress against target and budget

Result and Indicators	Target	Achieve-ment	% Achieve-ment	Budgeted costs (US$)	Actuals expended	Rationale for costs less or more than anticipated
Crosscutting indicators						
Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV (OVC_SERV)	581,042	418,152	72%			
Percent of community-based referrals issued for health and social services completed among OVC and caregivers	80%	4,802	92%			
Number of HCWs and community and health and PSWs who successfully completed an in-service training program	23,212	There was no training in Q1				
Result 1: Parents and caregivers have the financial resources to meet the needs of vulnerable children and adolescents						
Number of OVC, caregivers and PLHIV benefited from a minimum of one ES intervention or opportunity (TZ_ECON)	OVC – 42,954 Caregivers – 116,122	OVC – 3,808 Caregiver –84,989	OVC – 9% Caregiver – 73%	1,456,280	1,291,160	On target with estimate
Percent of caregivers that participate in VSLGs	72%	84,989	59%			
Percentage of VSLGs that are active	90%	5,914	70%			
Number of new income-generating activities established by individual members of VSLGs	22,241	4,306	19%			
Number of female participants in VSLGs designed to increase access to productive economic resources (assets, credit, income, or employment) (GNDR-2)	33,362	3,561	11%			
Result 2: Parents and caregivers have the skills to meet the needs of HIV infected and vulnerable children and adolescents						
Number of caregivers of children under 5 reached with CCD education during household visits	124,229	CCD Implementation will start in Q4		609,714	553,354	On target with estimate
Number of OVC who received food and/or other nutrition services outside of a health facility (TZ_NUT)	324,962	170,162	56%			
Number of children ages 0–5 assessed for nutritional status (MUAC) at last case management visit	60,186	41,446	87%			
Number of OVC, youth, or caregivers referred for HIV testing based on use of standardized risk assessment tool	OVC – 65,384 Caregivers – 24,712	HIV risk tool is under pilot preliminary data will be available from Q4				
Number of beneficiaries (OVC, caregivers, and youth) linked in an HIV support group	OVC – 1,526	OVC: 5,579	OVC: 366%			

Result and Indicators	Target	Achieve-ment	% Achieve-ment	Budgeted costs (US$)	Actuals expended	Rationale for costs less or more than anticipated
	Caregivers – 2,594	Caregivers : 8,685	Caregivers : 335%			
Percent of HIV-positive beneficiaries provided with ART adherence counseling by a trained case manager during most recent case management visit	OVC – 2,650 Caregivers – 4,505	OVC: 6,639 Caregivers : 14,086	OVC: 251% Caregivers : 313%			
Result 3: High-quality services are available to HIV infected and vulnerable children and adolescents						
Number of the priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake (PP_PREV)	2,400	Activities contributing to this indicator has not started		1,778,810	1,660,063	On target with estimates
Percent of adolescents who completed livelihoods trainings and rated their skills as high in the areas of starting, running, and growing a micro business	90%	Activities contributing to this indicator has not started				
Percent of caregivers who complete Sinovuyo report improved ability to communicate with their adolescent about HIV risk behavior	85%	Preparation under way				
Percent of adolescents who complete Sinovuyo report improved ability to communicate with their parents/ caregivers about HIV risk behavior	82%	Preparation under way				
Number of identified child abuse cases by case managers that have a case file opened at the district social welfare office	2,321	Activities contributing to this indicator has not started				
Result 4: High-quality services are available to "hard-to-reach" HIV-infected and vulnerable children and adolescents						
Number of CLWS reached with support by street-based outreach workers	500	The actual implementation will start in Q3		244,225	184,451	On target with estimates
Number of CLWS who are reintegrated into protective family care	50	The actual implementation will start in Q3				
Number of OVC, youth and caregivers engaged in mining reached with pilot service model	200	Activities contributing to this indicator has not started				

Project Management

Coordination with Government

In Q3, Pact continued to build on the foundational relationships with government departments in Tanzania mainland and Zanzibar that were established in Q1 and Q2. The terms for the relationship between the project and the Tanzanian government is outlined in a national-level MOU signed between Pact and PO-RALG. The ultimate aim of these relationships is to promote government ownership of OVC programming and to pave the way for sustainable support beyond the life of the project.

The following collaboration occurred in Q3, by sub-section of the MOU.

Establish a collaborative relationship

Pact's COP continued to communicate regularly with the focal person at PO-RALG, Mr. Rasheed Maftah (Acting Assistant Director for Social Welfare). Through this relationship, Kizazi Kipya is able to receive the support and advice necessary for Pact, the consortium partners, and CSOs to carry out their duties effectively and efficiently. For example, in Q3 Mr. Maftah supported the project with guidance on paying government staff allowances during their participation on project activities.

Kizazi Kipya cluster staff continued to nurture relationships with regional- and council-level government during CSO visits. In Q3, Pact signed a tripartite MOU in 64 of 67 councils between Pact, the CSO, and the LGA. The MOU is an adapted version of the national MOU with PO-RALG and includes more details on relationships for social welfare, child protection, health, referrals, and education components. The remaining three councils in mainland Tanzania were delayed simply due to signatory availability and will be signed in early Q4. The government of Zanzibar is making specific changes to the MOU to reflect different government structures in that area. The COP will sign the MOU in Q4 with the Zanzibar Principal Secretary for Labor, Empowerment, Elders, Youth, Women, and Children.

Share plans

Pact shared the project work plan with PO-RALG in Q1 and shared the final list of proposed CSOs selected by the RFA process in Q2. During Q3, the 48 CSOs selected by RFA began to share their FY17 plans with LGAs in scale-up councils; these discussions will continue into Q4.

When Pact met with the PS-Health in Q1 to introduce the project, he requested that Pact provide an operational plan describing the cadre of volunteers the project planned to use and also describing integration of the various results areas of the project. Pact submitted the operational plan to NACP for review in January 2017. Despite several requests, Pact had still not received any feedback from NACP by the end of Q3 and was unable to schedule a meeting with NACP for further discussion. Submission of the operational plan to the PS-Health is a pending action for Q4. In the meantime, Pact submitted the Q2 narrative report to the PS-Health, PS-Community Development, and PS-PORALG to provide an update on implementation status.

Pact is planning to meet with key department heads and with the PS-Health, PS-Community Development, and PS-PORALG in Q4 to discuss preliminary FY18 plans. Other requirements in this section of the MOU largely comes into effect later in 2017, when the government planning process commences.

Coordinate implementation of services

In Q2, Pact participated in several national-level meetings convened by the DSW, JSI, and/or MEASURE that discussed systems strengthening aspects of the social welfare system that directly impact implementation of Kizazi Kipya. Topics discussed included the printing requirements for case management and referral forms, CCW recruitment, and the drafting of the National Integrated Case Management Framework.

Pact conducted a joint site visit to Arusha CC, Arusha DC, and Moshi DC with PO-RALG in April 2017. Together with the CSO partners (ELCT and NAFGEM) and the cluster manager, they made a round of visits to meet the RAS for Arusha Region, RMO for Arusha CC, a representative for the RSWO for Arusha

Region, DSWO for Arusha CC, the DED/DMO/DCDO for Arusha DC, and the DSWO for Moshi DC. Points of discussion included the National Case Management Framework, the MOU between the project and government, and the importance of integration of CSO activities with government plans. While in Arusha, they visited the social welfare officer at Mt. Meru Regional Hospital and observed the process for fee exemptions for specific categories of patients. They also visited Amani Center for Street Children in Moshi to understand how this CSO complements the work of government to provide social welfare, health, protection, and education services to children living and working on the streets. The visit helped Pact's cluster office to solidify relationships in these regions and councils, which was important due to politics related to selection of new CSOs through the RFA process who had not previously worked on Pamoja Tuwalee. Following the visit, Pact noticed a clear uptick in invitations issued by government to attend regional and council collaboration meetings. Pact intends to schedule these joint field visits on a quarterly basis.

In Q3, two priority focus areas for coordination at council level were the selection of CCWs for training and the planning for roll out of the bidirectional referral system. To help government staff better understand the project's implementation strategies, Pact and consortium partners invited key government staff to the majority of capacity-building activities with CSOs (refer to individual results areas in this report for more details). Each CSO has already budgeted for inclusion of government staff to participate in roll out of activities in wards and communities in their respective councils. Pact will monitor this council-level coordination of implementation during mentorship and supportive supervision visits in Q4.

Monitoring, evaluation, learning, and reporting

Pact is developing an electronic dashboard which can generate aggregate reports at national, regional, and council levels using a graphic representation of results. In Q3, Pact Tanzania received support from the DC communications team to select the appropriate software and design the quarterly dashboard report for key indicators. Pact plans to distribute the Q3 results to government using the new format.

Pact procured computers for 67 DSWOs to enable them to generate and analyze M&E results for their councils. Pact will hand over the computers in Q4, and MEASURE Evaluation is assisting DSWO to obtain passwords for DHIS2 access.

Coordination with USAID/PEPFAR IPs and Other Stakeholders

In Q3, Pact continued to coordinate with USAID/PEPFAR IPs and other stakeholders. The organization, project, funder, and type of interaction in Q3 are outlined in the table below.

Table 17: USAID/PEPFAR IPs and other stakeholders met by USAID Kizazi Kipya

Name of organization	Name of project	Funder	Type of interaction in Q3
Ariel Glaser Paediatrics AIDS Healthcare Initiative (AGPAHI)	Care and Treatment Program	CDC	Pact hosted an ART/PMTCT Implementing Partners meeting to discuss and collaborate on: 1. Enrollment of HIV+ OVC and caregivers into Kizazi Kipya at CTCs 2. Case identification using the HIV Risk, Services, and Adherence assessment tool 3. Rolling out the bi-directional referrals and linkages system with CTCs
Deloitte*	Boresha Afya	USAID	
Elizabeth Glaser Pediatric Aids Foundation (EGPAF)	Boresha Afya	USAID	
Henry Jackson Foundation Medical Research International (HJFMRI)*	Care and Treatment Program	DOD	
Management and Development for Health (MDH)	Care and Treatment Program	CDC	
University of Maryland Baltimore (UMB)	Reaching, Engaging and Acting for Health (REACH)	CDC	
Africare	Mwanzo Bora Nutrition Program	USAID	Discussed linking beneficiaries to Mwanzo Bora Nutrition Program's agricultural activities and food security services.
Deloitte*	Boresha Afya	USAID	Deloitte shared the list of CTCs their program works with, specific interventions by CTC, and focal people at each CTC to ensure linkages of OVC and caregivers to HIV services at CTCs. Pact shared the list of community volunteers in councils where Deloitte implements Boresha Afya.
Interchurch Medical Assistance (IMA)*	Addressing Stunting in Tanzania Early (ASTUTE)	DFID	Discussed the possibility of IMA training CCWs, who are also CHWs, on NACS
Jhpiego	Sauti	USAID	Reviewed referral processes, specifically around linking children of sex workers to Kizazi Kipya.
John Snow Inc (JSI)	Community Health System Strengthening Program	USAID	Discussed the National Integrated Case Management System with other stakeholders, coordinated for JSI to print government and project specific case management and referral tools, reviewed schedule of CCW and PSW trainings, and coordinated around Pact's SOP orientation with CSO staff and community volunteers.
Palladium	MEASURE Evaluation Tanzania Associate Award	USAID	Collaborated on the final review of the National MVC Referral Tool; attended Measure Evaluation's refresher training in Zanzibar on the National MVC M&E Plan; worked with MEASURE Evaluation on Kizazi Kipya's first data quality assessment
UNICEF*	Accelerating stunting reduction		Introduced Kizazi Kipya project and received MUAC tapes from UNICEF
Universités Aspirants et Médecins (CUAMM)*	Accelerating stunting reduction	UNICEF	Discussed the possibility of CUAMM training CCWs, who are also CHWs, on NACS

**Denotes a new project USAID Kizazi Kipya has begun to collaborate this quarter*

Operations, Finance, and Grants Update

Operations

In Q3, Pact continued to run its operation through its six offices in Dar es Salaam, Dodoma, Mtwara, Moshi, Mwanza, and Mbeya.

Pact, at the request of PO-RALG, has procured 67 computers, printers, UPS and modems for use by District Social Welfare Officers in the 67 scale-up councils where Pact is implementing Kizazi Kipya activities. The DSWOs will receive training in DHIS2 from MEASURE Evaluation and then use the computer equipment for data entry and analysis to feed into program decision-making. The computers will be handed over to PO-RALG officially in Q4 and then distributed to all the 67 councils.

In Q3, Pact completed the selection of 48 CSOs to implement in 67 scale-up councils. To enhance the project implementation, CSOs require laptops for their staff to be able to accomplish their task. Pact issued the RFQ in this quarter for supply of 338 laptops that will be distributed to the CSOs as per their pre-determined needs. The RFQ was closed in Q3, and Pact selected two suppliers for a total of 338 laptops. These laptops will be delivered in Q4.

Finance

General Spending

Total expenditure reported in Pact's financial system for Q3 FY17 is US$ 3,689,028 of which direct spending (non-sub-awards) is US$ 1,494,304, sub-award spending is US$ 1,595,621, and indirect cost spending is US$ 599,103 (Table 18).

Pact had projected the expenditure in Q3 to significantly increase compared to Q2. However, expenditure was less in Q3, at $3,689,028, compared to $4,108,236 that was reported in Q2. The root cause of the lower expenditure is delayed incremental funding from USAID. Pact requested the incremental obligation on 20th February 2017 and received the incremental funding in May 2017. Due to this delay, Pact had to scale down activities in April, and delayed the signing of contracts with the CSOs selected by RFA from 1st April to 1st June. This delay in start date pushed back the start date for some key council-level activities in scale-up councils.

Table 18: Detailed Expenditure Summary (July 2016 to June 2017)

Cost Category	Total Budget Year 1	Cummulative Through End of Previous Quarters (July 2016 - March 2017)	Expenditure For Q3 (April - June 2017)	Cummulative Expenditure July 2016 - June 2017
Salaries	2,101,622	1,161,312	680,517	1,841,829
Fringe Benefits	638,236	346,321	197,800	544,121
Allowances	264,285	116,090	64,770	180,860
Travel	218,620	384,036	144,427	528,463
Equipments	293,782	232,564	8,103	240,667
Supplies	545,488	334,144	128,833	462,977
Consultants	32,194	30,814	4,008	34,822
Workshops and Program Activities	2,104,163	300,482	39,903	340,385
Subcontracts & Subgrants	18,080,678	2,010,750	1,595,621	3,606,371
Other Direct Costs	431,044	449,146	225,943	675,089
Subtotal Direct Costs	**24,710,112**	**5,365,659**	**3,089,925**	**8,455,584**
Overhead	2,803,124	1,171,498	599,103	1,770,601
Subtotal Indirect Costs	**2,803,124**	**1,171,498**	**599,103**	**1,770,601**
Total Budget	**27,513,236**	**6,537,157**	**3,689,028**	**10,226,185**

In Q3, CSOs under bridge funding continued to liquidate their expenses. Their expenses increased 10% between Q2 and Q3, from $1,451,015 to $1,561,000 due to escalated implementation to complete the bridge funding work plans before the end of bridge funding. Pact projects that expenditure in Q4 will increase as the new RFA CSOs rush to complete planned activities from Q3 and implement activities planned for Q4. As part of this scale-up, CSOs will enroll new volunteers and beneficiaries in scale-up councils in July 2017. In addition, Pact and Consortium Partners will roll out the majority of training activities, cascading to CSO staff, who then cascade to volunteers. These activities will greatly improve expenditure.

Pact continues to fund five Kizazi Kipya consortium partners: EGPAF, AKF, RCA, IHI, and Restless Development. The consortium partners have continued to use their current obligation to implement the project. Consortium Partners expenditure for Q2 were reported in Pacts financial system in Q3. Expenses for Q3 will be reported in Pact's financial system in Q4. As of June 2017, cumulative financial report expended by all consortium total is $530,129.10.

Pact has adequate funding available to support escalated spending in Q4. Pact received the incremental funding on 4th May 2017. At the end of the quarter Pact's total obligation stood at $32,806,939 (50.47%) of Pact's 5-year budget funding for Kizazi Kipya.

Pact continues to fund its five consortium partners: EGPAF, AKF, RCA, IHI, and Restless Development. The consortium partners have continued to use their current obligation to implement the project.

Grants to Civil Society Organizations

In Q3, Pact completed the RFA process that was initiated in Q1, and engaged 48 CSOs to cover 67 Councils. Pact received approval of all the 48 CSOs from USAID in April 2017 and finalized the contract with each CSO in this quarter. Pact extended the bridge funding grants in scale-up councils from an end date of April 30 to a new end date of May 31 while waiting for the new modification from USAID to increase the project's obligation. Pact obligated a total of $ 6,062,035.96 (60%) to all the 48 CSOs out of the total five-month CSO budget of $ 10,103,393 to cover the period of May to September 2017. The CSOs expenses on spending on this obligation will reflect in the next Q4 report.

In the 62 sustained councils, Pact extended bridge funding to 48 CSOs to 31st August 2017. In these councils, the CSOs will ensure that the transitioned OVC and their families continue to receive services from the stakeholders who accepted to continue with provision of services to these OVC and their families. As part of this responsibility, the CSOs will encourage the stakeholders to whom the OVC and their families have been transitioned to honor their commitment to continuing service provision to these OVC and their families. The CSOs will coach, mentor and provide continue technical support to MVCC, CSOs, VSLG, and other stakeholders who accepted transitioned OVC and their families for continuity and sustainability of services.

Pact's Grants and Finance team continued to build capacity to the bridge funding CSOs on financial management during Q3. The Grants and Finance team continued to provide one-on-one direct mentorship and coaching to 67 CSOs to strengthen good financial management practices and improve liquidation of advances. In Q3 CSOs improved in financial management and liquidations of advances as a result of the mentorship and training offered by Pact's cluster and grants accountants whereby CSOs were able to quickly resolve the questioned costs. Training on advanced financial management will continue in Q4 targeting CSOs senior finance managers and directors. The training topics to be covered will include; budget management; compliance to financial policies and procedures; training on best accounting practices; internal control management and improvement; and fraud prevention and detection.

Pact has continued to support all the CSOs by vigilantly reviewing their expenses to ensure they comply with the cost principles. In Q3, Pact finalized the funds mismanagement actions to COCODA that was reported in Q2. Pact recovered all the disallowed amount of Tsh 10,880,000 and issued warning with an action of reducing COCODA geographical coverage (through transfer of 1 council to another existing CSO).

Despite the strong financial performance of the majority of CSOs, Pact detected one case of fraud by Muheza Hospice Care (MHC) in this quarter involving fictitious receipts relating to stationery procurement and inflated staff field allowances, vehicle costs and unreported expenses. Pact is following up on getting the refund from MHC amounting to Tsh 13,838,067 and will reflect in Q4 report as reimbursed.

To prevent future cases of fraud related to volunteer stipend payments, Pact is setting up a system for paying volunteers directly using mobile money payments, generated by Pact and verified through CSO records as well as M&E reports (OVC Service Delivery). Pact will roll out this system from Q4.

Human Resources

As of this report, Pact has 104 Kizazi Kipya staff based in the main Pact Dar es Salaam offices and six cluster offices (Dar es Salaam, Mtwara, Moshi, Mwanza, Dodoma, and Mbeya). This count does not include additional consortium partner staff, whose advisors sit in the Pact main office and program and support staff at their respective organizations' offices in Dar. Restless Development also has staff placed in three cluster offices.

In Q3, the Kizazi Kipya team had seven new staff join the team to fill open positions: TSC Parenting & Child Protection in Dar, Mbeya and Dodoma cluster offices (3 new positions), TSC Education in Mbeya (1 new position), Integrated Cluster Manager in Dodoma (1 replacement), Senior Health Informatics Officer (1 replacement), and Health Informatics Officer (1 new position added). A Peace Corps Volunteer also joined the Lake Cluster team to support SRH programming for youth and nutrition referrals and linkages for OVC.

Thirteen District Coordinators contracts ended as planned in Quarter 3. The District Coordinators had supported councils that did not have CSOs during bridge funding in Q1 and Q2. In Q3, the coordinators in scale-up councils handed over beneficiaries and groups to CSOs selected through the RFA process, and the coordinators in sustained councils transferred transition monitoring responsibility to either the cluster staff or to new CSOs in nearby scale-up councils.

Pact also had four positions open in Q3. Three positions opened due to resignations (Sr. HR Officer, M&E Officer/Mwanza, and Logistics Assistant/Mwanza), while one position was mutual agreement to separate (Senior Economic Strengthening Advisor). Recruitment for replacements of these positions started in Q3. Pact also initiated recruitment for 1 Cluster Accountant (Mtwara), 2 Data Managers (Dar and Mwanza clusters), and two additional finance staff in Dar main office (Finance Officer and Finance Assistant).

Pact identified two external consultants in Quarter 3: Public Private Partnerships and Communications and Knowledge Management.

After not identifying a suitable candidate during earlier recruitment, Pact re-advertised for a DREAMS Coordinator in anticipation of receiving the DREAMS modification from USAID. Pact has struggled to find a candidate who is the right fit for this position. With the modification still not received at the end of Q3, Pact is currently exploring other options to manage this portfolio given that DREAMS will integrate into wider youth programming in FY18.

Pact held a meeting with the Integrated Cluster Managers in May 2017, bringing together the six cluster managers with the Senior Management Team to review mid-year performance and discuss management and implementation across the clusters. As part of this discussion, the team identified potential ways to redistribute councils across the cluster offices in FY18 to reflect the transition of sustained councils and the number and location of the CSOs that cover scale-up councils. The team also reviewed the cluster staffing plan and identified the need to add an Operations/Admin person at each cluster in FY18. The new plan for cluster offices will be presented in the Q4 report. The HR Director and the Senior Program Manager also started plans for management capacity-building for the Integrated Cluster Managers, which will be included in FY18 plans.

Monitoring and Evaluation (M&E)

Development of Tools

In Q3, the project sent 1 M&E staff to attend a National MVC M&E Plan refresher training in Zanzibar which was organized and coordinated by MEASURE Evaluation. This training was also attended by Kizazi Kipya CSOs staff from ZAMWASO, WAMATA Pemba and other partners like JSI and Zanzibar department of Social Welfare. The key outputs in this meeting included pilot testing MVC national tools and revising the tools based on pilot findings. The next step is to train MVC partner's CSO staff and national volunteers on the National MVC tools.

Meanwhile, while awaiting the official tools printing by CHSSP, CSOs continued to photocopy tools for recording service delivery data by volunteers. However, photocopying has not been working well for the referral tool which requires printing on a slightly larger paper size, triplicate copies and a referral slip for tracking referral success. CCWs have been relying on previous Pamoja Tuwalee referral books which are at present out of stock in most areas which has hugely affected documentation of referrals and underreporting. The project is working closely with CHSSP to print need tools for Q4 to improve reporting of referrals.

Data Management Systems Set-Up

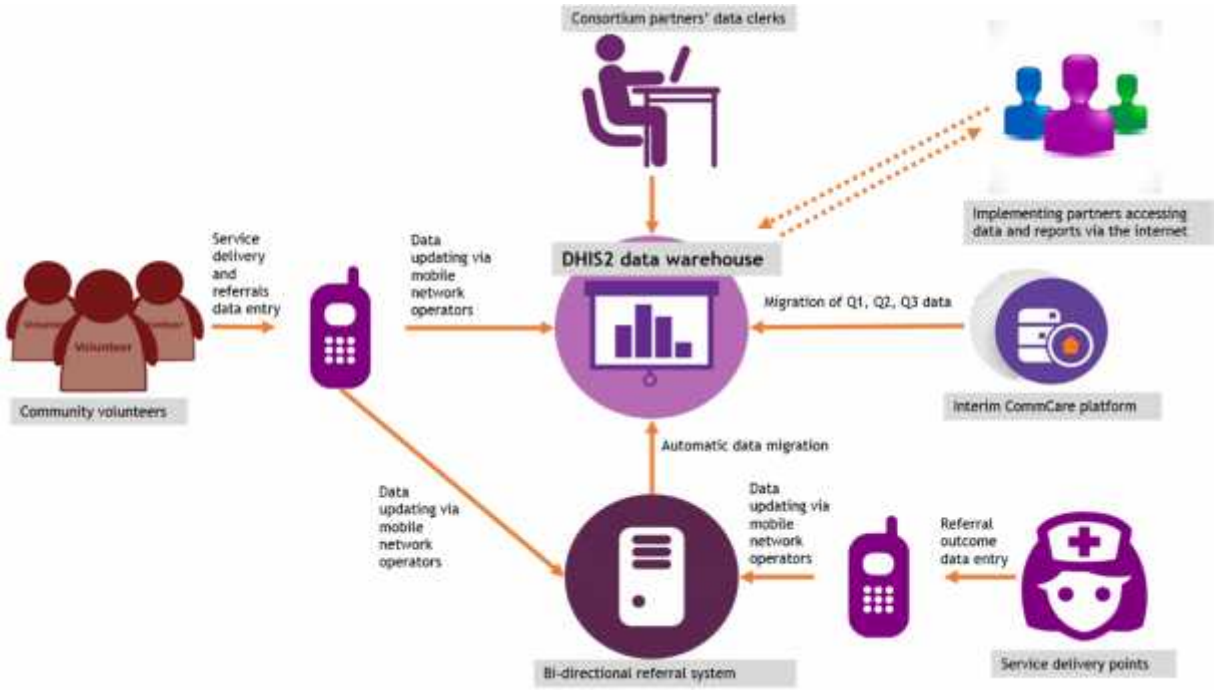
Kizazi Kipya deployed an interim mobile data collection system in Q1 to capture household-level service delivery data, VSLGs, referral and Family and Child Asset Assessment data. The system is based on CommCare platform and enables data entry through tablets and smartphones. The project procured about 450 tablets used for data entry at COSs using temporary data clerks. By Q2, the total number of temporary data clerks has increased 498 across all CSOs due large amounts of data that need to be entered on quarterly basis with some Wards having over 5,000 beneficiaries, for instance Wazo ward in Kinondoni, Dar es Salaam where 6,379 were served in Q1. The project also spent a significant amount of time in Q2 to create and verify profiles of beneficiaries that were enrolled in Kizazi Kipya in Q1. The project also implemented additional logic checks in the mobile app to improve data validation and overall quality.

Pact worked with EGPAF to develop the e-referral system. In this quarter the team integration the USSD short code with the top three mobile network operators in the country and is finalizing the technical testing of the USSD data collection for bi-directional referral tracking system.

Pact finalized the technical set-up of the DHIS2 software for data entry and data management. DHIS2 will primarily be used for housing and management of household level services delivery data and data from community based interventions.

To ensure all program data are on one platform, in Q4 the project will work on migration of data from the interim mobile data entry platform into the DHIS2. Set-up for data migration will also include integration of the already developed bi-directional referral system and service delivery system. Service delivery and bi-directional referral system will be accessible directly by the community volunteers via USSD which will enable the project at different levels to have real-time access to data.

Figure 6: Kizazi Kipya data system's integration process (implemented in Q3 and Q4 integration plans)



In relation to the new data systems introduced in Q3 and those that will be deployed in Q4, the M&E team plans to conduct extensive trainings to all project M&E persons from the project consortium partners and CSOs. The planned training will include building skills on real-time electronic data management and ensuring that M&E persons can develop performance tracking tools, reporting tracking templates and data quality checks on DHIS2 database and beyond.

Capacity Building

The Kizazi Kipya M&E team, worked with technical team to train a total of 384 CSO staff (Case Management Officers, Health and HIV Officers, Case Worker Coordinators and M&E officers) and 42 LGA staff (DSWOs, DCDOs, CHACCs) on M&E requirements for case management, child protection, referrals, and HIV linkages. The key areas that M&E team supported in this training included building capacity of CSOs and LGAs to understand how to complete all M&E related forms used to track service delivery, referrals, screening and enrolment, FCAA and VSLG. CSO staff were also trained on key program indicator definitions, reporting requirements, data management, quality and use for decision making.

The M&E team used this opportunity to discuss M&E challenges noted during Q2 reporting period, and to identify persistent errors and discuss solutions with CSO staff. The main part of the M&E agenda discussion included data review, data flow, data recording using different M&E tools, reporting errors, sorting of beneficiaries QR codes, data quality assurance and management.

In Q3, M&E team conducted supportive supervision to 44 CSOs (6 Central, 20 Lake, 3 Northern, 3 Southern, 4 Coast and 8 Southern highlands) in 58 councils. The key areas that CSO were supported in includes; support data entry process on the mobile data entry system, filling system, data collection tools, data quality checks, data visualization and use.

These on-site visits addressed challenges which were experienced in Q2 including: mismatching of QR codes with respective households; improper review of filled-in volunteer forms prior to submission to CSO; mismanagement of forms; or improper filing systems. Cluster M&E teams worked closely with CSO staff by coordinating community case workers monthly meeting (April – June) to ensure volunteers understand proper sorting techniques of QR codes against respective household served, identify and confirm beneficiaries served by each case worker and review filled in forms to ensure completeness of data prior submission to CSOs. CSO M&E staff with technical support from cluster M&E team took the

lead to orient over 20,000 LCWs (Lead Case workers) and CCWs (Community Case Workers) on SOPs including data recording, completion, accuracy and importance of timely submission of reports to CSO. Action plans for all visited CSOs were developed and shared with CSO team for implementation and follow-up.

At CSO level, M&E team continuously provided feedback to CSO on daily data entry progress and assisted to follow-up of daily data entry to increase coverage of service delivery. The M&E team also provided technical support to CSO M&E staff by directly supervising and monitoring data entry exercise. In this quarter, new temporary data clerks were hired by different CSOs and received orientation of Kizazi Kipya data collection tools, use of data entry system, syncing data and updating new versions of forms into to the mobile app.

Data Quality

In Q3, Northern and Coast clusters conducted a data verification activity. In Northern cluster, verification was conducted together with the new CSOs in two councils, Moshi DC and Arusha City Council, with a focus on verifying existing beneficiaries who were inherited from the previous CSO. The M&E team oriented CCWs on how to conduct the verification of beneficiaries during household visits, and each received a list of beneficiaries' names and QR codes in Arusha and Moshi DC to make verification of their existence. Out of 1,773 and 3,870 households visited in Arusha CC and Moshi DC respectively, 915 (52%) and 3,238 (84%) confirmed to exist and qualified for Kizazi Kipya program. In Coast cluster, the M&E team also conducted data verification to measure accuracy of Q2-reported beneficiaries against what was documented in forms. Data verification was implemented through the following two approaches: verifying beneficiaries reported to receive services against recorded information in monthly service tracking forms; and interviewing caregiver during household visit to confirm services provided against reported data in monthly service tracking form.

In this quarter, MEASURE Evaluation in collaboration with Kepler, conducted DQA (Data Quality Assessment) on the project data reported to USAID by Pact. The scope of this exercise was limited to the OVC_SERV indicator which was reported in Q2. The DQA exercise started at Pact's main office in May and proceeded to the Central cluster office in June. The DQA is scheduled to continue to two representative CSOs (Allamano and HACOCA) in Iringa MC and Kilosa DC in July. The project expects to receive feedback from MEASURE Evaluation in Q4 and immediately start implementing action plans as required.

Research and Learning

In Q2, the project agreed with USAID to make changes to the baseline evaluation approach. Baseline evaluation protocol for Kizazi Kipya was submitted to USAID in Q3 and received approval. The revised approach will analyze data from the Family and Child Asset Assessment tool administered to all new beneficiaries enrolled in Kizazi Kipya in Year 1 as opposed to just a representative sample of new beneficiaries enrolled. This change will provide a very large coverage and statistical power because the program will enroll new beneficiaries continuously over time covering all 225,697 OVC and 75,232 caregivers enrolled in the project in FY17, additionally it provides a basis for comparison between beneficiaries enrolled at two points of time, i.e., at enrollment and at graduation. As a result of this change, the project revised the baseline evaluation protocol and will submit a comprehensive baseline report by September 30, 2017. Data collection will be conducted in Q4 during new beneficiaries' enrollment at CTC facilities.

Pact moved forward with additional research and learning activities in Q3.

- Pact developed a draft protocol for validating the HIV Risk, Services, and Adherence Assessment for Children and Adolescents (age 0–19) tool, and it is currently under review by the project team.
- Pact mapped priority aspects of the learning agenda, whereby initial plans were made to develop the agenda with research questions that are framed around the program results areas. In Q4, Pact will conduct a workshop with Kizazi Kipya consortium partners to further discuss the agenda framework and set out priorities, roles and responsibilities for each partner.
- Pact's Research and Learning Coordinator continued analysis of program data analysis, not only for reporting, but also exploring some relationships within the data to enhance implementation

as well as for research purposes. Some of these analyses have yielded household vulnerability categories based on a set of tested vulnerability criteria.
- Pact started preliminary work on scientific writing in forms of abstracts and publications to communicate program successes and achievements.

Upcoming Events

Month	Event
July	DSWO computer handover to Minister Tamisemi
July	DSWO computer equipment handover in 67 LGAs
August	Meetings with Permanent Secretaries of PO-RALG and MOHCDGEC to discuss FY18 planning
October	External dissemination of the CLWS Head Count Report, jointly with DSW

Environmental Mitigation and Monitoring Plan (EMMP)

Pact submitted a revised EMMP to USAID on December 16, 2016. Pact has taken the step to ensure that all sub-awards and relevant procurement documents contain language that requires that programs and activities to comply with Tanzania environmental requirements, legislation, and standards.

The project has no planned activities that exceed the threshold of "positive determination." In the EMMP, Pact identified actions for specific ES activities that were considered to have "negative determination with conditions." Diversifying the economic opportunities for youth and OVC caregivers through activities falling under IR 1.2, IR 1.3, and IR 3.3 could involve linking beneficiaries to various industries and strengthening small-scale businesses, which could potentially have environmental impacts, such as those involving agriculture or any type of waste production. The selection of training materials and roll-out of the capacity-building activities is scheduled to start later in the project. At that time, Pact plans to review the various types of livelihoods and businesses supported under Kizazi Kipya, including agro-business, and the related training curricula to categorize those livelihood activities that would result in direct and indirect effects on the environment and those that will not.

Challenges and Lessons Learned

Challenges	Lesson learned	Plan for resolving challenges
Delay in the modification for incremental funding to Pact, which delayed signing of sub-agreements with the CSOs that were selected through RFA. This resulted in delay of some activities, pushed to Q4, and also resulted in a lower overall burn rate than projected.	Pact will continue to submit timely incremental funding requests to USAID and strategize together on contingencies in case of funding delays. Pact needs to clearly explain the root causes of the fluctuation in burn rate to USAID, so that there are no surprises or incorrect assumptions about life of project spending patterns. Because such a significant portion of the budget rests in sub-grants, spending by CSOs drives the overall project burn rate.	This challenge is now resolved: • Pact extended bridge funding to the existing CSOs so that service delivery continued to communities and beneficiaries. • The RFA CSOs signed sub-agreements as of 1st June, but while waiting for the agreements they started preparations, such as obtaining quotes for procurement, advertising and interviewing for vacant positions, etc. • Pact adjusted CSO work plans to move the start date for April/May activities to start in June.
Delay in activities in the JSI CHSSP work plan which are prerequisites to Kizazi Kipya's community-based activities with CCWs. This impacts Kizazi Kipya's ability to reach targets against core indicators. Delayed activities include: • CCW case management training, which was scheduled to fully scale up in April, which is now pushed to Q4. • Printing of case management forms, particularly the national referral forms. • Purchase of job aids for CCWs, including MUAC tape, which is essential for the TZ-NUT indicator.	Pact and JSI developed a close working relationship from the start of Kizazi Kipya, which has had widespread benefits to both Kizazi Kipya and CHSSP projects. Purposeful, proactive joint planning by the complementary projects enables each project to understand respective challenges with implementation (in this case, funding delay to JSI) and sets the stage for mid-course changes and adjustments to ensure that both projects achieve their respective objectives.	Pact and JSI continue to communicate regularly with one another, reviewing targets for CCW training numbers by ward against Kizazi Kipya data and adjusting training schedules together. The teams also used this time to review and update the number of forms to be printed by council. In the meantime, Pact photocopied some of the forms for CCWs' use. Pact cluster offices and CSOs continue to work closely with JSI on recruitment of CCWs in preparation for the training. JSI activities are now adjusted to a revised timeline, and Pact and CSOs are aware of the new schedule.

Pact was unable to meet with high-level decision makers at NACP to discuss key implementation strategies, namely: • Approval of the project operational plan, which was requested by the PS Health for NACP review and submitted by Pact to NACP in January for review. • Role of the CCWs in relation to the role of CHBC and CHW cadres, in particular the HIV Risk Assessment screening by CCWs. • Shared confidentiality between community and clinical programs to track HIV testing yield, lost to follow up, adherence behavior, etc. • Bidirectional referral system design and roll out (paper and electronic)	While PORALG and Department of Social Welfare fully own the National Case Management Framework and the community approaches to implementation (i.e., creating and training the CCW cadre), there is general lack of widespread understanding by government health officials at all level of the framework and the role of CCWs. In additional to signing MoU with LGAs; health facilities staff, CTC-in charge and other health and community services providers need to be oriented further on project contribution in improving the wellbeing of OVC and caregivers who are HIV positive or at risk of being infected. NACP staff are frequently out of their offices due to strategy meetings, workshops, curricula review, etc. Pact needs to start to travel where they are for meetings rather than waiting for an office appointment.	Pact will continue to try to get an appointment with NACP, including engaging clinical partners who already have more established working relationships with NACP. Pact will discuss with PORALG, DSW, USAID, and JSI the strategies for raising awareness of the National Case Management Framework to NACP, RMOs, and DMOs. At council and community level, Kizazi Kipya management will consider more strategies of engaging CTC focal persons, health facilities in charges and other service providers, including inviting them in relevant project trainings and meetings to understand better the project. Signed MoU with LGAs will facilitate smooth discussion.

Annex 1: Success Story

An HIV-free generation is possible through proper adherence to treatment

Bi Mariam Masasi Willison lives in Bugulula village, Bugulula ward, Geita District Council, Tanzania with her husband, Salum Robert Dutu,

Mariam is currently enrolled in USAID Kizazi Kipya (2016–2021), a program that aims to improve the care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing of Tanzanian orphans and vulnerable children. Mariam first discovered USAID and Pact's services through Pamoja Tuwalee (2010–2016), the predecessor to Kizazi Kipya that reached more than 500,000 vulnerable children and their families with key health, nutrition, education, and protection services in Tanzania

In 2010, Mariam suffered a tragedy when her newborn fell ill and passed away. Around that time, Pamoja Tuwalee found and enrolled her in the program and advised her to undergo HIV testing. She discovered she is HIV-positive.

In 2015, Mariam became pregnant again. Pamoja Tuwalee community case worker Amina Maonyesho visited Mariam in her home, counseled her, and advised her to attend Geita care and treatment clinic (CTC) for more counseling and support. "Amina gave advice to both of us, me and my husband," Mariam explained. "After she left our home, we discussed about the advice and decided to go to hospital the following day. At the hospital, we received enough knowledge on anti-retroviral therapy, and how we can prevent our baby from contracting HIV."

Staff at the CTC started Mariam on medication to prevent mother-to-child transmission of HIV, advised her to deliver her baby at a health facility, and instructed her that when she starts to feel labor pain, she should immediately go to the hospital. Mariam enthusiastically followed these instructions, and Amina was there to support and encourage her during regular home visits. "I felt good and comfortable talking to Amina about health because she is someone I know and trust," Mariam shared. "She gave me advice while cracking jokes here and there, which made the talk easy and comfortable."

Mariam followed the CTC's instructions and Amina's guidance and delivered a healthy baby girl, Elizabeth. Afterward, the CTC gave her other drugs for the baby. Mariam shared that "it was easy to follow the instructions. When I attended CTC class with my husband, they told us if we follow treatment instructions, I will give birth to a child free from HIV infection. To me that was good news because I didn't want to lose the baby as the other one, so instruction wasn't hard for me to follow." Six weeks after giving birth, "I went back to the health facility, my baby was tested for HIV and later (after a moth) received results and the results were negative. I was very happy and Amina was there to celebrate with me the good news".

Bi Mariam, in the red T-shirt, pictured with her one-year-old daughter Elizabeth and others, who is holding a juice box. The family's community case worker, Bi Amina, stands between Mariam and her husband, Salum

Kizazi Kipya project staff recently checked in with Mariam to see how she is doing. "I plan to have another child," Mariam said, "and I will take part in the prevention of mother-to-child transmission of HIV services again because I believe this will enable me to give birth to a healthy child. If I knew this treatment before, I would have started treatment early and my child would be alive now."

While smiling, Mariam was very happy to talk about baby Elizabeth, who is now one year old, healthy, and HIV free. "My child likes juice. You see she cried for your juice and she finished all the juice you gave her and still she needs more."

Kizazi Kipya will continue to support Mariam and her family including support to access family planning and counseling, ART adherence and support to Amina and her siblings with health and social services

Annex 2: Progress toward Goal

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Start-up					
Start-up meeting with USAID and GOT, regions and district introductions	Pact	Startup meetings conducted with USAID, GOT, MOHCDGEC, RAS, and LGAs	Continued with high level government official meetings both at national and LGAs level. These meetings mainly addressed action agreed in Q2	Continued with high level government official meetings both at national and LGAs level. These meetings mainly addressed action agreed in Q3	Startup meetings have been completed. However, the project will continue to engage USAID, the GOT and other key stakeholders
Start-up team deployed and key personnel on board	Pact	HQ sends a startup team; all key personnel are on boarded	Pact recruited 4 new staff to fill open positions: 3 M&E Officers and the Research and Learning Coordinator. The Consortium partners also filled all of their planned positions during the quarter.	Recruited and on boarded Technical Services Coordinator - Education (2 positions at cluster level), Technical Services Coordinator - Parenting & Child Protection (3 positions at cluster level	All key personally and major positions have been filled. However, the project will continue to recruited new staff and do replacement when need arise
Branding and marking plan submitted for approval	Pact	Branding and marketing plan approved	Approved in FY 16 Q4	N/A	Completed
First annual work plan and PMP finalized	Pact	Work plan and PMP approved	Work plan approved in FY 17 Q2	N/A	Completed
Procure equipment and supplies	Pact	Equipment and supplies available to enable success implementation	Continued to procure equipment and supplies including vehicles, laptops, tablets, IT equipment, and the Coast Cluster office furniture	Continued this quarter- new staff were given laptops	To be continued- this is ongoing, new staff will be given laptops
Baseline data collected	Pact	Baseline data collected	Continued to finalize the tools	Tools have been finalized	Conduct baseline survey
Develop SOPs and tools including screening tools for HIV testing services, reassessment of MVC, enrolment of OVC	Pact	Full set of finalized SOPs are developed and disseminated to consortium partners, clusters, CSOs, and community volunteers as relevant	Developed various SOPs including: Bi-directional Referrals and Linkages; Absorbing and Supporting Inherited VSLGs; Establishing, Supporting, and Monitoring ECD Corners; Establishing, Supporting and Monitoring Teen Clubs; Identifying and Responding to Cases of Abuse, Neglect, and Exploitation	All relevant SOPs for FY 17 drafted	SOPs printed and compiled in binders and sent to CSOs

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Assess, engage and orient CSOs in the sustained councils	Pact	CSOs are engaged and oriented as necessary to implement sustained council activities	Completed transitioning beneficiaries to appropriate stakeholders in alignment with the SOP in all 62 sustained councils	CSOs completed monitoring activities to encourage stakeholders to delivery services to transitioned families; to coach, mentor, and provide continuous technical support to MVCC, CSOs, VSLGs, and other stakeholders; and to address any technical administrative gaps in service delivery to OVC and their families.	CSO will continue monitoring activities and hold final meetings with LGAs regarding close out; CSOs in sustained councils will submit final reports.
Issues CSOs RFA	Pact	RFA issued	Assessed and selected CSOs; USAID approved CSOs	Pact issued sub-awards to selected and approved CSOs	Completed
Assess, engage and orient CSOs in the scale-up councils	Pact	CSOs are engaged and oriented as necessary to implement the project	Oriented CSOs and worked with CSOs to develop work plans for the remainder of FY 17	CSOs selected through RFA and approved by USAID have started implementation of the planned activities	CSOs will continue to implement the project planned activities
Result 1: Parents and caregivers have the financial resources to meet the needs of vulnerable children and adolescents					
Categorize OVC households using the Family and Child Assets Assessment	Pact/CSOs	Categorize household into Provision, Protection or Promotion	Administered the Family and Child Asset Assessment to Pamoja Tuwalee Beneficiaries enrolled in USAID Kizazi Kipya; conducted Focus Group Discussions to refine criteria for categories	Refined criteria for categories; conducted the analysis and categorized all households as “provision,” “protection,” “production” or “promotion”	Completed
Inclusion of ESSPs into referral system mapping by service type	Pact/CSOs	ESSP directory developed	Continued to map ESSP and conducted meetings with four service providers to discuss the areas of linkages and how all targeted beneficiaries can benefit from identified opportunities.	Included economic strengthening opportunities in the service directory template; CSOs oriented on how to develop/update service directories	Finalize Service directories
Linkages into bi-directional referral system of WORTH/savings groups	Pact/CSOs	WORTH/VSLGs are included in the bi-directional referral system	Ensured ES activities, including VSLGs, were included in the National Referral Tool and the bi-directional referral system	Continued to ensure that activities, including VSLGs, are included in the bi-directional referral system.	Completed
IR 1.1: Increase temporary consumption support and social protection					
Link destitute households to consumption support and early stage HES interventions	Pact/CSOs	To the extent possible, work with TASAF to ensure that OVC households are	Held a meeting with TASAF on how TASAF and USAID Kizazi Kipya can collaborate.	Trained TSCs-TS and CSOs on updated WORTH model (WORTH Yetu) which includes topics around social responsibility and inclusion of destitute households.	CSO staff will train Livelihood Volunteers who will establish WORTH Yetu groups in the community.

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
		assessed to become TASAF beneficiaries			
In USAID Kizazi Kipya TASAF districts, work with TASAF ES staff and mobilizers to align and strengthen activities	Pact/CSOs	TASAF staff oriented on the project's VSLG SOP	Conducted meetings with TASAF district coordinators to strengthen working relationship between Pact, CSOs and TASAF at council level.	Continued to collaborate with TASAF staff at the council level.	Continue to collaborate with TASAF staff at the council level.
Develop strategy on how to mobilize resources from the public and private sectors	Pact/CSOs	Resources from the public and private sector mobilized and used to support destitute households.	Developed TOR for a PPP consultant who will work with the project team to identify key gaps in resources to support OVC, youth, and their caregivers.	Recruited the consultant. The consultant started to develop the tools for conducting assessment of existing PPP capacity across the CSOs	Consultant will conduct assessment of existing PPP capacity across the CSOs
IR 1.2: Increased participation in savings and credit opportunities					
Create, strengthen, and/or engage VSLGs	Pact/CSOs	Absorb VSLGs from Pamoja Tuwalee; establish and support newly formed WORTH groups to meet TZ_ECON target	Finalized the SOP for absorbing and supporting all saving groups from Pamoja Tuwalee.	Finalized SOP for Establishing and Supporting WORTH Yetu groups; updated the WORTH Yetu training materials and trained TSC-ES and CSOs staff.	CSO staff will train Livelihood Volunteers who will establish WORTH Yetu groups in the community.
Capacitate households with money management skills	Pact/CSOs	Money management curriculum piloted	Developed criteria for developing selecting an evidenced based Household Financial Literacy and Money Management curriculum.	Pact reviewed ASPIRES' draft literature review on money management curriculums and begin reviewing curriculum	Pact will hire a consultant to assist with the final selection and adaptation of the curriculum.
IR 1.3: Diversified opportunities for increasing income and assets					
Assess economic opportunities and resources that are available	Pact/CSOs	Economic opportunities and resources identified	No activity	CSOs begin developing/updating service directories, which include economic strengthening opportunities.	Based on this mapping exercise, Pact will select 6 councils (one from each cluster) to begin to conduct deeper council-level assessments of local markets and opportunities for OVC households to enter or strengthen their position within promising value chains.
Provide trade and/or industry specific ES services	Pact/CSOs	Networks for trade, and/or production learning and enterprise, market and production development trainings are piloted	Pact drafted the council level local market opportunities and market assessment tool.	No activity	Draft pilot guidance and tools for networks for trade, and/or production learning and enterprise, market and production development trainings

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Create external credit linkages for mature groups	Pact/CSOs	External credit linkages for mature groups is established	No activity	No activity	Develop tool to assess mature groups and strategy for linking groups to external credit.
Result 2: Parents and caregivers have the skills to meet the needs of HIV infected and vulnerable children and adolescents					
IR 2.1: Improved and expanded parent education and support services					
Strengthen the capacity of caregivers' skills in positive parenting for children (0-19 years)	Pact/CSOs	CCW can deliver parenting messages and basic skills building for caregivers of children and adolescents ages 0-19.	Reviewed the ISW PSW training materials to understand parenting gaps; participated in the National Parenting Task Force Technical Working Group meeting to review the National Parenting Education Manual for Families	Participated in the National Parenting Taskforce; developed two pager Parenting messages from the National Parenting manual for Families.	Pact will work with Department of Community Development and trainers in Kibaha TC and Kilolo DC to schedule trainings to CSOs' Case Management Officer on the National Parenting Education Manual for Families; continue to refine parenting messages job aid.
Work with MNCH workers and other health professionals and nutritionist to address the health and nutrition status of children 0-5	EGPAF/ Pact/CSOs	Caregivers and children receive MNCH related services	Identified and met with nutrition program partners that will benefit the project's beneficiaries; continued providing nutrition services to beneficiaries.	Established partnership with nutrition programs, including: Interchurch Medical Assistance (IMA), Mwanzo Bora Nutrition Program, Universities Aspirants et Medecins (CUAMM), and UNICEF. Developed a service directory template for health and social services including nutrition services. TSCs and CSO staff were trained on how to collect information and complete the service directory.	Pact will set up a clear mechanism on partnership with other nutrition programs; finalize service directories and compile a national level service directory.
Strengthen capacity of case manager to deliver CCD services	AKF/CSOs	CCW deliver the CCD package during household visits to address developmental needs of children ages 0-3	AKF's ECD Advisor was on boarded and met with the UNICEF's CCD focal person and Chief of the Health department to discuss UNICEF's role in supporting the adaptation of the CCD package for Tanzania.	A consultant engaged by UNICEF to review the current curriculum, finalized the work and submitted the report with recommendations to UNICEF. AKF, EGPAF and UNICEF have been working closely on integrating the recommendations into the CCD package.	Close collaboration between AKF and EGPAF will continue to finalize the adaptation and prepare training package for CCD training within Kizazi Kipya. UNICEF will convene a meeting with MOHCDGEC to share the recommendations and discuss the way forward for adoption of the CCD materials. CCD training for CCWs will start in September.
Formation, support, and supervision of CCD to Care Groups	AKF/CSOs	Provide platform for Care Groups a forum where caregivers can discuss issues related	AKF's ECD Advisor participated in the East Africa CCD meeting and presented the plan for the delivery CCD under Kizazi Kipya and received feedback from	No Activity - delayed due to delayed national CCD adaptation.	N/A

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
		to parenting their children under age 5	experienced practitioners and personnel.		
Formalize relationship between the case managers, CHWs, and HBC providers to improve caregivers ' health and ART adherence and retention	EGPAF/ Pact/CSOs	Mutual understanding among project and MOHCDGEC on the different roles of community cadres in supporting ART adherence and retention.	Initiated discussions with PEPFAR care and treatment IPs (THPS, AGPAHI, MDH, and Baylor College of Medicine Children's Foundation). Among other topics, this meeting discussed the collaboration of care and treatment partners and shared lists of how many CHWs and HBC providers are supported by the facility.	Held a meeting with all care and treatment partner to discuss, among other topics, roles of LCWs/CCWs in improving caregivers' health and ART adherence and retention. CSOs have encouraged available community volunteers as well as HBC/CHW to apply for CCW cadre.	Continue encouraging CHWs and HBC volunteers to apply for CCW cadre.
Strengthen the capacity of the case managers to improve caregiver's socio-emotional wellbeing	Pact/CSOs	To pilot a depression detection tool to administer to caregivers	Met with MUHAS to discuss depression detection and screening tools to be adapted to a community setting.	Developed a Terms of Reference to conduct a literature review and pilot a depression detection tool to administer to caregivers	Pact will hire a consultant to complete a literature review of depression detection and screening tools and Kizazi Kipya, in collaboration with MOHCDGEC, will select the councils for piloting the tool and adaption.
IR 2.2: Improved and expanded support services for the caregivers of HIV infected children					
Strengthen capacity of case managers to provide case management to caregivers of HIV infected children 0-15	EGPAF/ Pact/CSOs	CCWs have the skills and ability to support HIV-positive OVC	Reviewed the last version of the National Integrated Case Management Training Manual for CCWs	Developed HIV sensitive case management supportive supervision tools for TSCs, CSO staff, and LCWs; oriented TSCs, CSOs staff, and DSWOs on the tools.	Once CCWs are trained by JSI, CSO staff and SWOs will conduct joint supportive supervision visits to LCWs and CCWs to provide on-site mentoring and coaching.
Strengthen Community Volunteer cadres' skills to support caregivers of HIV positive children	EGPAF/ CSOs	CCWs trained on addressing key areas of HIV including early infant diagnosis, ART initiation, pediatric treatment regimen, risks and signs of development delays, importance of adherence, psychosocial support, etc.	Identified high volume CTCs where CCWs selection for pediatric will based; developed the SOP to guide CCWs to provide support to caregivers of HIV-positive children; held a 5-day meeting with National Pediatric HIV Facilitators to review the contents of the Supplemental Pediatric HIV Orientation for PSWs/CCWs	Met with the National AIDS Control Program (NACP) to share the orientation package for their review and approval, before commencement of the activity. After the review NACP shared their recommendations including their concern on the nature of the orientation materials versus the level of knowledge of the CCWs on basic HIV issues.	Finalize Supplemental Pediatric HIV Orientation materials; rollout orientation of CCWs who are also CHW/CHBCs.
Facilitate and link OVC households to HIV services (Birth – 15 years)	EGPAF/ Pact/CSOs	HIV assessment tool rolled out to ensure referrals and linkage	Finalized the HIV Risk, Services, and Adherence Assessment for children and adolescents; worked	Pact began to pilot the HIV Risk, Services, and Adherence Assessment tool in Zanzibar.	Complete pilot in Zanzibar; pilot the HIV Risk Service and adherence

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
		for HTC is targeted and based on risk	with JSI and DSW to include the assessment in the National Integrated Case Management training package and Practical handbook for PSWs/CCWs.	CSOs, continued to issue referrals using existing referrals systems established under Pamoja Tuwalee while the National Referral System is under development.	Assessment in areas with moderate and high prevalence. Continue providing referral using established paper based Bidirectional Referral and Linkage System.
Support children who are HIV-positive to access further support at child/ECD corners and youth teen clubs	EGPAF/ CSOs	HIV-positive OVC access ECD corners and teen clubs	Continued meeting with PEPFAR IPs to discuss existing (and planned) child- and adolescent-friendly clinic models implemented by CTCs; drafted SOPs on Establishing, Supporting and Monitoring ECD Corners; Establishing, Supporting, and Monitoring Teen Clubs; and Health System Engagement.	Met other PEPFAR IPs (Henry M. Jackson Foundation and Deloitte) and discussed, among other topics, existing child- and adolescent-friendly clinic models implemented by CTCs.	Pact and CSOs to finalize service directory mapping that will include child and adolescent group-based psycho-social support. CSOs continue to meet with CTCs to coordinate linkages of HIV positive OVC to child and adolescent friendly HIV services.
High-quality services are available to HIV-infected and vulnerable children and adolescents					
Enrollment of beneficiaries into USAID Kizazi Kipya, including assessments	Pact	All households under USAID Kizazi Kipya will receive high quality case management session	Administered the Family and Child Asset Assessment to Pamoja Tuwalee Beneficiaries enrolled in USAID Kizazi Kipya	Continued data entry of Family and Child Asset Assessments conducted during the previous quarter	Finish conducting the Family and Child Asset Assessment to all enrolled beneficiaries.
Design logical referral system	EGPAF	Functional bidirectional referral system to support referrals and linkages to HIV clinical services to support 90-90-90 goals	Developed the Bi-Directional Referrals and Linkages SOP; began developing electronic bi-directional referral system	Developed electronic system contains all three tiers (Android, USSD and Dashboard applications); trained TSCs, CSOs, and DSWOs on Bi-Directional Referrals and Linkages SOP and job aids	Conduct user testing to improve the system as well as going live with USSD application. Pilot the electronic bi-directional referral platform in selected health facility sites in targeted councils. In non-EGPAF sites, CSOs' will train LCWs/CCWs on the bi-directional referral and linkage system and job aids.
IR 3.1: Improved and expanded education services					
Prepare DITs to deliver WSA in target schools	AKF/CSOs	11 scale-up councils in FY 17 have schools under the WSA	Hosted a workshop with AKF field officers experienced in delivering the WSA and education managers from across the East African region (Kenya, Tanzania, and Uganda) as well as regional and international AKF education advisors.	Finalized the development of WSA SOP and Master Trainers and Facilitator manuals; Facilitator manual has been reviewed to incorporate issues of OVC as well as girls transition.	Training the Trainers and DIT on the WSA

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
DITs support target schools to develop and implement SDP and block grants through WSA	AKF/CSOs	DITs deliver the WSA at the community level to conduct community mapping and develop SDP or add OVC and girls transition issues to existing SDP.	This activity is contingent on 3.1.1 and, as indicated in the work plan, did not begin until Q3.	This activity is contingent on 3.1.1.	DITs will begin to support targeted schools.
Support LGA to develop and review a coordinated retention and transition between secondary and primary schools	AKF/CSOs	The WSA provides a supportive environment that promotes transition of girls from primary to secondary school.	This activity is contingent on 3.1.1 and 3.1.2 and, as indicated in the work plan, did not begin until Q4.	This activity is contingent on 3.1.1 and 3.1.2	Preparation to start in Q4.
District tutors prepare low-cost material package to pre-school teachers and train zonal trainers	AKF/CSOs	District tutors are trained in low-cost material package to pre-school.	AKF drafted ToR for development and delivery of low cost materials training and supportive supervison support. MECP-Z will be contracted to develop the low-cost materials.	A three-day workshop was held in Zanzibar between AKF and MECPZ to work on the framework for delivery of LCMD; AKF began mapping preprimary classes and developed selection critiera; adapted LCMD to Kizazi Kipya project and context.	AKF/MECPZ will finalize the LCMD training materials. AKF will finalize the selection of the pre-primary classes and work with LGAs to select DITs. MECPZ will deliver the LCMD trainings to district tutors.
District tutors deliver low-cost material package to pre-school teachers	AKF/CSOs	Children interact with and use age appropriate teaching and learning materials in early learning in selected pre-primary schools.	No activity	No activity	This activity is contingent on 3.1.4 and, as indicated in the work plan, does not begin until Q4.
IR 3.2: Expanded interventions for health, HIV, and SRH services					
Targeted health facilities provide ECD services and establish ECD corners	EGPAF	ECD corners are established; HCW are trained on CCD package	Drafted SOP to guide the establishment of and support to ECD corners.	Worked on addressing recommendations by UNICEF/MOHCDGEC on CCD package	Roll out CCD training in identified health facilities
Establish Teen Clubs for adolescent girls and boys (age 10-14 and 15-19)	Pact/ Restless Development	Teen clubs are established and supported for in and out of school adolescents	Developed Teen Clubs SOP with NPEs as reviewing and updated the Teen Club Toolkit and NPE and CPE training materials.	Conducted foundational training for all 50 recruited NPEs. Supported CSOs to recruit CPEs, who will oversee out of school teen clubs for OVC ages 10-14 and 15-19. Developed and adapted materials to deliver trainings on establishing and supporting Teen Clubs to CSOs and CPEs.	Train CSOs and support NPEs and CSOs to train CPEs in establishing and supporting teen clubs Begin mobilizing teen clubs comprised of Kizazi Kipya beneficiaries

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Implement adapted "Girls Let's Be Leaders" toolkit with Teen Clubs	Pact/ Restless Development	Framework for Working with Adolescent Girls" developed in 2012 by TACAIDS.	Reviewed their "Girls Let's Be Leaders" Toolkit to the USAID Kizazi Kipya context, including developing activities to also address boys during curriculum delivery.	Trained NPEs in the "Girls Let's Be Leaders" Toolkit	Train CSOs and support NPEs and CSOs to train CPEs in the "Girls Let's Be Leaders" Toolkit
Conduct Stepping Stones curriculum to Teen Club participants	Pact/CSOs	Stepping Stones administered to teen clubs or groups of mobilize girls age 15-19 enrolled in the project.	Pact conducted a follow-up meeting with Sauti to better understand how Sauti-trained Stepping Stones facilitators could be utilized under USAID Kizazi Kipya.	No activity	Work with the MOHCDGEC to explore the possibility of training national trainers to train CCWs Stepping Stones.
Provide SRH education outreach to Teen Clubs (12 – 18 years)	EGPAF/ CSOs	SRH educational outreaches conducted with teen clubs	Preliminary meeting with USAID Boresha Afya to establish collaboration around SRH educational outreaches and referrals to adolescent friendly health facilities; drafted SOP on conducting SRH outreached	EGPAF continued with SOP development by incorporating details on how the activity will be operationalized. EGPAF identified HCWs from high volume sites who are already trained on ASRH through EGPAF CIFF – Adolescent project	Orient CSO District Reproductive and Child Health Coordinator (DRCHCo), Health and HIV officer, NPEs/CPEs and other stakeholders on the developed SOP. Continue identification of trained HCWs in other councils and engaging them on facilitation of outreach sessions. Rollout the sessions in non-Restless Development supported councils
Implement DREAMS interventions with the aim to reduce HIV incidence and increase school attendance among adolescent girls	Pact	Reach in-school girls age 10-14 with HURU and educational subsides; reach girls out of school 15-19 with vocational scholarships	Pact attended meeting with several DREAMS partners.	No activity	Activities are contingent on receiving DREAMS funding.
Link adolescents to MTH/DREAMS drop-in centers	Pact/CSOs	Established linkage between DREAMS drop-in centers and MTH	Mapped Restless Development's 26 MTHs across Dar es Salaam, Iringa, and Ruvuma regions.	No activity	Bi-Directional and Referral Coordinators will continue collaborating with care and treatment IPs and RHMTs at the regional level. CSOs will continue to maintain relationships with CHMTs and care and treatment partners at the council level. CSOs, with technical support from Bi-Directional and Referral, will establish partnerships with targeted

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
					168 CTCs in scale-up councils (links to IR 3.0.2).
Case Managers work with high pediatric volume CTCs to trace HIV-positive OVC who miss appointments, enroll them in KIZAZI KIPYA, and link them back to CTCs	Pact/CSOs	Begin tracing HIV-positive OVC who miss appointments	Met with other IPs (THPS, MDH, AGPAHI, EGPAF, and BIPAI) and discussed models for pediatrics, adolescents, and adult LTFU tracing and shared confidentiality, as well as other services related to USAID Kizazi Kipya's beneficiary's MOU template for LGA to specify sharing sensitive information for tracing HIV-positive OVC has started to be developed.	Cluster staff and CSOs held meetings with 20% of RHMTs and 35% of CHMTs during the quarter.	TSCs-BDRL will continue collaborating with care and treatment IPs and RHMTs at the regional level. CSOs will continue to maintain relationships with CHMTs and care and treatment partners at the council level. CSOs, with technical support from Bi-Directional and Referral, will establish partnerships with targeted 168 CTCs in scale-up councils (links to IR 3.0.2).
IR 3.3: Improved and expanded opportunities for developing livelihoods and employment skills and engaging in life skills education					
Orientation/top up training of SIYB trainers on policies (gender and child protection), project strategy and contents of training manuals	Restless Development	Administer SIYB model to teen clubs	Developed an SOP for rolling out the SIYB model, demonstrating integration with other USAID Kizazi Kipya activities, including education promotion, ES activities with caregivers, case management, and OVC identification. Selected and trained, 10 NPEs as TOTs for the SIYB packages.	Trained all NPEs on the SIYB package.	The trained 50 NPEs will start preparation for training CSOs and CPE on the SIYB package
Training of CSOs- youth engagement, life skills, livelihood and youth employability	Restless Development	To have CSOs, NPEs and CPEs trained in youth engagement, life skills, livelihood and youth employability	Developed an SOP on training CSOs in youth engagement, life skills, livelihoods, and youth employability.	Conducted organizational capacity assessments to nine CSOs (WAMATA, KIWWAUTA, ACT- DSH, ADP Mbozi, IRDO, COCODA, Allamano Centre, TAHEA and Afya Women Group).	Support CSOs to develop the action plan for addressing the identified gaps. Support CSOs to engage in Public-Private partnership in livelihoods.
Support CSOs in marketing of youth products through local and national-led initiatives organized by government and other partners, e.g., Nanenane, Sabasaba	Restless Development	Youth supported at national events to market their products	No activity	No activity	This activity has been moved to FY 18
IR 3.4: Improved and expanded child protection and related services					

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Conduct Sinovuyo Caring Families for Parents and Teens to reduce risk of violence, neglect and abuse	Pact	Conduct Sinovuyo Caring Families for Parents and Teens in selected councils	Worked with Clowns without Border to review the Sinovuyo Caring Families for Parents and Teens into Tanzania context	Pact worked with Clowns without Borders and in collaboration with MOHCDGEC to finalize the adaption of the Sinovuyo Caring Families for Parents and Teens curriculum to the Tanzanian context. The curriculum has been renamed Furaha Caring Families for Parents and Teens and has been translated to Kiswahili. Conducted a CSO readiness assessment, held a preparation meeting with CSOs and government representatives, and trained its first wave of Furaha facilitators.	Mobilize Kizazi Kipya beneficiaries to take part in Furaha Caring Families for Parents and Teens. Conduct Furaha Caring Families for Parents and Teens sessions with approximately 400 OVC age 10-17 and their caregivers.
Refer cases of violence, abuse neglect and exploitation to DSW and CPTs	Pact/CSOs	CCW have the skills to identify and respond to cases of abuse, neglect, and exploitation	Finalized SOP on identifying and responding to cases of child abuse, neglect, and exploitation.	Oriented TSCs, CSO staff, and DSWOs on the Identifying and Responding to Cases of Abuse, Neglect and Exploitation SOP, which included training on a Child Abuse Incident Reporting form that CCWs can use to refer cases to DSWOs and CPTs. Pact in collaboration with UNICEF, conducted a CPT functionality assessment using the National Child Protection Monitoring System Tool in two councils: Kilolo DC and Mufindi DC.	Orient LCWs/CCWs on Identifying and Responding to Cases of Abuse, Neglect and Exploitation, Case management and Bi-directional referral and linkages SOPs. Continue assessing child protection systems in targeted councils to identify specific training needs using the National Child Protection Monitoring System Tool. Meet with the Commissioner for Social Welfare and UNICEF to develop a training plan to address gaps among DSWOs and CPTs.
Conduct case conferencing and develop care plans with multi-disciplinary panel members if a child is removed from home	Pact/CSOs	CCW are conducting case conferencing when a child is removed from the home.	Finalized SOP on identifying and responding to cases of child abuse, neglect, and exploitation, which includes steps for conducting case conferencing.	Pact and UNICEF assessed CPTs in Kilolo DC and Mufindi DC, which included examining the extent to which case conferencing is conducted in adherence with Tanzania's Child Protection Regulations.	Continue assessing the extent to which case conferencing is conducted in adherence with Tanzania's Child Protection Regulations in targeted councils. Include case conferencing in the training plan to present to the Commissioner for Social Welfare
USAID Kizazi Kipya ensures proper investigation of child abuse, neglect and exploitation are conducted in partnership with SWOs- to see if more interventions are required	Pact/CSOs	Child abuse cases managed by CCW/PSWs are investigated	Finalized SOP on identifying and responding to cases of child abuse, neglect, and exploitation, includes steps for PSWs/CCWs, CSOs, and project staff to ensure collection of forensic evidence, follow-up with	During the CPT functionality assessment in Kilolo DC and Mufindi DC, noted lack of forensic evidence training/availability of forensic evidence collection as a bottleneck to convict child abuse perpetrators.	Include forensic evidence training in the training plan to present to the Commissioner for Social Welfare

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
			police, and support survivors during investigations.		
Strengthen systems for child protection at council and community level	Pact/CSOs	Functional CPTs	Worked with DSW to map the councils with established child protection systems apart from those mapped under UNICEF and existing one-stop centers	Met with district stakeholders specifically with One Stop Centers focal persons in Ilala MC and stakeholders interested in reviving the One Stop Center in Mbeya CC.	Support the One-Stop Center quarterly meetings for service providers at Amana Regional Referral Hospital to discuss continuation of services after normal government working hours. Follow-up with MOHCDGEC and HJF on the plans to re-establish the One Stop Center in a survivor friendly location in Mbeya CC.
Strengthen networking among district stakeholders, including health facilities and case managers, to ensure victims of violence receive services	Pact/CSOs	Functional district stakeholders' meetings to support linkages, referral, and networking	Finalized the above-mentioned SOP on identifying and responding to cases of abuse, which includes the important of sexually abused survivors to get appropriate post-rape care within the specified time including access to PEP within 72 hours and other clinical/forensic services.	Developed and rolled out a child protection job aid which outlines sign and symptoms of potential abuse for CCWs to easily reference, as well as a one-page guide to record names of DSWOs, CPTs, Police, ASWO, WCDO, OSC, and Hospital/Dispensary/Health facility to know exactly who to contact if a child abuse case has been identified.	Pact will provide on-site technical assistance to CSOs and CCWs to ensure the Child Abuse Incident Reporting form is used properly to ensure completed referrals.
Result 4: High-quality services are available to "hard-to-reach" HIV-infected and vulnerable children and adolescents					
IR 4.1: Improved and expanded services for children living or working on the streets (CLWS)					
Conduct headcount	RCA	Headcount report	Conducted Headcount exercise in Mwanza (Nyamagana MC and Ilemela DC) and Arusha (Arusha CC) regions	Conducted Headcount exercise in the remaining seven councils	Analyze the Headcount exercise data and prepare the report
Identification of community-based organization (CBO) partners to work in the 6 target cities	RCA	CSOs to implement CLWS	Six CSOs identified to implement CLWS interventions Supported these CSOs to develop the work plan		Completed
CBO partner training	RCA	Trained CSOs	Began preparation for SOPs and training materials	Finalized SOPs and prepared training curriculum for street and family work. Conducted training to CLWS CSOs staff	Continue training to CLWS CSOs on case management
Ongoing support and work with partner CBOs	RCA	CSOs addressing the needs of CLWS	Supported CSOs to develop their implementation work plan for six months (April-September 2017)	RCA continued to support CSOs to ensure timely implementation of the planned activities	Continue to support the CSOs in implementing the planned activities

Activity/output	Partner(s)	Annual benchmark	Progress through previous quarter	Progress this quarter	Status/activities for next quarter
Identification of strategic stakeholders engaged with CLWS in the 6 target cities	RCA	Strategic partners	Identified both Government and other stakeholders including a consultant for conducting the headcount	Continued to identify and work with different stakeholders in the six cities	To be continued
IR 4.2: Improved service models for one category of hard-to-reach children					
Develop research question, Proposal, tools for data collection and IC forms and submit to IRB for approval	IHI	Tools to support formative research developed and submitted to IRB	Submitted the research proposal to IHI research and learning board and received approval Submitted the research proposal to NIMR	Received approval from NIMRI to conduct the formative research Started data collection in Bukombe, Chunya and Songwe districts	Analyze the data and prepare the report and disseminate the research finding Prepare the tools for conducting the qualitative baseline data collection on children working in mining
Site reconnaissance visits to all potential sites for the children in the mining sector	IHI	Trip report providing overview of mining sites with regard to children in those sited and current projects	Site visit to Chunya and Geita Site visit to Bukombe DC following advice to change the intervention site from Geita DC to Bukombe DC		Completed