USAID Kizazi Kipya Project

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AGA KHAN FOUNDATION
An agency of the Aga Khan Development Network

Elizabeth Glaser Pediatric AIDS Foundation

RESTLESS DEVELOPMENT
THE YOUTH-LED DEVELOPMENT AGENCY

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About USAID Kizazi Kipya:

The USAID Kizazi Kipya Project aimed to enable more than 1 million 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.

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Cover photo:

A group of adolescent girls and young women (AGYW) who were supported by the project with vocational scholarships and income-generation toolkits. Currently, they own small-scale entrepreneurial businesses and are advocacy champions for ending HIV and AIDS.

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Abbreviations and Acronyms

ACHIEVE	Adolescents and Children HIV Incidence Reduction, Empowerment, and Virus Elimination project
AGYW	adolescent girls and young women
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ASRH	adolescent sexual and reproductive health
ASWO	Assistant Social Welfare Officer
BDRL	bi-directional referrals and linkages
CBIM	Coaching Boys into Men
CC	Community Council
CCD	Care for Child Development
CCW	Community Case Worker
CD	capacity development
CHACC	council HIV and AIDS control coordinator
CHMT	Council Health Management Team
CHSSP	Community Health and Social Services Project
CHW	Community Health Worker
CIM	children in mining
CLHIV	children living with HIV
CM	case management
CMO	Case Management Officer
COBET	complementary basic education for Tanzania
COFSW	children of female sex workers
COP	Chief of Party
COVID-19	coronavirus disease 2019
CPP	child protection and parenting
CRM	community resource mobilization
CRMC	Community Resources Mobilization Committee
CSO	civil society organization
CST	Cheka Sana Tanzania
CTC	Care and Treatment Centre
CWB-SA	Clowns Without Borders South Africa
CYLWS	children and youth living or working on the streets
DC	District Council
DCDO	District Capacity Development Officer
DCOP	Deputy Chief of Party
DFA	Director of Finance and Administration
DHIS2	District Health Information Software Version 2
DMO	District Medical Officer
DQA	data quality assessment
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSW	Department of Social Welfare
DSWO	District Social Welfare Officer
EAC	enhanced adherence counseling
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ES	economic strengthening
ESLO	Economic Strengthening and Livelihood Advisor
FCAA	Family and Child Asset Assessment tool
FCI	Faith and Community Initiative

FSW	female sex worker
FY	fiscal year
GBV	gender-based violence
GOT	Government of Tanzania
HCW	Health Care Worker
HEI	HIV-exposed infant
HES	household economic strengthening
HHO	HIV and Health Officer
HIV	human immunodeficiency virus
HR	human resources
HRAQM	HIV Risk Services and Adherence Quarterly Monitoring Tool
HTC	HIV testing and counseling
HTS	HIV testing services
iCHF	Improved Community Health Fund
ID	identification
IGA	income-generating activity
IHI	Ifakara Health Institute
ILV	Independent Livelihood Volunteer
IP	implementing partner
IR	intermediate result
iTIKA	improved Tiba Kwa Kadi
LCMD	low-cost materials development
LCW	Lead Community Case Worker
LGA	local government authority
LOP	life of project/life of the project
LTFU	loss/lost to follow-up
LV	Livelihood Volunteer
MC	Municipal Council
MER	monitoring, evaluation, and reporting
MERL	monitoring, evaluation, reporting, and learning
MNCH	maternal, newborn, and child health
MOHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
MUAC	mid-upper arm circumference
MVC	most vulnerable children
MVC_MIS	National Most Vulnerable Children Management Information System
NACP	National AIDS Control Program
NACS	Nutrition Assessment, Counseling, and Support
NGO	non-governmental organization
NICMS	National Integrated Case Management Systems
NIMR	National Institute for Medical Research
NMB	National Microfinance Bank
NPA-VAWC	National Plan of Action to End Violence Against Women and Children
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PGCD	Police, Gender, and Children Desk
PLHIV	people living with HIV
PO-RALG	President's Office – Regional Administration and Local Government
QI	quality improvement
RCA	Railway Children of Africa
RCCE	risk communication and community engagement
RDQA	routine data quality assessment

RHMT	Regional Health Management Team
SDP	school development plan
SECD	Science of Early Childhood Development
SIMS	Site Improvement Monitoring System
SOP	standard operating procedure
SRH	sexual and reproductive health
STI	sexually transmitted infection
SWO	Social Welfare Officer
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TPB	Tanzania Postal Bank
TSC	Technical Service Coordinator
TZS	Tanzanian Shilling
UIC	unique identification code
USAID	United States Agency for International Development
USG	United States Government
USSD	unstructured supplementary service data
VAC	violence against children
VAT	value added tax
VAWC-PC	Violence against Women and Children Protection Committee
VETA	Vocational Education and Training Authority
VIG	Video Interaction Guidance
VSLG	village savings and loan group
WASH	water, sanitation, and hygiene
WEO	Ward Executive Officer
WSA	Whole School Approach
WHO	World Health Organization
$	United States dollars

Executive Summary

Kizazi Kipya increased the health and well-being of 1,234,426 Tanzanian orphans and vulnerable children (OVC) and young people affected by HIV, and 469,624 caregivers. From 2016 to 2021, Kizazi Kipya enabled children and youth in 85 councils across 25 regions to use client-centered services for improved health, nutrition, education, protection, and livelihoods. Funded by the US President's Emergency Plan for AIDS Relief (PEPFAR) through the US Agency for International Development (USAID), the project worked with 67 local partners, operationalizing family-centered case management and impacting the health and resilience of over a million vulnerable Tanzanians, including children living with HIV (CLHIV).

As one of USAID's largest OVC programs, the scale of Kizazi Kipya's impact is extensive – reaching over one-third of the estimated 3.3 million OVC affected by HIV in Tanzania.[1] The partners implemented in over 80% of Tanzania's regions (25 of 31) and nearly half of its councils (85 of 172— at one point in 132 councils). Activities tailored using real-time data drove contributions to UNAIDS's testing, treatment, and viral suppression goals, with the number of OVC served meeting or exceeding targets each year, despite the disruptions of COVID-19 during the last two years of the project. Kizazi Kipya closed at the end of 2021 having served approximately 12% of all the OVC and caregivers reached by PEPFAR programming globally.[2] After proving the success of Kizazi Kipya's integrated approach to meeting the needs of vulnerable children and young people via differentiated services in 67 priority councils, project funding increased from $65 to $162 million in FY19 to scale up implementation to 85 councils.

The project was implemented by ***Pact*** and five consortium partners:

- ***Aga Khan Foundation (AKF)*** implemented early childhood development (ECD) and education services, including low-cost material development, the Whole School Approach (WSA), and care for child development (CCD).
- ***Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)*** rolled out an electronic bi-directional referral system, the National Pediatric HIV Supplemental Orientation package for lead community case workers (LCWs) and community case workers (CCWs), ECD Corners in health facilities, and adolescent sexual and reproductive health (ASRH) outreach education.
- ***Ifakara Health Institute (IHI)*** conducted formative research in mining and evaluated the children in mining (CIM) intervention.
- ***Railway Children of Africa (RCA)*** specialized in programming for children and youth living and working on the streets (CYLWS).
- ***Restless Development*** rolled out teen clubs, specializing in youth livelihoods and empowerment.

Aligned with PEPFAR's priorities, Kizazi Kipya designed strategies and interventions to contribute to UNAIDS' 95-95-95 targets, and by project close served 60,871 HIV-positive OVC. Focused support on Antiretroviral Therapy (ART) adherence led to 98% of CLHIV on ART and, of those with available viral load results, 89% achieving viral load suppression. Notably, among CLHIV on ART age 0-14, the project outperformed national pediatric viral load suppression (VLS), reaching 91.4% VLS among project clients as compared to 84% nationally. As another testament to community engagement and the quality of services delivered by the project as well as the trust built by case workers among OVC and their caregivers, 92% of the 1,028,972 OVC under age 18 who received case management services disclosed their HIV status, and this increased over time, from 64.0% in FY18 to 99.7% in FY21.

Throughout the project, Kizazi Kipya continually strengthened the CLHIV package of services, for these OVC to be empowered and thriving while reaching viral suppression. CLHIV face psychological and social challenges along with health concerns such as ART side effects, opportunistic infections, stigma and discrimination, and difficulty accessing child friendly services. To maximize service quality while increasing the number of CLHIV served, the project designed tools for scale-up including an HIV risk assessment tool, an electronic bi-directional referral system, an enrollment register- at Care and Treatment Centers (CTCs), and a mechanism for CTC staff to determine a pediatric client's enrollment status and case worker support needs.

In Kizazi Kipya's successful child-focused case management (CM) approach, Lead Case Workers (LCWs) and Community Case Workers (CCWs) screened and enrolled vulnerable households, assessed household and individual needs of children, developed, and monitored care plans—and delivered and referred to holistic services including health, HIV services, violence prevention and response, nutrition, education, psychosocial, and economic strengthening. Over the life of the project, LCWs/CCWs issued 802,071 referrals, 90% of which resulted in families accessing essential services. The project also designed and delivered differentiated service packages and approaches for highly vulnerable groups including CLHIV, children and youth living and

[1] Tanzania has an estimated 3,305,429, million OVC affected by HIV/AIDS (MEASURE Evaluation, 2016).
[2] Using the most recent publicly available data for the OVC_SERV indicator, for Fiscal Year 2020 (FY20).

working on the streets (CYLWS), children of female sex workers (COFSW), and children in mining (CIM). By the end of the project implementation period, 99,478 households that included 297,947 beneficiaries had graduated from the project – 20% of those receiving CM services.

Kizazi Kipya's economic strengthening component aided families in improving their livelihoods, so that caregivers had the financial resources to meet their children's needs. Pact's economic empowerment model, WORTH, integrates health literacy with financial literacy via village savings and lending groups. Kizazi Kipya established and/or supported over 12,000 WORTH "Yetu" groups, with savings and lending over $11.5 million and $11 million, respectively—resources that enabled families to feed their children, keep them in school, stay on HIV medications, and invest in their future. In addition, Kizazi Kipya increased employment and entrepreneurship opportunities for out of school youth participating in the project. A 2021 survey among participants who completed vocational training found that the majority reported a source of income after completing economic strengthening activities, with most starting a business using start-up kits provided by the project, and continuing the business, using their income to acquire assets including land.

Along with meeting the needs of OVC households via case management and economic strengthening, Kizazi Kipya worked to reduce the HIV risk of the hundreds of thousands of OVC age 9-17 enrolled in the project. Through community engagement and outreach with health care workers, the project's adolescent sexual and reproductive health (ASRH) promotion activities aimed to increase knowledge and promote healthy behaviors and positive gender norms. Prevention activities targeted vulnerable adolescent girls and young women (AGYW) age 10-17 through DREAMS programming, along with in- and out-of-school adolescent boys and girls age 9-14 through broader prevention activities such as youth groups delivering a national ASRH curriculum. Kizazi Kipya's DREAMS interventions reached two key and priority populations—in-school girls age 10-14, and out-of-school AGYW age 15-19. These aimed to reduce AGYW risk of HIV, through promotion of health, prevention of violence, support for schooling, and economic strengthening through efforts such as vocational scholarships. DREAMS activities scaled-up continuously for in-school girls age 10-14 throughout the project, initially implementing in seven councils and scaling up to 11 councils by project end, resulting in the delivery of the complete DREAMS primary service package to 107,405 girls.

In FY20, the project adapted to updated PEPFAR COP guidance, expanding prevention of HIV and sexual violence via a new OVC Preventive component which targeted boys and girls age 9-14. Evidence-based DREAMS interventions already reached adolescent girls in DREAMS councils, and the OVC Preventive component allowed scale-up of prevention activities to councils beyond DREAMS. Over 112,733 adolescents age 9-14 gained key knowledge on HIV prevention, and with funding from PEPFAR's Faith and Community Initiative (FCI), Kizazi Kipya reached 98,057 adolescent boys age 9-14 in schools with the "Coaching Boys into Men" curriculum that emphasizes respectful relationships, including with women and girls.

Each of Kizazi Kipya's achievements required cooperation and capacity development, with government representatives, civil society organizations (CSOs), and community volunteers. The project coordinated with the President's Office-Regional Administration and Local Government (PO-RALG); and the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), including the Department of Social Welfare (DSW) and the National AIDS Control Program (NACP), and); Tanzania Commission for AIDS (TACAIDS); local government; CTCs; and PEPFAR care and treatment implementing partners. Collaboration included designing and rolling out the National Integrated Case Management System (NICMS) with the MOHCDGEC and PO-RALG, then strengthening their capacity to sustain this work. The project worked with the NACP to develop a training package for LCWs/CCWs, and in the validation of the HIV risk screening tool, which the government has since adapted at the national level. With CSOs, Pact's capacity development experts conducted technical and operational strengthening, visiting CSO sites (in-person and virtually) and coaching CSO staff to deliver complex interventions at scale. Also, as volunteers served as the heart of case management, the project aided the recruitment, training, mentoring, and stipends of 28,940 LCWs/CCWs, who supported OVC households through household visits, as well as 2,005 Livelihood Volunteers (LVs) who provided household economic strengthening support to caregivers through WORTH Yetu groups.

Focusing on data-driven evidence along with community engagement made these achievements possible. Hundreds of thousands of Tanzanian caregivers; 67 CSOs and over 30,000 caseworkers and volunteers; many multi-sectoral government staff, teachers and school administrators, health facility staff and service providers; and the USAID Mission in Tanzania took ownership of project efforts at every level. The project bolstered OVC and their households along a pathway toward resilience, with community stakeholders supporting the needs of vulnerable families and youth even as the COVID-19 pandemic complicated access to and use of health and social welfare services. As a result of this joint work of Kizazi Kipya stakeholders, 473,842 OVC households have made significant gains in the health and welfare of children and youth at risk of and living with HIV.

Project Introduction

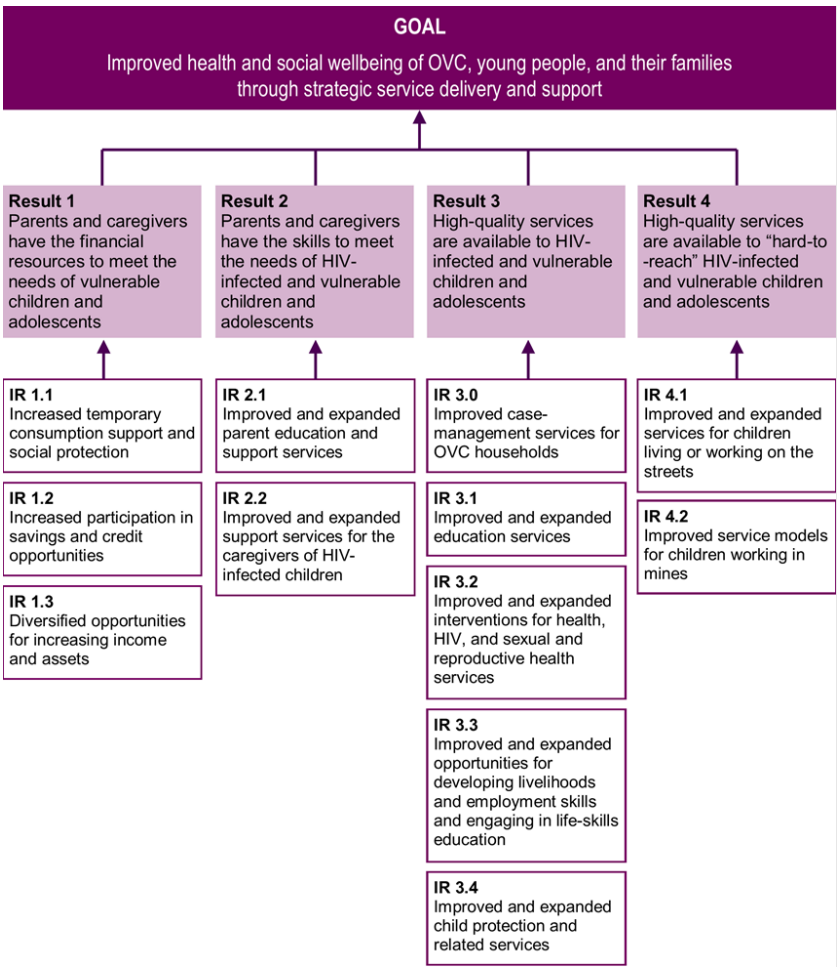
Pact has implemented a successful USAID Kizazi Kipya project since 2016, in partnership with ***Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)***, ***Aga Khan Foundation (AKF)***, ***Restless Development***, ***Railway Children Africa (RCA)***, and ***Ifakara Health Institute (IHI)***. The consortium partners and local (CSOs) have been able to expertly advance the continuum of care in Tanzania and have contributed to an accelerated response to the 95-95-95 HIV epidemic control objective. In line with the President's Emergency Plan for AIDS Relief (PEPFAR) 3.0 principles and priorities for impact, Kizazi Kipya scaled up core interventions to save lives and prevent new infections, ensuring that 1,705,636 orphans and vulnerable children (OVC), youth, and their caregivers (748,282 male, 957,354 female) survive and thrive through sustainable improvements in their health and social wellbeing.

This report narrates a successful implementation journey from the year 2016 through 2021, in which USAID Kizazi Kipya rapidly scaled up proven family-centered impact-mitigation efforts for OVC, reinforced with cross-sectoral, evidence-driven interventions to reduce HIV incidence while improving performance across the HIV continuum of care. Kizazi Kipya fully integrated the response with TACAIDS; the MOHCDGEC referral and data reporting framework; the Department of Social Welfare (DSW); and PO-RALG. The project also supported the Government of Tanzania (GOT) to measurably advance the global 95-95-95 goals and measurably contribute to the National Multi-sectoral Strategic Framework, the Health Sector HIV and AIDS Strategic Plan IV, USAID's 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.

Program Goal and Results Framework

The overall goal of USAID Kizazi Kipya was to ensure that children and youth thrive and survive through sustainable improvements in health and social wellbeing. To achieve this goal, the project implemented activities under the four results in the results framework presented in Figure 1.

Figure 1: Kizazi Kipya results framework



Timeline of Project Activities and Achievements

Figure 2: Kizazi Kipya implementation journey

FY17	FY18	FY19	FY20	FY21
• Project start up, introductory meetings with GoT, and MOUs signed with LGAs • Transitioned eligible OVC and caregivers from Pamoja Tuwalee project to Kizazi Kipya • Enrolled OVC and caregivers from key health and community platforms • Began supporting LCWs/ CCWs to deliver case management services	• Project further refined focus to 95-95-95 • Rolled out electronic bi-directional referral and linkages system • Began implementing DREAMS interventions in 7 councils • Over 1 million OVC and caregiver served	• Project funding increased from $65 to $162 million • First OVC households began graduating • Strengthened collaboration with HIV clinical partners	• Introduction of OVC Preventive component and Faith and Community Initiatives • Push to enroll 90% of CLHIV attending CTCs into the project • Linked project and clinical data to capture HIV outcomes among CLHIV	• Expansion of DREAMS councils from 8 to 11 • OVC households continued graduating and transitioning • Project hosted close out events • Developed compendium of project's lessons learned
• The project was implemented in 130 (67 scale up councils and 63 sustained councils)	• The project was implemented in 81 scale up councils (additional 14 CDC councils)	• The project was implemented in 81 scale up councils	• The project was implemented in 81 scale up councils	• The project was implemented in 85 councils
• 67 CSOs implemented the project	• 49 CSOs implemented the project	• 49 CSOs implemented the project	• 46 CSOs implemented the project	• 45 CSOs implemented the project

To launch the project in FY16, Pact conducted national, regional and council-level introductory meetings, and formalized the partnership with local government authorities (LGAs) through memoranda of understanding. At the same time, Pact engaged the MOHCDGEC in the roll-out, implementation, and monitoring of the NICMS across target councils nationwide. In strengthening service delivery quality, the project supported the recruitment and training of LCWs/CCWs and engaged DSW in developing standard operating procedures (SOPs), holding training on and disseminating those SOPs, and developing quality improvement (QI) tools.

Upon roll-out in FY17, Kizazi Kipya began delivering an integrated and mutually reinforcing package of high-impact, evidence-based gender-transformative interventions. The team ensured that project activities were age and stage appropriate, client-centered, and aligned with GOT, United States Government (USG), and international policies, standards, and guidelines. Pact also screened and enrolled OVC and their caregivers from targeted platforms, including from CTCs and from Pamoja Tuwalee, the previous OVC program.

During this year, the project adapted to shifts in PEPFAR requirements, including responding to a geographic shift by transitioning OVC and caregivers to LGAs and other service providers in 63 sustained councils. In the remaining scale up councils, Kizazi Kipya focused on providing holistic services to OVC and caregivers and ensured those that required HIV services were linked with appropriate support. To make this process systematic and data-driven, Kizazi Kipya developed efficiency tools such as the HIV-risk assessment tool to screen OVC for HIV risk factors as well as an electronic bi-directional referral system.

At the start of FY19, Pact developed and launched a project-specific database on the DHIS2 platform, in response to the large volume of individual- and program-level data that provided information on service delivery, HIV-specific needs, referral completion, and layering of interventions by gender and age. This database helped track individuals across intervention areas over time. Pact continued intensely monitoring project performance against the set targets and continued reporting on PEPFAR-required indicators (such as OVC_SERV and OVC_HIVSTAT) and on custom project-specific metrics. During this year, the project continued to strengthen collaboration with clinical partners, through joint planning and combined supportive supervision in target sites and in semi-annual data review meetings.

In FY20, the project again shifted in accordance with PEPFAR COP guidance. Technical adaptations included the introduction of the OVC Preventive component, plus expansion to an additional four councils in response to new funding from PEPFAR's FCI. In FY 20, COVID-19 also emerged as a global pandemic, requiring Kizazi Kipya to make adaptations as schools closed, and to introduce measures to ensure safety of staff, volunteers, and beneficiaries (see details under the Collaboration and Management sections).

In the final project year, while implementing at scale Kizazi Kipya also expanded DREAMS work into three more councils. The project also began close-out and transition activities. Households who met PEPFAR's

benchmarks graduated from program support. Eligible households will continue to be served through the ACHIEVE project, a Pact-led global USAID effort to reach and sustain HIV epidemic control among pregnant and breastfeeding women, adolescents, infants, and children. Pact hosted a Kizazi Kipya close-out event in October 2021 in Tanzania, and held meetings with national, regional, and local government to celebrate the many project successes. Pact released project documentation, such as *A Compendium of Interventions and Lessons Learned from the USAID Kizazi Kipya Project*.

Intervention Approaches

HIV epidemic control (95-95-95): Pact considered UNAIDS' 95-95-95 goal as central to Kizazi Kipya's design and ensured that strategic interventions addressed each "95." Integrating OVC approaches with antiretroviral therapy (ART); maternal, newborn, and child health (MNCH); and sexual and reproductive health (SRH) program platforms provided opportunities to improve prevention, care, and treatment outcomes and achieve an AIDS-free generation. Using the clinical, social service, community, and household entry points, Kizazi Kipya maximized opportunities to generate demand for HIV services, reduce barriers to access and uptake of HIV services, ensure comprehensive tracking to reduce treatment interruption, and facilitate effective bi-directional linkages to HIV facility- and community-based services.

DREAMS and preventive programs: To reduce the HIV risk among adolescent girls and young women (AGYW) ages 10–14 years, Kizazi Kipya implemented DREAMS and other interventions. The project provided DREAMS primary package, including ASRH education, education subsidies, and hygiene sanitary pads. As part of the DREAMS secondary package to out-of-school girls ages 15-19, Kizazi Kipya provided vocational training support and business start-up kits to improve livelihood opportunities among this vulnerable group. Additionally, the project implemented evidence-based violence prevention and other HIV prevention interventions for at-risk girls and boys during the critical window between ages 9–14 years. The project also delivered specific education sessions with faith and community leaders through Faith and Community Initiative (FCI) activities.

Child-focused and family-centered programming in a social ecosystem: Kizazi Kipya ascribed to the Ecological Systems Theory, noting that behavior, health, and social outcomes depend on multiple actors from family to community, CSOs, and government. A secure, protective family with a responsive caregiver is the foundation for children's optimal growth and development; thus, Kizazi Kipya worked to fortify families with direct interventions to strengthen caregiving and economic capacity.

Differentiated service delivery: Kizazi Kipya also targeted children and young people with high levels of HIV-related vulnerability with differentiated services, including CLHIV, CYLWS, CIM, and children of female sex workers (COFSW). To meet the specific needs of these groups, Kizazi Kipya conducted formative research, and engaged beneficiaries to design tailored interventions and approaches to deliver high impact services while addressing the barriers to access and use that affect the well-being of these vulnerable children. With CYLWS and CIM, Kizazi Kipya used professional case managers to deliver the package of services and added aspects such as Drop-In-Centers and Youth Associations. With COFSW, the project recruited peer CCWs to support case management, health, nutrition, parenting and psychosocial services.

Comprehensive case management (CM): Leveraging the close collaboration with PO-RALG, DSW, and other partners, Pact utilized trained LCWs/CCWs to conduct CM at the community level. LCWs/CCWs provided customized CM support for up to 20 OVC households each, using standardized tools to assess vulnerability and to plan, implement, and monitor provision of services and referrals to address these vulnerabilities. The project supported LCWs/CCWs via monthly meetings with supervisors, who conducted the strengths-based child and family assessments and developed and reviewed care plans with the families to respond to priority needs. Annual household-level assessments were conducted to address arising needs and determine progress towards case closure and graduation from program support.

Graduation and case closure: The project graduated households and closed cases based on two criteria—an enrolled child, caregiver and household meeting the basic level of wellbeing; and an enrolled caregiver reaching a level of self-sufficiency to consistently provide for the basic needs of children while accessing services and support as needed. Kizazi Kipya's CM approach emphasized graduation through care plan development and monitoring as well as annual vulnerability assessments to determine readiness for graduation. Households graduated when individuals in the household attained self-sufficiency in accordance with the eight PEPFAR graduation benchmarks in the four domains of Healthy, Safe, Stable, and Schooled (*"all or nothing rule"*). Beyond graduation, cases were closed for a variety of reasons, such as enrolled caregivers refusing CM services, enrolled caregivers and their children relocating to districts outside project areas, and death of an enrolled beneficiary.

Targeted and data-driven: To help achieve PEPFAR 3.0's goal of sustainable epidemic control, Kizazi Kipya targeted councils with the highest HIV prevalence and incidence, so that the project would provide strategic service delivery to the most vulnerable, including HIV-positive children and adolescents and their families. The project designed and developed sophisticated M&E systems to collect granular data and then throughout the life of the project regularly used the data to make strategic decisions to improve service delivery.

Activities Contributing to Tanzania's Epidemic Control, Including 95-95-95 Achievements

Priority 1: Scale Up Case-Finding: Kizazi Kipya contributed to the first 95 through strategic approaches integrated into CM (Intermediate Result [IR] 3.0). These involved conducting HIV risk screening, including identifying index cases for OVC during CM visits. LCW/CCW issued referrals to HTS to at-risk OVC with unknown HIV status and accompanied OVC to HTS when needed. The project used the HIV Risk Services and Adherence Quarterly Monitoring Tool (HRAQM) to track self-reported results from recent HIV tests. These approaches aimed to ensure that all children at risk of HIV were identified and linked for HTS. Out of 846,131 OVC under age 18 years reported under OVC_HIVSTAT since project inception in 2016, 60,871 (7%) reported to be HIV-positive, 701,200 (83%) reported negative HIV status, 19,062 (2%) were determined as not requiring HIV testing, and 64,998 (8%) had unknown HIV status. Overall, 92.3% reported their HIV status or were determined to not be at risk ("known status proxy"). By the end of the project, of the 64,998 active OVC whose HIV status was not known, 31,821(48.96%) were not assessed, 5,754 (8.85%) were assessed and determined to be at risk of HIV; and27,423 (42.19%) OVC were also assessed but did not disclose their HIV status to the project.[3] The not-assessed status was mainly due to the short time from the time of enrollment and graduation for some beneficiaries, or service access issues for some highly-mobile and hard-to-reach beneficiaries such as children working in mines (CIM) and children and youth living and working on the streets (CYLWS)

Priority 2: Prevention: Of the 846,131 OVC under age 18 years actively enrolled in Kizazi Kipya at the end of the project, 294,355 were age 9–14 years and 191,354 were age 15–17 years. The project aimed to reduce these children's HIV risk by keeping them in school and providing them with ASRH education, including prevention of HIV and sexual violence. Kizazi Kipya supported OVC, including the most at-risk populations, to help them remain in school and access health and social services. Kizazi Kipya also implemented DREAMS interventions (see Activity 3.2.2) for in-school girls ages 9–14 years and out-of-school girls age 15-19, as part of scaling up evidence- based HIV prevention interventions to vulnerable AGYW.

Priority 3: Treatment: Kizazi Kipya supported linkages to treatment and same-day ART initiation, by addressing barriers to ART initiation for CLHIV not on ART, using escorted referral and provision of ART counseling by trained nurses and clinicians. Throughout the life of the project (LOP), the project served 60,871 CLHIV. The project used its "sticker model" in high-volume Care and Treatment Centres (CTCs), which helped the health facility providers identify any project CLHIV who had an interruption in treatment and to present the cases to Kizazi Kipya's CSO Health and HIV Officers (HHOs) during their visits to CTCs. The HHOs worked with LCWs/CCWs and the project team to ensure those CLHIV with interrupted treatment were tracked and supported to return to treatment. The project worked with 521 CTCs in 81 councils. A total of 4,052 OVC (ages 0–17 years) and 4,910 caregivers were reported as having treatment interruptions. Through the LCWs/CCWs, Kizazi Kipya managed to trace 1,961 OVC (48%) and 3,385 (69%) caregivers and facilitated linkages back to CTCs to continue with treatment.

Progress against Targets

Pact's data-driven approaches and adaptive management led to annual improvements against targets. Scaling up the use of tools enabled the project to efficiently screen, enroll, and track OVC and their households. Strengthening the capacity of LCW/CCW and Livelihood Volunteers, CSOs, and government counterparts enhanced the quality of HIV and social welfare services, including economic and nutrition-related services. Developing the skills of OVC caregivers during CM visits and WORTH Yetu group meetings improved household ability to meet OVC health and nutrition needs. The table shows the results of these efforts for the project's required indicators, highlighting increases in targets achieved year over year – resulting in Kizazi Kipya meeting or exceeding 100% of all targets before the project closed.

3 OVC_HIVSTAT indicator is a cross-sectional indicator, and cannot be reported cumulatively. Therefore, the narrative uses FY21APR results.

Table A: USAID Kizazi Kipya LOP results against targets

FY	OVC_ HIVSTAT[4] actual	OVC_ HIVSTAT Proxy achieved	OVC_SERV actual	% OVC_ SERV target achieved	TZ_ ECON actual	% TZ_ ECON target achieved	TZ_ NUT actuals	% TZ_NUT target achieved
FY17	N/A	N/A	464,471	73%	147,285	81%	238,460	81%
FY18	491,091	64%	706,384	92%	263,428	92%	390,079	88%
FY19	463,183	95%	658,558	88%	236,921	97%	367,466	97%
FY20	521,909	97%	788,050	100%	239,986	90%	342,836	92%
FY21	449,610	100%	818,774	103%	245,149	102%	370,013	103%

[4] OVC_HIVSTAT: Percentage of orphans and vulnerable children (<18 yrs old) enrolled in the OVC comprehensive program with HIV status reported to IP.
OVC_HIVSTAT Proxy: Percentage of orphans and vulnerable children (<18 yrs old) enrolled in the OVC comprehensive program with known HIV status (Positive, Negative, or test not required) reported to IP.
OVC_SERV: Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV
TZ_ECON: Number of beneficiaries that benefited directly from a minimum of one economic strengthening intervention or opportunity
TZ_NUT: Number of OVC who received food and/or other nutrition service outside of a health facility

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

HIV/AIDS negatively affects households economically. HIV-related illnesses and deaths lead to reduced productivity and household earnings, diminished consumption, and reduced household capacity to pay for basic needs. Addressing the financial needs of families through economic strengthening (ES) can contribute to improved treatment outcomes of CLHIV, by diminishing economic barriers to access and use HIV services. Reducing household economic vulnerability, increasing economic empowerment, and building skills in managing household finances allows families to pay for required school materials as well as health expenses, and even health insurance where it is available. Expanding a household's agricultural or entrepreneurial enterprises can provide stability and enable children and adolescents to focus on school and not have to work. Kizazi Kipya implemented ES interventions to ensure that parents and caregivers have the financial resources to meet the needs of vulnerable children and adolescents, supporting households to progress along a pathway out of poverty and become more economically resilient.

IR 1.0: Categorize OVC households according to the Family and Child Assets Assessment

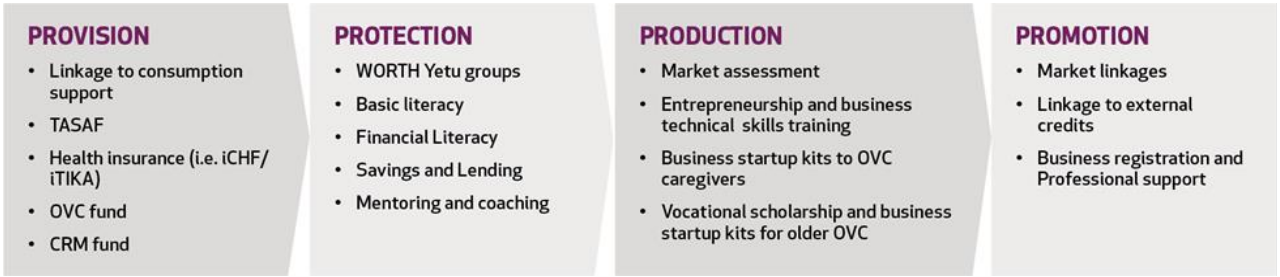
Kizazi Kipya viewed ES as a pathway towards growth and reduction of OVC households' vulnerability. Using the Family and Child Asset Assessment (FCAA) tool, Pact categorized OVC households into four economic wellbeing categories and tailored ES interventions accordingly:

- ***Provision:*** "households in destitution"—engagement focused on consumption support and enabling caregivers to meet basic needs and reduce the immediate impacts of food insecurity.
- ***Protection:*** "families struggling to make ends meet"—households that have enough to get by but need help to protect their meager resources and manage shocks. Engagement focused on basic asset building and protection and consumption smoothing by improving money management skills and creation/retention/rebuilding of key assets.
- ***Production:*** "households ready to grow"—households are more stable and prepared to focus on income and asset growth. Engagement focused on growth and consumption improvement through preparing households to assume greater context-appropriate expansion of income generating activities.
- ***Promotion:*** "households that are relatively economically secure and ready to further grow income and consumption levels" – This category of households is ready for greater levels of investment and often more specialized productions and as such are primarily beyond the scope of Kizazi Kipya's ES interventions.

These categories align with the criteria of the Tanzania Social Action Fund (TASAF'), National Guidelines for Economic Strengthening for Most Vulnerable Children (MVC) Households, and PEPFAR's OVC_MONEY indicator. The pathway sees OVC households progressing sequentially from Provision to Protection, Production and Promotion status. The entry point in the pathway depends on the initial status of the household. The project's ES service package was determined by the economic wellbeing status of the OVC household which was assessed annually (see Figure 3).

The project reached 409,814 OVC caregivers and 311,788 older OVC with TZ_ECON services over LOP. Households reached with TZ_ECON services included 50,344 CLHIV, representing 83% of all CLHIV enrolled in Kizazi Kipya. Improving individual and household economic security allowed caregivers to meet the health needs of CLHIV, by enabling access to funds for transport to CTCs for medical appointments and ART retrieval. Increased funds also aided families in purchasing food to meet the heightened nutrition needs of CLHIV on ART. These improvements in household status contributed to ART adherence and VLS.

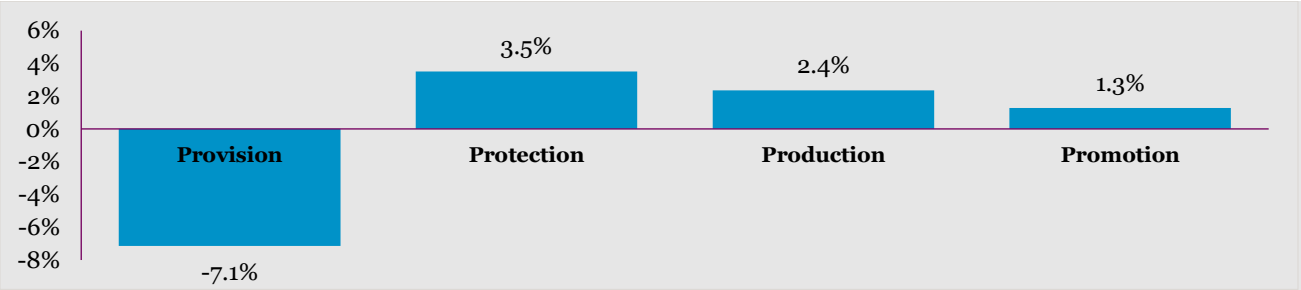
Figure 3: Kizazi Kipya ES service package by household economic status category



TZ_ECON services included facilitation of OVC households' participation in saving and lending groups, support to establish income-generating activities (IGAs), linkages to entrepreneurship/skills trainings, support for OVC households to prepare succession plans, and linkages to extension services and markets for their products. The project provided referral services to households in need of consumption support. Referral stakeholders include religious institutions and WORTH-Yetu groups—Pact's tailored model for village savings and lending groups (VSLGs).

Kizazi Kipya conducted an assessment comparing baseline and endline household economic status for a random sample of 161,593 households enrolled in the project between 2017 and 2020 (Figure 4). The assessment indicated a positive trend among 32% of households, which moved upwards by at least one category, while 45% of households remained in the same household economic status. A negative trend was noted, with 23% of households sliding back to a lower household economic status. Of 55,493 households that were at the provision category at baseline, 29,643 (53%) moved to protection, 6,079 (11%) moved two steps upwards to provision, 1,640 (3%) moved 3 steps upwards to promotion status, and the remaining 18,134 (33%) remained in provision status. These results highlight that progressing families along the livelihoods pathway is complex and not always linear, yet overall the project contributed towards improvements.

Figure 4: Change in household economic status between baseline and endline (n = 161,593)



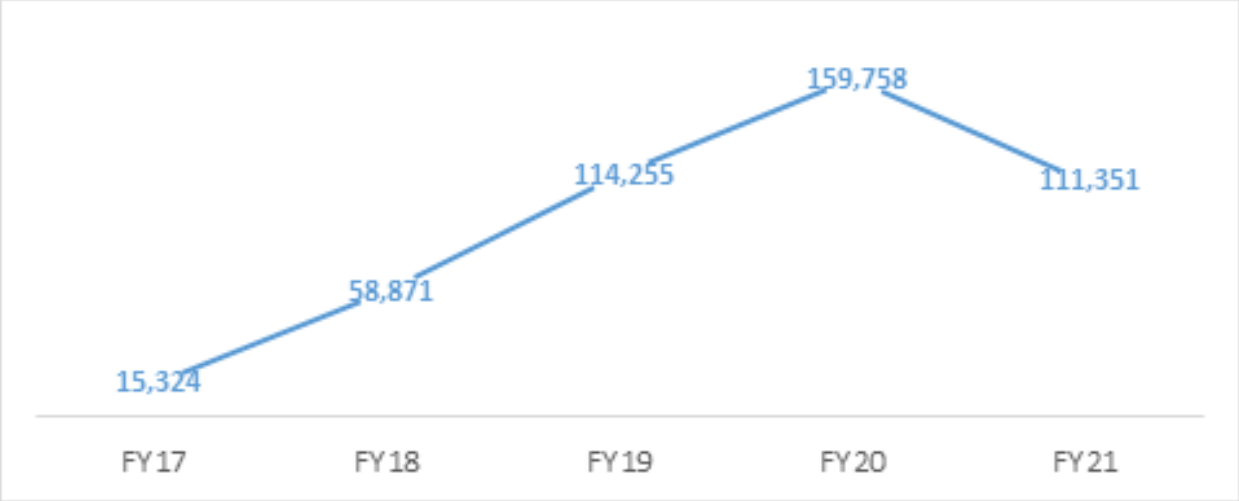
IR1.1: Increase temporary consumption support and social protection

Kizazi Kipya worked to increase temporary consumption support and social protection by linking destitute OVC households (those categorized under *provision*) to immediate support for basic needs while integrating them into early-stage household economic strengthening (HES) interventions to build greater economic security. Over the five years of project implementation, 274,077 destitute households were linked to early-stage HES interventions and other community-level support, including support from WORTH-Yetu groups, through which 459,559 OVC received consumption support. The project provided a total of 101,211 improved Community Health Fund (iCHF)/ improved Tiba Kwa Kadi (iTIKA) cards (health insurance cards) to households caring for 289,634 OVC (137,337 female, 152,297 male).

Kizazi Kipya facilitated linkages to WORTH-Yetu groups for 47,816 OVC caregivers (37,650 female, 10,166 male) from households that received monthly TASAF cash transfers. Through the WORTH-Yetu groups, the poor households accumulated TZS 1,204,002,642 ($523,479) in savings and accessed loans for IGAs along with financial literacy and business management skills. By the end of project, the 47,816 TASAF beneficiaries (52.5% of targeted 91,000) with membership to WORTH-Yetu groups accessed 16,952 loans amounting to TZS 720,900,120 ($313,435) for investment in IGAs.

With the aim of providing support to destitute OVC households, the project's WORTH-Yetu model included community resource mobilization (CRM) funds, social funds, and OVC funds. CRM funds include value of monetary and in-kind support mobilized from non-WORTH-Yetu community members for the purpose of supporting OVC identified by WORTH-Yetu groups. Social funds enable members to take interest free loans to meet emergency consumption needs, and OVC funds are a WORTH-Yetu group fund established by group members to meet the needs of OVC in their localities through voluntary contributions made by group members. By the end of project, 7,024 (74%) of 9,476 active groups had OVC funds, 7,802 (82.3%) had social funds, and 6,281 (66.3%) had active Community Resource Mobilization Committees (CRMCs) who collected donations for the CRM fund. Through CRMCs, TZS 1,216,094,547 ($528,737) was mobilized from local communities, with the support of local government leaders. An additional TZS 3,244,239,862 ($1,410,539) was mobilized through WORTH-Yetu groups' OVC funds over five years. Through the two funds, 459,559 OVC from poor households were supported with basic needs including support to facilitate access to transport to health facilities, payment of medical bills, school uniforms, scholastic materials, food, hygiene items, and clothing.

Figure 5: Number of OVC supported through CRMCs and OVC funds each year



IR1.2: Increased participation in savings and credit opportunities

Kizazi Kipya supported households in the protection category to build financial safety nets through savings by organizing OVC caregivers and older OVC into WORTH-Yetu groups. The project, with CSOs' Economic Strengthening and Livelihoods Officers (ESLOs) and community-based Livelihood Volunteers (LVs), provided training and supervision visits to WORTH-Yetu groups. To promote sustainability, the project introduced a fee-for-service model for groups and LVs, under which LVs become certified to work as Independent Livelihoods Volunteers (ILVs) who deliver services to WORTH-Yetu groups at a set cost. By the end of the project, 1,392 (100%) active LVs were certified to work as ILVs.

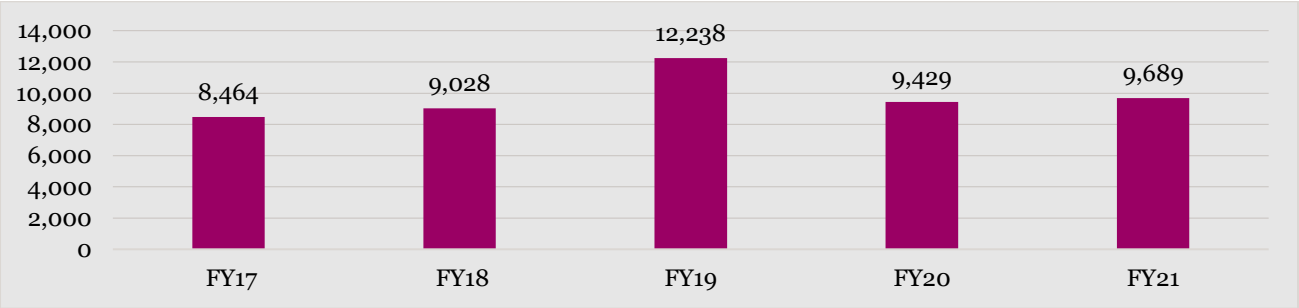
From the project onset, Kizazi Kipya focused on supporting WORTH-Yetu groups to eventually become self-sufficient. As part of this effort, the project administered an assessment to determine WORTH-Yetu groups' readiness for self-management to 9,476 WORTH-Yetu groups that reached at least their third banking cycle (a banking cycle is 25 weeks for new groups and 12 months for mature groups). The assessments identified 8,739 (90.2% of active groups) ready to manage themselves and 3,417 (39%) having established a group development fund for ILV payment and groups' training needs. A total of 642(46%) ILVs reported to have received payments amounting TZS 27,797,900 ($11,651) mobilized by groups for service rendered. Payments ranged between TZS 2,000 ($0.9) to TZS 87,500 ($38), with median pay of TZS 50,000 ($21.70) per month.

The project facilitated the formalization of WORTH-Yetu groups through LGA registration. By the end of the project, with the enforcement of the 2018 Microfinance Act by the Bank of Tanzania, a total of 6,387 (67.4% of active) groups were registered using the paper-based council-level system, while 4,106 groups had both paper-based and online registration status.[5] A total of 740 ILVs were supported by the project to officially register with the government to work as community promoters as per the Microfinance Act 2018.[6] Beyond registration, Kizazi Kipya further promoted sustainability by facilitating the development of standardized locally made, paper-based accounting ledgers to facilitate proper records management after project close.

Over LOP, 12,238 WORTH-Yetu groups (156% of targeted 7,823) were attended by 295,630 members (Figure 6). Membership to WORTH-Yetu groups include both project beneficiaries and non-project beneficiaries. Savings amounting to TZS26,587,542,300 ($11,559,801) were mobilized in five years' time. Through savings accumulated, 315,028 loans amounting to TZS 14,927,715,300 ($6,490,311) were issued to WORTH-Yetu group members, of which 121,374 loans amounting to TZS 4,559,450,409 ($1,982,370) were provided to WORTH-Yetu members from registered OVC households. Loan usage indicated 82% invested in IGA and 18% used for consumption needs of the WORTH-Yetu group members.

5 https://cmg.bot.go.tz/cmg-portal/login
6 This differs from ILV registration as it is a more formalized kind of registration in which all individuals who provide training support to VSLG are certified under Bank of Tanzania through council business officer. They are provided with certificate renewable after 2 years. ILV certification was done at project level basing on Pact's pre-defined benchmarks basing on LVs' performance.

Figure 6: Active WORTH-Yetu groups over LOP

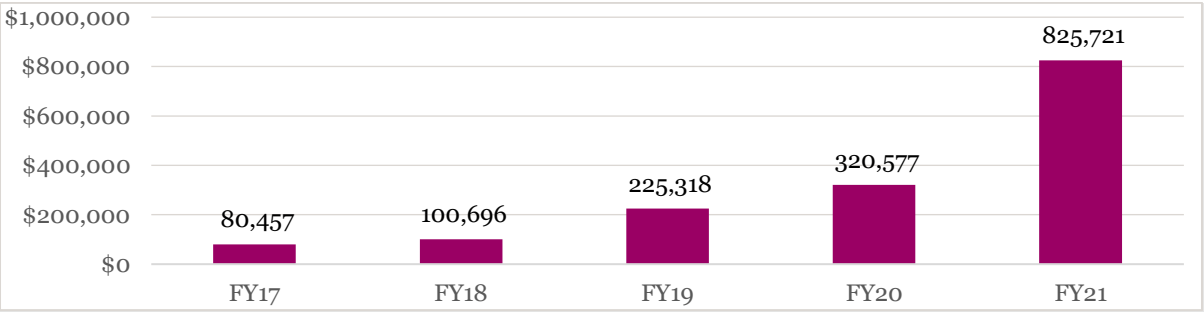


IR1.3: Diversified opportunities for increasing income and assets

Kizazi Kipya enhanced OVC caregivers' capacity to diversify opportunities for income and assets by increasing participants' ability to develop foundational and industry-specific enterprise skills, identify economic opportunities, and link to local resources. Working through WORTH-Yetu groups, Pact integrated income generation and diversification principles to ensure savings are used productively to empower members to become entrepreneurs. The project used money management and selling made simple curriculums to impart knowledge and skills on establishment and or scaling of businesses and to access various markets and opportunities in the community. The selling made simple curriculum equipped caregivers with selling strategies for application in their everyday businesses. Improved spending habits and entrepreneurial mindsets and IGAs, with peer mentorship and use of professional local expertise, were noted among group members who attended the skills and money management sessions. A total of 108,255 OVC caregivers were reached with financial literacy trainings, delivered through money management curriculum and the three[7] *Women in Business* series books.

Council-level market assessments were conducted in 76 councils to guide skills development and training, with a focus on growing industries targeting local industries or micro-and small-scale enterprises. The assessments conducted informed the selection of business start-up kits for caregivers of CLHIV. Kizazi Kipya provided a total of 19,409 business start-up kits to OVC caregivers over the LOP. Furthermore, Kizazi Kipya facilitated linkage of WORTH-Yetu groups to other service providers for enhanced financial inclusion. Over five years, WORTH-Yetu groups were supported to access external credit amounting TZS 3,571,365,254 ($1,552,768). External creditors include the GOT's (10% of council revenue allocated for women and youth empowerment), and commercial banks including National Microfinance Bank (NMB), Tanzania Postal Bank (TPB), and Equity banks. WORTH-Yetu groups were also linked to other ES service providers and stakeholders from both government and private sectors for specialized tailor-made training based on needs. Access to external credit increased significantly in the last year of the project. This was in large part due to increased activities to promote sustainability including joint supportive supervision visits that allowed the District Community Development Officers to evaluate group projects and provide guidance on loan applications with LGAs.

Figure 7: External credit accessed by WORTH groups



7 Our Group, Road to Wealth, and Selling Made Simple

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 upon family capacity and coping skills. A stable, skilled, and stimulating caregiver is essential for vulnerable children's recovery and resilience. The parenting interventions across Kizazi Kipya contributed to the 95-95-95 goals: the activities aimed to identify OVC in need of referral for HIV testing services and 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 were integrated across all Kizazi Kipya results, specific parenting skills related to HIV-specific needs of caregivers were the focus of Result 2.

IR 2.1: Improved and expanded parent education and support services

Kizazi Kipya aimed to improve caregivers' health and socio-emotional wellbeing. Skills were provided via home visits for individualized CM and mentoring and via WORTH-Yetu VSLGs to strengthen caregivers' health and economic resiliency to help their children.

Activity 2.1.1: Support improved caregiver health through formalized relationships between LCW/CCWs and other community cadres

Kizazi Kipya's LCWs/CCWs were responsible for conducting CM for OVC households, which involved identifying and assessing OVC caregivers' and households' strengths and challenges and supporting them to develop care plans to improve their children's health, social, and economic wellbeing. It was through CM that LCWs/CCWs provided support to HIV-positive caregivers and children. LCWs/CCWs were supported to attend parenting sessions, child protection, psycho-social counseling and support, and referral pathways needed to support at-risk CLHIV and other adolescents/youth. These cadres were also supported through ongoing mentorship and involvement in supportive supervision and council- and regional-level meetings with Council and Regional Health Management Teams (CHMTs/RHMTs) for them to learn or share specific successes and challenges and generate action plans. Over LOP, 234 CHMT/RHMT meetings were conducted focused on improvement of the enrollment of CLHIV and HIV-exposed infants (HEI), iCHF/iTIKA cards distribution, implementation of the CLHIV package, beneficiary graduation and transitioning, and performance monitoring across the 95-95-95 targets.

A total of 8,800 LCWs/CCWs were trained in community-based health services, and 5,570 LCWs/CCWs received nutrition-specific guidance during LCWs/CCWs monthly meetings in which Health Care Workers (HCWs) and nutritionists were invited to provide brief training sessions. From FY19, community-based health services messages incorporated the added focus on HIV referral pathways, to address gaps in CLHIV and HEI care and maximize the availability of HIV services at health facilities.

Activity 2.1.2: Strengthen caregiver skills in positive parenting and childcare and development

Kizazi Kipya strengthened caregivers' skills in positive parenting, childcare, and development by delivering ECD counseling as well as general positive parenting messages during CM visits and WORTH-Yetu group meetings. The project also worked with MNCH workers and other health professionals and nutritionists to provide nutrition assessment and address the health and nutrition needs of OVC and caregivers.

2.1.2.1: Strengthen caregivers' skills in positive parenting and childcare development for OVC ages 0–3 years

Care for Child Development (CCD) is a holistic and evidence-based package developed by WHO/UNICEF to address the developmental needs of children ages 0–3 years. Kizazi Kipya collaborated with the MOHCDGEC to adapt CCD as an approved national curriculum, and through CSO staff, the project trained, supported, and monitored LCWs/CCWs to deliver ECD services through routine CM household visits. By the end of the project, a cumulative total of 254,026 OVC and 137,182 caregivers were reached with CCD services targeted by the project. The project trained 1,875 LCWs/CCWs to use the evidenced-based CCD package to deliver these early childhood development (ECD) services. CSOs' Case Management Officers (CMOs), in collaboration with

District Social Welfare Officers (DSWOs) or Assistant Social Welfare Officers (ASWOs), conducted supportive supervision with LCWs/CCWs to strengthen their skills to deliver CCD education to caregivers during the implementation of the project. In addition to ECD services delivered through CM, Kizazi Kipya established a total of 334 ECD corners at high-volume health centers, and 150,782 OVC attended the ECD corners, which were managed by trained HCWs.

2.1.2.2: Work with MNCH workers and other health professionals and nutritionists to address the health and nutrition status of OVC and caregivers

Child health and nutrition for all OVC is essential for growth and development, particularly for children ages 0-5 years as well as those who are HIV-positive. Child health depends heavily on the availability of and access to immunizations, quality management of childhood illnesses, and proper nutrition.

Pact provided nutrition related services, reaching 933,824 OVC (98% of LOP TZ_NUT target). LCWs/CCWs provided nutrition education and counseling support to caregivers for them to support their children. Additionally, cumulatively8 over LOP, LCWs/CCWs conducted nutrition status assessments using mid-upper arm circumference (MUAC) tapes to 301,643 OVC under the age of five years. Of those assessed, 17,970 (6%) had severe malnutrition, 37,021 (12%) had moderate malnutrition, and 255,652 (82%) were well nourished. Of the 54,991 malnourished OVC, 44,834(82%) were HIV-negative, 3,010 (7%) were HIV-positive, and 7,147(12%) had unknown HIV status.

Cumulatively over LOP, 14,285 malnourished beneficiaries received referrals for nutritional support and 13,285 (93%) referrals were completed. Many malnourished OVC did not receive referrals because nutrition services were not available. Given the shortages of supplemental and therapeutic food, Pact linked 2,434 identified malnourished beneficiaries to WORTH-Yetu groups so that beneficiaries could be provided with funds to access nutritious food to improve their health; the groups were able to support 1,757 beneficiaries. CSOs' HHOs, with support from Pact's Technical Service Coordinators - Bi-Directional Referrals and Linkages (TSCs-BDRL), continued to advocate with the government, private sector, and other external stakeholders for the procurement of such food for malnourished children from CHMTs and RHMTs; however, at project close the lack of therapeutic and supplemental food for malnourished children is still a notable gap.

2.1.2.3: Deliver positive parenting messages for children ages 0–17 during case management visits

Positive parenting messages were a core strategy used by Kizazi Kipya to deliver and reinforce messages that prevent violence against children and adolescents. In FY18, Pact, in partnership with the USAID *Tulonge Afya* Project, created videos of parenting practices to share with LCWs/CCWs during their monthly meetings. The videos demonstrate how to implement high quality social and behavioral change communication on parenting skills to parents and caregivers of OVC. By September 30, 2021, the project oriented 19,598 LCWs/CCWs on positive parenting messages and reached 196,387 caregivers (134,475 females, 61,912 males), i.e., 103% of the target of 191,000.

2.1.2.4: Deliver positive parenting messages for children ages 0–17 during WORTH-Yetu/VSLG meetings

Through LVs, with support from CSOs' ESLOs, Kizazi Kipya delivered positive parenting messages to 124,833 (93,563 female, 31,270 male) caregivers through WORTH-Yetu groups. Out of these 62,323 (50%; 48,055 females, 14,268 male) were project OVC caregivers, while 62,510 (50%; 45,508 females, 17,002 males) were non-Kizazi Kipya OVC caregivers. LVs led discussions that aimed to prevent violence, abuse, and harmful social practices against children through effective and responsive parenting education.

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

A stable, nurturing family environment is critical to effectively addressing the needs of CLHIV. Capitalizing on EGPAF's technical expertise in addressing the needs of HIV positive children and adolescents, Kizazi Kipya worked with NACP to ensure that trained LCWs/CCWs have the skills and ability to support the sub-set of HIV-infected OVC and their caregivers. LCWs/CCWs conducted frequent household case management visits of families with CLHIV to ensure that their unique health, nutrition, protection, and socio-emotional care needs were met and to improve HIV clinical outcomes.

8 There could be overlap of beneficiaries between quarters.

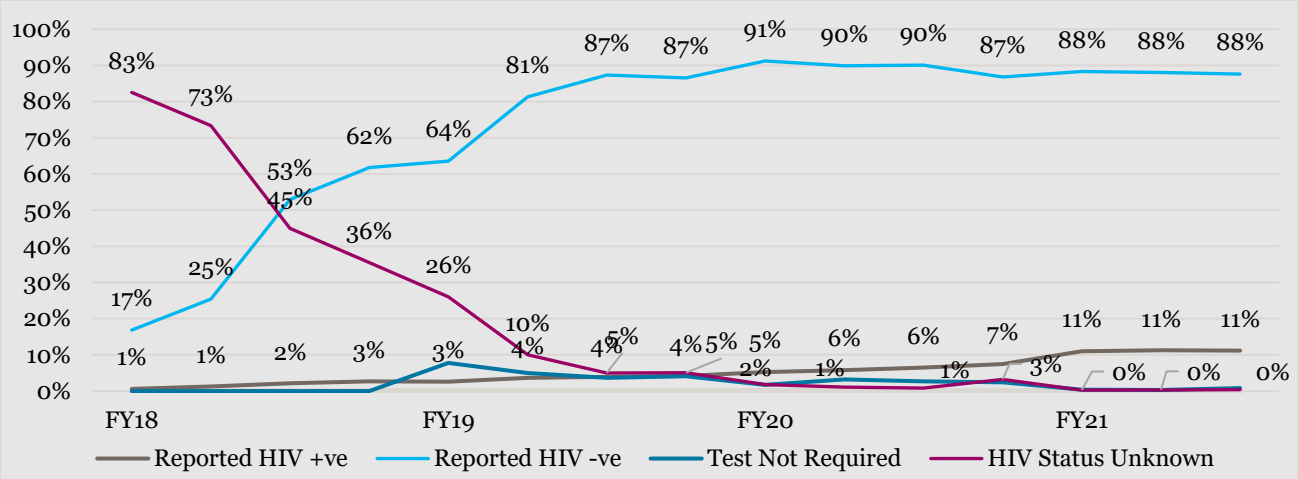
Activity 2.2.1: Strengthen community volunteer cadres' skills to support caregivers of HIV-positive children ages 0–17

In FY18, EGPAF and Pact worked with the NACP to develop a National Pediatric HIV Supplemental Orientation package for LCWs/CCWs to enhance their skills to better support caregivers of CLHIV. The five-day package was rolled out by mid-FY20, and later a simplified facilitation guide was developed on core topics from the package to refresh LCWs/CCWs during their monthly meetings to further build their capacity to respond to the specific needs of CLHIV. Trained LCWs/CCWs utilized the additional knowledge gained to improve their skills in case identification, early infant diagnosis, ART initiation, ART adherence, and support of long-term retention and viral suppression.

Activity 2.2.2: Facilitate and link OVC ages 0–19 to appropriate HIV services

At the onset of the project, Kizazi Kipya developed the HIV Risk, Services, and Adherence Assessment tool, responding to a need to accelerate the identification and enrollment of CLHIV, and to assess the level of HIV risk among OVC whose status was unknown. Working with the NACP, the project adapted the Bandason *et al* HIV screening tool[9] to incorporate national guidelines requirements. The tool also became important for linking OVC to HIV services, then for documenting and monitoring the services for which LCWs/CCWs issued referrals. Project partners validated the tool through the Supporting Operational AIDS Research (SOAR) Study, incorporating lessons learned within two published studies.[10] Figure 8 shows the trend of known status of OVC following the introduction of the HIV risk screening tool. While the HIV-positive status and test-not-required categories remained low throughout LOP, Kizazi Kipya continued to address the percentage of OVC with unknown HIV status. In FY18, the first year that PEPFAR required the OVC_HIVSTAT indicator, the percentage of CLHIV with known status was 17% and by project close this increased to 99.7%.

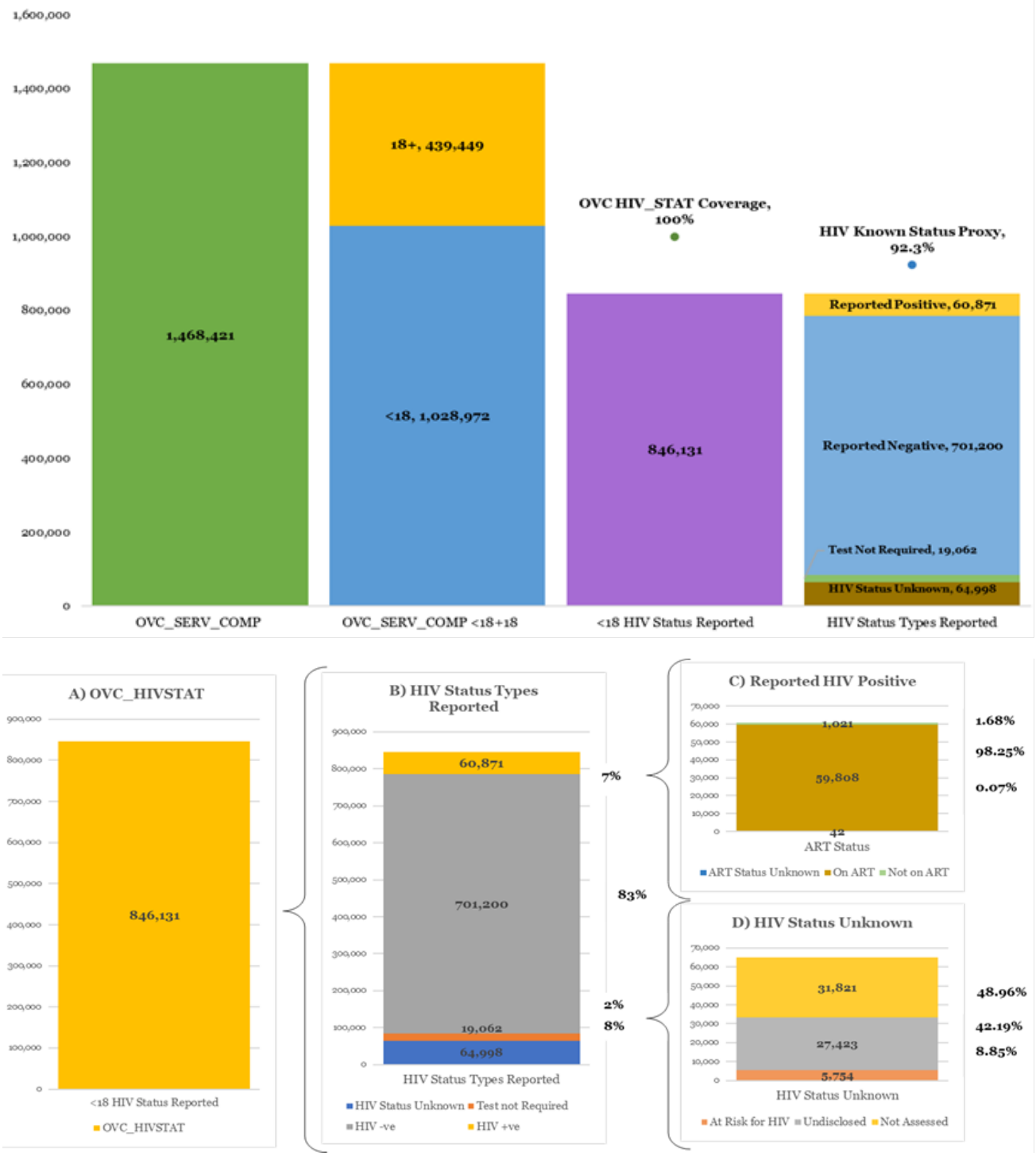
Figure 8: OVC_HIVSTAT indicator (known status proxy trends)



In FY20, a programmatic shift required that 90% of CLHIV attending high volume CTCs in priority councils be enrolled in the OVC program. To achieve this target, the project developed and rolled out the CTC enrollment registers at facility level and intensified support to facility staff to enroll CLHIV into the project. Through these efforts, the project increase the number of CLHIV enrolled in Kizazi Kipya from 19,532 at the end of FY19 to 60,871 by project close. CLHIV in the project received targeted and high-impact services (see 3.0.2) and over the life of the project, among CLHIV enrolled in Kizazi Kipya, 98% were on ART (Figure 9).

[9] Bandason T, Dauya E, Dakshina S, McHugh G, Chonzi P, Munyati S, et al. Screening tool to identify adolescents living with HIV in a community setting in Zimbabwe: A validation study. PloS one. 2018;13(10):e0204891.
10 Antelman, et al. 2021. Balancing HIV testing efficiency with HIV case-identification among children and adolescents (2-19 years) using an HIV risk screening approach in Tanzania. *PLoS One* 16(5): e0251247.

Figure 9: OVC_HIVSTAT results throughout LOP



In FY20, Kizazi Kipya collaborated with the NACP to develop a dashboard in the National CTC3 Macro Database to track and monitor HIV service provision to CLHIV at CTCs. Through this mechanism, the project tracked CLHIV not yet initiated on ART, those with treatment interruption, in need of viral load testing, and with high viral load counts. This important link between Kizazi Kipya data and verifed clinical outcomes in the national datbase enabled the project to provide more tailored support to CLHIV. As this data link requires CTC IDs, this also allowed the project to record CTC IDs of 61% of CLHIV active in the project. Pact then worked with clinical IPs to follow up on the viral load data, which showed that of 13,730 CLHIV with verifiable CTC IDs, 9,939 CLHIV had updated viral load results, and 8,818 (89%) achieved VLS.

Activity 2.2.3: Support children and adolescents who are HIV-positive to access group-based psycho-social support

Reaching epidemic control will require focus on cultural issues that hinder access to and use of HIV and social welfare services. Promoting treatment adherence includes addressing barriers that lead to interrupted treatment, including hesitation toward disclosure, and lack of social support that reinforces stigma within communities. Thus, client-centered care includes strengthening linkages to child- and youth-friendly services, including psycho-social services such as support groups. Supportive networks encourage use of services through the sharing of experiences—including examples of facing and overcoming stigma and discrimination.

As per the GOT's guidelines, health providers have a role to play in facilitating disclosure by empowering caregivers to facilitate the disclosure process to CLHIV. However, both providers and caregivers need support in their roles in this process. To aid both disclosure and support, Kizazi Kipya strengthened the capacity of LCWs/CCWs. The project linked LCW/CCW with caregivers who need disclosure counseling support, and with health providers trained on age-appropriate HIV disclosure counseling. The project also supported health providers' interactions with families during facility visits.

Kizazi Kipya also supported the disclosure process of CLHIV for them to be able to attend support groups. This was done through monitoring of undisclosed CLHIV and escorting the beneficiaries and their caregivers to facilities for disclosure support or conduct a home visit by a trained service provide from a nearby health facility to provide disclosure support. Of the 51,146 OVC who reported to be HIV-positive, 40,857 (80%) reported to be in support groups or attending age-appropriate pediatric/adolescent-friendly clinics.

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

Kizazi Kipya expanded implementation of PEFFAR 3.0 OVC programming, with a focus on HIV services, by working closely with the GoT and PEFPAR IPs to strengthen coordination of service delivery, implement robust HIV prevention activities, 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.

During LOP, the project served 1,705,636 OVC and caregivers (126% of the five-year target of 1,350,000). Of the served beneficiaries, 1,234,426 were OVC under age 18, equal to 123% of the under-age 18 target (1,000,000) and 590,807 were OVC caregivers (167% of the total target of 350,000). The 1,705,63611 beneficiaries served received the following service packages:

- OVC Comprehensive: 1,468,421 beneficiaries were reached with case management services and received parental education, psycho-social services, nutritional services, and ART adherence support, among other services (see Activity 3.0.1).
- DREAMS: 124,482 vulnerable AGYW were reached with evidenced-based HIV prevention interventions (see Activity 3.2.2).
- OVC Preventive: 112,733 adolescent boys and girls ages 9-14 were reached with HIV prevention and sexual violence prevention modules (see Activity 3.2.3), and 98,057 boys ages 9-14 completed the evidenced-based Coaching Boys into Men (CBIM) sessions intervention (see Annex 5).

IR 3.0: Improved case management services for OVC households

Child-centered CM facilitates access to HIV testing, care and treatment, and social welfare services for all members of OVC households—and contributes to viral suppression among CLHIV. Building on the efforts of previous USAID programming, GOT structures, and ongoing CSO efforts, Kizazi Kipya worked with PO-RALG to revitalize the provision of integrated CM. To standardize the delivery of CM services within the social welfare system, the GOT developed the NICMS, to document CM processes, coordinating structures at all levels, and standard training requirements for LCWs/CCWs; and to provide tools and forms for delivering and tracking services. In partnership with the GOT, Kizazi Kipya supported trained volunteer LCWs/CCWs to conduct household visits and provide tailored CM services to OVC and their families in 81 high HIV burdened councils, aiming to improve the well-being of OVC and their families while contributing to PEPFAR's objective of mitigating the impact on this population, as well as UNAIDS 95-95-95 goals. By the end of the project, Kizazi Kipya had supported 28,940 LCWs/CCWs to provide CM services to 473,842 OVC households.

After IR3.0 was added to the project results, Kizazi Kipya invested in developing two critical systems for volunteer management. The first is an unstructured supplementary service data USSD (text message) based system for LCWs and CCWs to input data from the National Most Vulnerable Children Management Information System (MVC_MIS) forms using their mobile phones. This enables the collection of real-time and individual level data. The second is a mobile payment system, allowing stipends to be paid directly to volunteers via mobile money, which significantly reduced the resources involved and risks associated with providing stipends in cash. With these innovations, volunteers successfully supported children and households along a pathway out of poverty, facilitated their development of resilience via improved use of local resources, and celebrated with them when they graduated from external support.

Activity 3.0.1: Case management

3.0.1.1: Identification, eligibility screening, and enrollment into Kizazi Kipya

To identify and prioritize OVC households for enrollment into Kizazi Kipya, the project used evidence-based criteria to screen eligible beneficiaries from the previous OVC project, Pamoja Tuwalee. During FY17-Fy19, the project also leveraged health and community platforms such as CTCs, PMTCT sites, and child protection committees, to improve targeting the most vulnerable children and adolescents. In FY20, with new PEPFAR

11 The age overlaps when we look at cumulative OVC_SERV. For cumulative OVC_SERV , the total adds up if it looks at current age and not age at the time of service.

COP guidance, Kizazi Kipya intensified efforts to enroll 90% of CLHIV attending CTCs, and prioritized enrollment of HEIs, CYLWS, AGYW in DREAMS programming, and FCI beneficiaries.

3.0.1.2: Direct services provision, including iCHF/iTIKA cards

In addition to the package of services provided to children and adolescents living with HIV (see section 3.0.2), the project, through LCWs/CCWs, provided other direct services. Due to the benefits of community-based health insurance – funds allow participants to use preventive health services as well as to pay for unexpected medical care – throughout LOP, the project provided access to GOT community health financing. Kizazi Kipya helped roll out the Improved Community Health Fund (iCHF/iTIKA), distributing iCHF/iTIKA cards to 101,211 destitute households with CLHIV, covering a total of 289,634 beneficiaries (137,337 male,152,297 female). Through the health insurance provided, the beneficiaries improved their health-seeking behaviors. The project compiled and shared a list of all beneficiaries who received iCHF/iTIKA cards with PO-RALG and the MOHCDGEC who will be supporting the lamination of the cards.

3.0.1.3: Referrals and linkages

Providing referrals and linkages was crucial to addressing the needs of children, adolescents, and caregivers to help improve their health, social, and economic wellbeing. LCWs/CCWs issued referrals once the care plan was developed and needs were clearly defined, taking into account what services LCWs/CCWs could provide directly and what referrals to other clinical and non-clinical providers were needed. Activity 3.0.4 provides more details on these referrals and linkages.

3.0.1.4: Monitoring care plans

LCWs/CCWs worked with OVC (as age appropriate) and caregivers to jointly develop a care plan for each OVC enrolled in the program. Once the care plans were developed, LCWs/CCWs monitored the implementation of care plans through monthly home visits. However, depending on the type of vulnerability, LCWs/CCWs visited families more frequently. For cases in which OVC were HIV-positive or a child was malnourished, LCWs/CCWs conducted household visits more frequently. Monitoring care plans helped LCWs/CCWs understand improvements in the child's situation and their progress in achieving actions and basic goals of the care plan. =

3.0.1.5: Graduation

By the end of the project implementation period, 99,478 households including 297,947 beneficiaries had graduated from the project and had their cases closed. This represented 20% of the total number of beneficiaries who received case management services. The goal of graduation was two-fold:

- Enrolled child, caregiver, and household meet a basic level of wellbeing
- Enrolled caregiver had reached a level of self-sufficiency to consistently provide for the basic needs of children in the household and access services and support as needed

In FY19, Pact reviewed its graduation benchmarks to align with PEPFAR MER 2.4 requirements covering the four wellbeing domains (healthy, safe, stable, and schooled) and developed three new tools to capture data for the required benchmarks: HIV Prevention Knowledge for Adolescents, HRAQM, and violence against children (VAC)/gender-based violence (GBV) Screening tool.

In FY19, the project noted that there were many households that were falling short of meeting the stable benchmark but met the other benchmarks. It was suspected that households were choosing to respond ambiguously to questions about financial status, due to ongoing uncertainty. In response, Kizazi Kipya, with USAID's approval, altered the way the stable benchmark was measured—Pact proposed that households meet the stable benchmark if they are in either the provision or protection category and are participating in a WORTH-Yetu group, and USAID agreed. This adjustment enabled more households who had access to savings and credit to graduate from project support, freeing up space for Kizazi Kipya to enroll and serve households that were more vulnerable.

In preparation for project close, in Q4 FY21, Kizazi Kipya transitioned 277,536 eligible beneficiaries to the follow on OVC project that will be implemented under ACHIEVE through Pact. Another 312,663 beneficiaries were transitioned to their LGAs. This was a systematic and ethical process, guided by PEPFAR COP21 guidance, which required beneficiaries transitioning to another project must be CLHIV, HEIs, COFSWs, and people living with HIV (PLHIV). Beneficiaries falling into this category were transitioned to ACHIEVE, while beneficiaries who did not meet the key graduation benchmarks and came from CIM, FSWs, and CYLWS sub-populations were transitioned to LGAs for continuous CM services and will be linked to other partners for support. 3.0.1.6: In-service training, supportive supervision, and mentorship.

Central to ensuring LCWs/CCWs delivered high-quality CM services, these cadres received in-service trainings during their monthly meetings (conducted at ward level) and continuous supportive supervision from CSO staff, LGA representatives, and Pact cluster staff. By the end of five years of implementation, a total of 28,940 LCWs/CCWs (18,532 female, 10,408 male) were reached with in-service trainings. Since the in-service training was offered during CCW monthly meetings, not all CCWs could attend the meeting due to different reasons that led to the 11,087 variance. A range of topics were selected monthly to strengthen the capacity of LCWs/CCWs including strategic enrollment refresher for CLHIV/HEIs, CLHIV package refresher, FCAA refresher exercise, HTS for children and adolescents, nutrition cascade and MUAC assessment to OVC, and WASH and tracing unserved beneficiaries. These LCWs/CCWs monthly meetings also provided an opportunity for LGAs to increase their involvement in NICMS implementation, and often DSWOs would co-chair these meetings, substantially improving their ownership of the activities.

Activity 3.0.2: Deliver a package of services to CLHIV

The GoT in 2015 adopted the "test and treat" strategy for all HIV-positive children and adolescents under the age of 15 that mandated that all HIV-positive children and adolescents start ART immediately after being diagnosed with HIV. Specific barriers put CLHIV at risk of not being tested, missing clinic appointments, and defaulting treatment, thereby threatening their chances of achieving sustained viral suppression, hence higher HIV-related mortality. There was rampant shortage of trained or dedicated pediatric HIV HCWs at lower-level health centers and dispensaries, geographic distances with cost and time implications, and issues related to stigma and discrimination. Caregivers were often being referred to larger health facilities (usually with complex administrative and service delivery schedules) for HTS, ART initiation, and continued care. In this reality, Kizazi Kipya worked with facilities and community workers and engaged LGAs to roll out, mentor, and track the supportive supervision outcomes, including the use of the K2 ID stickers in high-volume sites to enable quick follow-up of ART adherence, continuity on ART, viral suppression, and referral completion. In total, over LOP, Kizazi Kipya worked in 521 high-priority CTCs. In these CTCs 4,052 OVC (ages 0–17) and 4,910 caregivers had discontinued ART, but through the support of Kizazi Kipya, 1,961 OVC (48%) and 3,385 caregivers (69%) restarted treatment.

In FY20, Kizazi Kipya expanded the services offered to CLHIV and rolled out a full ***CLHIV service package***; this differentiated package was important for CLHIV to mitigate the myriad medical, psychological, and social challenges ranging from side effects of ART, higher vulnerability to opportunistic infections, stigma, and discrimination to difficulty in accessing and utilizing age-appropriate and child-friendly health services. Kizazi Kipya aimed to provide comprehensive services to these CLHIV to address barriers to HIV diagnosis and ART initiation and adherence to not only achieve sustained viral load suppression, but to also improve the resiliency and overall wellbeing of these vulnerable children. CLHIV were provided with different services in the CLHIV package based on their age and an assessment of their needs conducted by LCWs/CCWs. An independent review of the project's CLHIV service package carried out in FY21 showed that the CLHIV service package elements were accepted by the beneficiaries and proved to be significant in improving ART, sustainable suppression of viral load, and overall resilience in enhancing the wellbeing and life of CLHIV. Statistical analysis indicated that the three services (clinical home visits, ART uptake calendar, and attendance to CCW/enhanced adherence counseling [EAC] sessions) were associated with improved HIV viral load suppression.

Table B: Service package for CLHIV, by age group

Package items	Age (years)				Focus
	0–5	6–9	10–14	15–17	
Escorted referrals	●	●	●	●	Facility support
Clinical home visits	●	●	●	●	Advanced home support
Social welfare home visit	●	●	●	●	CLHIV denied services
ART uptake calendar	●	●	●	●	All CLHIV: ART tracking
CCWs' EAC session attendance	●	●	●	●	CLHIV with high viral load
Peer home visit		●	●	●	Home-based psycho-social support
iCHF/iTIKA	●	●	●	●	All CLHIV
Vocational scholarship				●	Out-of-school adolescents
Educational subsidies		●	●		In-school adolescents
Start-up kits for caregivers	●				Caregivers of children under five
Linkage to food support	●	●	●	●	Food security

3.0.2.1: Clinical home visits

This is a visit conducted by clinician or ART nurse to the CLHIV household after informed consent is obtained from the caregiver. The visit is conducted for a beneficiary who has refused to start ART, has poor adherence to ART, has a high viral load, or is not attending CTC appointments regularly. Cumulatively in FY20–FY21, Kizazi Kipya provided clinical home visits to 1,933 CLHIV (924 female, 1,009 male). Specifically, 1,148 (555 female, 593 male) visits were for adherence support, 687 (317 female, 370 male) were for linkages to ART, and 98 (52 female, 46 male) were for HIV disclosure support.

3.0.2.2: Peer home visits

Cumulatively, a total of 440 CLHIV peer home visits (207 female, 233 male) were conducted; 299 visits (137 female, 162 male) were for adherence support and 141 (70 female, 71 male) were for linkages to ART. The visits were done by competent peer educators who are also CLHIV who visited CLHIV to discuss issues related to stigma, peer pressure, and coping with ART adherence. The peer educators were identified in collaboration with clinical partners to provide this advanced support when needed.

3.0.2.3: Social welfare home visits

Social Welfare Officers (SWOs)/ASWOs trained on pediatric counseling visited households of CLHIV that were identified for additional support. In FY20–FY21, CLHIV 548 (271 female, 277 male) received home visits from SWOs/ASWOs: 53% were for child protection services, 30% were for adherence support, 15% were for linkages to ART, and 2% were for HIV disclosure support.

3.0.2.4: ART uptake calendars

CLHIV enrolled in Kizazi Kipya were provided with ART calendars to assist in ART adherence. The calendar assists caregivers in monitoring daily adherence by their children on ART. LCWs/CCWs also used the calendars to monitor adherence, to understand the challenges in ART adherence, and to inform decisions about the need to provide escorted referrals or invite a clinician or SWO for a home visit to provide adherence support. Cumulatively, a total of 23,924 CLHIV were provided with an ART calendar.

3.0.2.5: Provisional support

Kizazi Kipya collaborated with clinical IPs to verify the names of CLHIV and their households who needed further support services from the project, including iCHF/iTIKA cards, vocational scholarships, educational subsidies, and start-up kits for caregivers. As described above, Kizazi Kipya provided these households with iCHF/iTIKA health insurance cards. The project also identified 1,150 out-of-school CHLIV to support with vocational scholarships. The project also distributed educational subsidies to 14,756 in school CLHIV, their siblings, and OVC from destitute households.

3.0.2.6: Enhanced adherence counseling

Clinical service providers provided the project with lists of enrollees with poor adherence and high viral loads, so that these beneficiaries could receive targeted support. Once identified, Kizazi Kipya LCWs/CCWs escorted these CLHIV and their caregivers to a facility to receive enhanced adherence counseling (EAC). In subsequent home visits, LCWs/CCWs followed up on action items from the EAC session to address barriers to adherence and to further support CLHIV to achieve viral suppression. In FY20 and FY21, Kizazi Kipya supported CCWs to attend 1,258 EAC sessions.

Activity 3.0.3: Deliver a package of services for children of caregivers who are female sex workers

Beginning in FY18, Pact developed a tailored service package for OVC and caregivers who are FSWs, prioritizing children of HIV-positive FSWs so they could be tested for HIV and those who were HIV-positive were started on ART. The tailored service package was evidenced-based interventions that aligned with international best practices and Tanzania's national integrated CM framework. To best implement this intervention, Pact conducted key informant interviews and focus group discussions with FSW mothers of children ages 0–19, HIV-positive FSW mothers of children ages 0–19, girls and boys whose mothers are FSWs, DSWOs, and Kizazi Kipya staff.

The discussions with FSWs and their children used an asset-based approach to draw out participants' strengths and the efforts they were already making to improve their lives to identify how Kizazi Kipya could build on these efforts. Human-centered design techniques, such as community and day-in-the-life mapping and simple prototyping were integrated into the discussions to elicit a deeper understanding of participants' experience and to encourage co-design of the service package that include psycho-social support Nutrition

Assessment, Counseling, and Support (NACS) positive parenting messages; economic support through WORTH-Yetu groups; and linkages and referrals.

COFSW are often not reached with health and social welfare services, and HIV testing data from the Sauti project in Tanzania indicated that these children may have higher levels of undiagnosed HIV (based on higher HIV testing yield rates) compared to other children of their age. The project trained 144 FSW-peer-CCWs on NACS, pediatric and adolescents' HIV packages, and CCD to effectively deliver services to this sub-population. The project enrolled caregivers who are FSWs and their children, reaching a total of 4,910 beneficiaries (1,431 caregivers, 3,479 OVC).

CMOs supported FSW-peer-CCWs to administer the FCAA for OVC households and to assess HIV status of OVC under 18 years. Out of 1,431 caregivers, 345 (24%) were tested for HIV and 31 (9%) of these were reported to be HIV-positive. Of the FSW caregivers who were reported to be HIV-positive, 30 (99%) were ART adherent. For the 3,479 COFSW, 3,119 were reported to know their status (HIV known proxy), of which 50 (3%) were HIV-positive and 49 (98%) were ART adherent.

The project, through FSW-peer-LCWs/CCWs, provided services to 1,431 FSW caregivers and 3,479 COFSW. iCHF/iTIKA cards were provided 2,674 FSW beneficiaries (male 1,182, female 1,492). This sub-population was also reached by FSW-peer-LVs, who supported 78 WORTH-Yetu groups that included 851 FSW caregivers. Furthermore, WORTH-Yetu groups supported 505 OVC (321 female, 184 male) with scholastic materials and medical expenses through their OVC funds.

Activity 3.0.4: Implement the bi-directional referral and linkage system

In FY17, Kizazi Kipya began developing an electronic platform which enhances the existing paper-based referral system to enable real time tracking of referrals between the project and other health and social services. The electronic system consists of an USSD system and a dashboard; the electronic system was integrated into the project's monitoring, evaluation, reporting, and learning (MERL) system. The project trained LCWs/CCWs and HCWs to use the system for reporting and follow-up of completion of referrals. The success of the system enabled the project to identify and follow up with beneficiaries who had incomplete referrals in a timely manner. One notable challenge with the system was that health facility staff had poor uptake of the electronic system, although they were able to complete the needed paper-based forms. To address this inefficiency, CSOs collected referral slips and entered data into the electronic system The other challenge was that referrals lacked dedicated facility contacts who had the capacity to take on this task. Thus, Kizazi Kipya worked with focal CCWs and HHOs to re-engage with facility focal persons to address this shortfall. In FY21, HHOs conducted supportive supervision to 521 CTCs to ensure the effectiveness of the referral system.

Throughout LOP, LCWs/CCWs issued 802,071 referrals to OVC and caregivers to appropriate health and social services, of which 723,880 (90%) were reported as completed. CSOs continued to work to strengthen the referral system by involving care and treatment partner staff when visiting health facilities.

IR 3.1: Improved and expanded education services

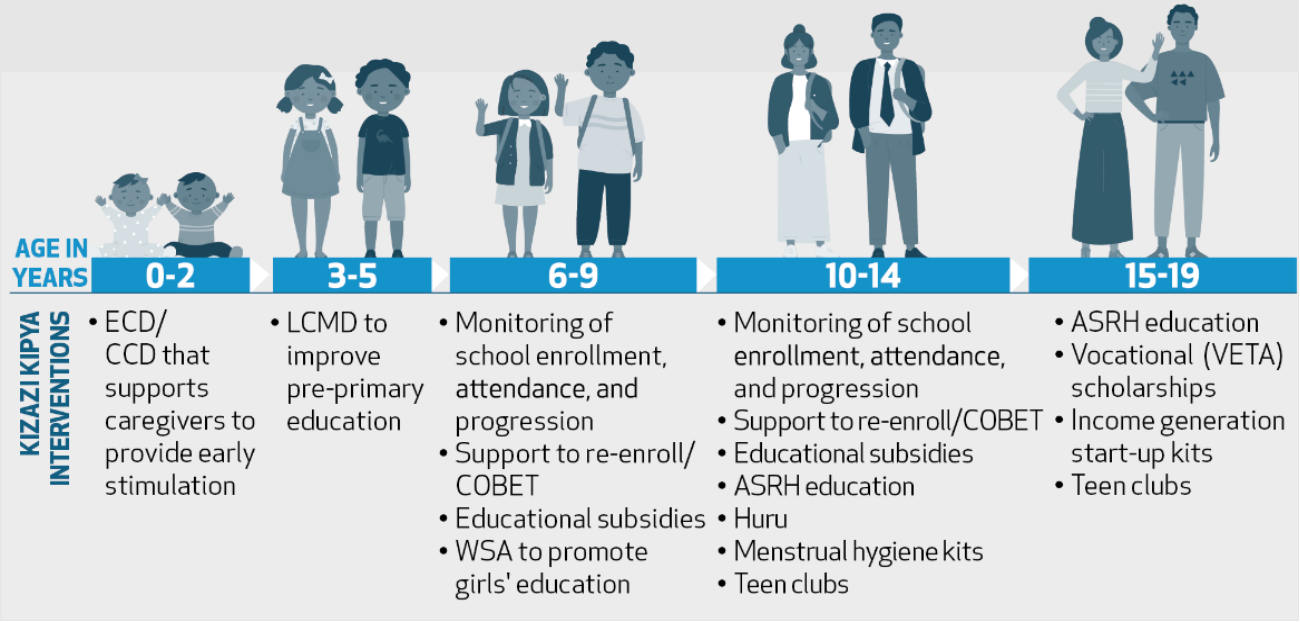
A 2015 UNAIDS report states that "some of the most powerful structural interventions for HIV risk reduction among adolescent girls across Africa are those that aim to keep girls in school."[12] Given this, Kizazi Kipya implemented the Whole School Approach (WSA) to support communities in overcoming socio-cultural norms affecting female education. The project also worked with schools and teachers to address challenges of education access and quality, at the pre-primary, primary, and secondary levels. At the pre-primary level, Tanzanian schools have few resources, resulting in missed opportunities for young children to benefit from ECD by interacting with age-mates as well as tailored teaching and learning materials. To address this gap, Kizazi Kipya implemented interventions with pre-primary schoolteachers to develop low-cost materials to use in their classrooms to improve age-appropriate learning.

Through technical partner AKF, in FY17–FY19, Kizazi Kipya worked with government officials in the education system to enhance learning for pre-primary school children by using low-cost materials development (LCMD) and facilitated communities to challenge existing socio-cultural norms around female education through the WSA in primary schools. These educational activities continued until the shift in FY20 in PEPFAR guidance prioritized interventions directly link with measurable 95-95-95 outcomes.

[12] Empower Young Women and Adolescent Girls: UNAIDS & The African Union | Reference | 2015 Fast-Tracking the end of the AIDS epidemic in Africa. https://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf

At household level, throughout the LOP, Kizazi Kipya supported OVC to stay in school by monitoring school status, attendance, and progression during regular CM visits, as well as by working with local government and schools to re-enroll OVC who were eligible to return to school. Further, Kizazi Kipya supported CLHIV who were in school with educational subsidies and CLHIV who were out of school with vocational scholarships and start-up kits (see Activities 3.0.2 and 3.3.1).

Figure 10: Kizazi Kipya educational interventions, by age group



Activity 3.1.1: Support District Implementation Teams to implement WSA in target schools

The WSA was a mechanism designed to engage communities and schools in a cross-planning, focused on enrollment, retention, and transition of children, particularly girls and OVC, from primary to secondary schools. It was delivered with and through government structures and public servants from both the education and community development sectors at council and ward levels. Between FY17 and FY18, the project, through AKF, supported 801 schools with the WSA intervention, which, in-turn, resulted in developing school development plans (SDPs), monitored by CSOs. For example, in Mwanza (Nyamagana and Sengerema DC), as part of implementing SDPs, members of the school committees provided girls with free locally made sanitary pads popularly known as "*sodo*." The WSA activity was discontinued in FY19 to focus on activities with measurable 95-95-95 outcomes.

Activity 3.1.2: Support pre-primary teachers to develop and use low-cost learning and materials

Under this activity in FY17 and FY18, Kizazi Kipya, through AKF, supported 437 pre-primary schools in 11 councils to implement LCMD by training and mentoring District Implementation Teams, head teachers, and pre-primary teachers. In FY19, CSOs' Education Officers continued to support LGAs to sustainably implement the LCMD intervention and share best practices within their councils. The aim of the LCMD activity was to enhance learning for pre-primary school children through better quality education, which not only gives children a strong start to learning and leads to better performance outcomes in higher grades, but also encourages parents to take their younger children for earlier enrollment into school. While these activities were widely supported by schools and LGAs, this activity was discontinued in FY19 to focus on activities with more direct links to 95-95-95.

Activity 3.1.3: CCWs monitor school status, attendee, and progression

Throughout LOP, Kizazi Kipya worked closely with Ward Executive Officers (WEOs) and Heads of Complementary Basic Education for Tanzania (COBET) centers within the project councils to improve education service provision to beneficiaries by ensuring out-of-school girls and boys are enrolled into primary school or designated COBET centers nationwide. The youth who met the primary school criteria were registered in primary schools, and those meeting COBET criteria were enrolled in COBET centers. LCWs/CCWs facilitated this process during their regular CM visits; monitored school status, attendance, and

progression of the children to ensure they stayed in school; and worked with LGAs and schools to re-enroll out-of-school OVC who were eligible to return to school.

Through CCW household visits, Kizazi Kipya was able to closely follow up and ensure that of 950,265 OVC ages 5–17 years enrolled in the project, 642,293 (68%; 331,803 female, 310,490 male) were enrolled in school. Of these, 540,309 (84%; 280,666 female, 259,643 male) regularly attended school. In FY21, the FCAA administered to 216,986 OVC determined that 203,150 (93.6%; 110,460 female, 92,690 male) showed school progression over time. These achievements in school enrollment and retention are vital for ending the HIV epidemic—the 2021 UNAIDS *Global AIDS Update* again emphasizes the importance of retention in school for reducing HIV risk. Schooling provides advantages especially for secondary school-age girls, and particularly during the COVID-19 pandemic, in terms of social and economic development as well as gender equity.[13]

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

The services provided through ECD corners and youth fora were designed to complement those provided by CCWs through household-level CM. Kizazi Kipya designed core youth packages that were age and gender appropriate and focused on key outcomes directly related to HIV prevention, including keeping adolescents in school (this is a protective factor for girls against HIV), reducing violence and abuse, improving knowledge and skills to access SRH services, and empowering older adolescents who are out of school with the skills and ability to improve their livelihoods. The ECD centers provided the opportunity for caregivers and health providers to systematically assess developmental progress of children under age 3 years and potentially identify any HIV-related delays.

Activity 3.2.1: Targeted health facilities provide ECD services through established ECD corners

A total of 155 ECD corners were established over LOP. CCD-trained HCWs conducted group counseling and one-on-one counseling in 147 ECD corners. The remaining 8 were in sustained councils in which Kizazi Kipya support was discontinued in FY18. Although there were numerous qualitative examples of how ECD corners contributed to the 1st 95, overall impact on 95-95-95 outcomes was not strong enough to warrant additional scale-up with PEPFAR funding. Thus, this activity continued to be monitored, but after FY18 no new ECD corners were established.

Activity 3.2.2: Implement DREAMS interventions with the aim of reducing HIV incidence and increasing school attendance among adolescent girls

The DREAMS partnership is an ambitious effort to decrease HIV incidence in AGYW using multi-faceted and layered approaches in DREAMS districts. PEPFAR Tanzania, in partnership with TACAIDS, NACP, Reproductive and Child Health Services, UNICEF, and PO-RALG, have worked closely to identify target areas and tailored evidence-based responses to reduce the vulnerability of AGYW in priority regions.

Pact implemented DREAMS interventions from FY18 to FY21 in 12 councils, reaching in-school AGYW ages 10–14 through an in-school intervention and (during FY18 and FY19 only) and out-of-school AGYW ages 15–19 through the support of vocational scholarship and start-up kits. Table C shows the DREAMS geographical coverage across the four years of implementation.

Table C: DREAMS coverage by cluster and year

Cluster	# of Councils	FY18 Coverage	FY19 Coverage	FY20 Coverage	FY21 Coverage
Coastal	1	Temeke	-	-	-
Southern Highlands	3	Mbeya CC Kyela DC	Mbeya CC Kyela DC	Mbeya CC Kyela DC	Mbeya CC Kyela DC Mbarali DC
Central	1	-	-	-	Mufindi DC
Western	5	Kahama TC Shinyanga MC Ushetu DC Msalala DC	Kahama TC Shinyanga MC Ushetu DC Msalala DC Shinyanga DC	Kahama TC Shinyanga MC Ushetu DC Msalala DC Shinyanga DC	Kahama TC Shinyanga MC Ushetu DC Msalala DC Shinyanga DC

[13] UNAIDS, *Global AIDS Update 2021,* https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf, accessed 23 December 2021.

Cluster	# of Councils	FY18 Coverage	FY19 Coverage	FY20 Coverage	FY21 Coverage
Lake	2	-	Muleba DC	Muleba DC	Muleba DC Nyamagana DC
Total	**12**	7	**8**	**8**	**11**

The DREAMS service package for 10–19-year-olds evolved in accordance with changing USAID guidance. Table D shows the DREAMS service packages provided to AGYW ages 10–14 and 15–19 over time.

Table D: DREAMS service packages for AGYW ages 10–14 and 15–19

Year	AGYW 10–14 Service Package	AGYW 15–17 Service Package
FY17 & FY 18	Primary Service Package: • HURU SRH Package and HURU Kits • Education Subsidies Kits	• Vocational Scholarship • Business Start-up Kits
FY19	Primary Service Package: • HURU SRH Package and HURU Kits • Education Subsidies Kits • Furaha Parenting Program	• Vocational Scholarship • Business Start-up Kits
FY20	Primary Service Package: • HURU SRH integrated with Primary Prevention of Sexual Violence and HIV Curriculum and Re-usable Sanitary Kits • Education Subsidies Kits Secondary Service Package: • Furaha Parenting Program	-
FY21	Primary Service Package: • HURU SRH integrated with Primary Prevention of Sexual Violence and HIV Curriculum and re-usable Sanitary Kits • Education Subsidies Kits Secondary Service Package: • Furaha Parenting Program • Financial Literacy Program	-

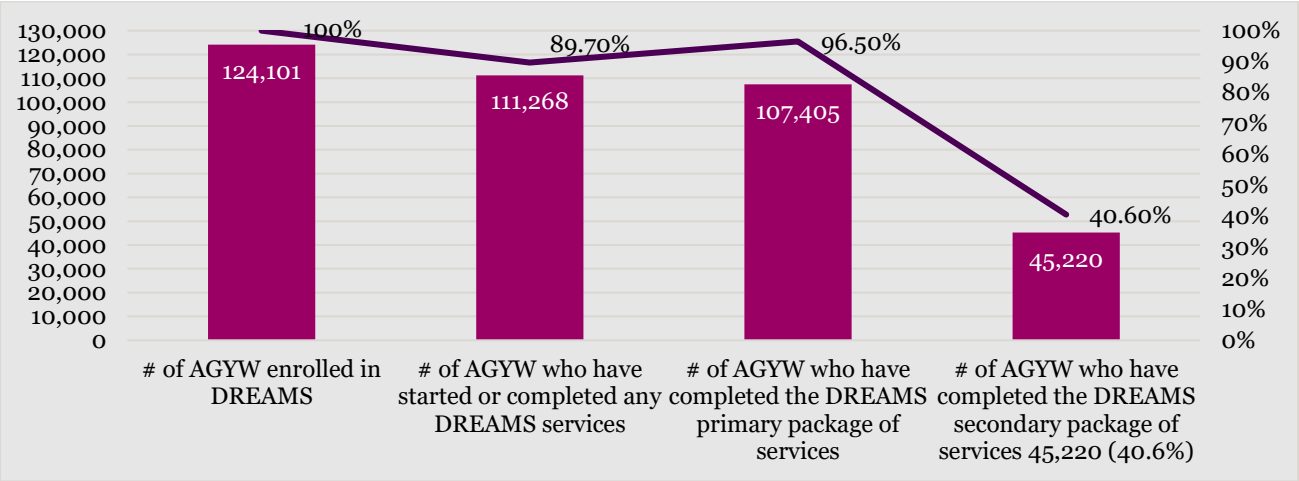
3.2.2.1: DREAMS intervention for in-school OVC girls ages 10–14

At the beginning of DREAMS implementation, Pact used community platforms through CCWs to enroll in-school DREAMS girls, but the services were provided at the school platforms. Because most beneficiaries use different names at school and at home, this approach proved challenging for ensuring service is provided to the appropriate beneficiary. In FY20, Pact changed its approach to enrolling DREAMS girls at schools using schoolteachers, which proved to be more efficient. In the process to select AGYW for DREAMS interventions, Pact, through CSOs, conducted meetings with LGA representatives (DEOs, WEOs, and the Council HIV and AIDS Control Coordinators (CHACCs) to identify schools with high HIV vulnerabilities (schools with higher reported rates of, e.g., dropouts, truancy, pregnancies, abuse) that would benefit from the DREAMS intervention.

In four years of implementation, Kizazi Kipya reached 834 (71%) schools of 1,182 schools in 12 councils, where 124,101 in-school AGYW ages 10–14 (110% of the target of 112,593) were enrolled into DREAMS. Out of the enrolled, 111,268 (90%) started or completed any DREAMS intervention and 110,948 (100%) completed any DREAMS service: 107,091 HURU ASRH Curriculum and Primary Prevention of Sexual Violence and HIV Curriculum, 105,111 received menstrual sanitary kits, and 104,868 received education subsidies kits. Over LOP, Kizazi Kipya reached 107,405 AGYW with the complete primary package of services, achieving 97% AGYW_PREV and 45,220 (41%) with secondary package of intervention (see Figure 11).

Additionally, of 605,138 OVC comprehensive program beneficiaries ages 10–14 years, 22,397 were served through both the comprehensive program and DREAMS, achieving 4% OVC_DREAMS overlap for four years.

Figure 11: In-school OVC girls reached through the DREAMS intervention



3.2.2.2: HURU intervention for in-school OVC girls ages 10–14

For in-school girls ages 10–14 years, Kizazi Kipya implemented DREAMS activities that included the delivery of the Huru ASRH sessions and the Primary Prevention of Sexual Violence and HIV modules and distributed reusable sanitary kits. These interventions increased girls' knowledge about ASRH and reduced period-related school absences. Kizazi Kipya integrated the Primary Prevention of Sexual Violence and HIV modules into the Huru Curriculum in FY20. Pact performed central procurement of all sessions' delivery materials, tools, and sanitary kits to be used during implementation. A total of 2,135 primary school teachers were trained to deliver the SRH curriculum and reached 107,091 DREAMS girls with SRH knowledge and 105,111 DREAMS girls in 12 councils with re-usable sanitary kits after completion of the SRH curriculum.

By the time when the implementation ended, 77% of OVC age 5-17 years in the project were enrolled in school, with 86% of the enrolled attending school regularly. In total, 107,405 in-school AGYW 10-14y completed the full-service package and 85.8% reported improved knowledge of ways of avoiding pregnancy (an increase from 75.5% at pre-test). In addition, 55% reported improved knowledge about safe sex practices (an increase from 40% at pre-test), and 91% had improved knowledge on HIV prevention (an increase from 87.6% during pre-test).

3.2.2.3: Education subsidies for in-school OVC girls ages 10–14

Although Tanzanian law mandates free primary education, scholastic materials still need to be covered by students' families, which is often a challenge for vulnerable families. Kizazi Kipya provided education subsidies to 104,868 DREAMS girls ages 10–14 in 12 councils. The composition of education subsidies kits increased over time from providing school bags, exercise books, mathematical sets, pens, and pencils to adding school shirts, school skirts/dresses, socks, and shoes towards the end of the project.

3.2.2.4: Financial literacy for in-school OVC girls ages 10–14

In FY21, Pact conducted an intensive literature review on the available curricula on financial literacy suitable for AGYW and selected the Empowerment and Livelihood for Adolescents Girls under BRAC as the most appropriate financial literacy package for in-school DREAMS AGYW ages 10–14, as part of the DREAMS secondary package. BRAC conducted a needs assessment with AGYW in three DREAMS councils to inform an adaptation of the financial literacy curriculum. The tailored package, comprised of a facilitators guide, sessions curriculum, and pre-/post -assessment questionnaires, covered eight topics/sessions, each delivered for 1.5 hours per day. The developed materials were simple and user friendly and provided room for the girls to share their thoughts on different topics. The approved curriculum package was used in training nine Pact master trainers who cascaded the training to 46 facilitators/primary school teachers from the selected DREAMS schools in three councils (Mufindi DC, Nyamagana MC, and Mbarali DC). By the end of FY21, 2,048 AGYW (98% of the 2,090 enrolled AGYW) had been reached with this financial literacy knowledge.

3.2.2.5: Furaha Parenting Curriculum for OVC ages 10–14 and their caregivers

Pact worked with Clowns Without Borders South Africa (CWB-SA) to scale up community-based violence prevention activities using the Furaha Teens package, adapted from Sinovuyo Teens, an evidence-based intervention aimed at reducing the risk of violence against adolescents and improving positive parenting practices. CWB-SA added HIV-related content to the original Sinovuyo Teens to create the Furaha curriculum. Kizazi Kipya implemented the Furaha program for four years, starting in three DREAMS councils, then scaling up to eight DREAMS councils. At first, the Furaha program was implemented as part of the DREAMS primary

package of services; then in FY20, it was moved to the secondary package of services due to programmatic considerations done by USAID.

Over four years, Kizazi Kipya trained 11 Furaha trainers, 75 supervisors, and 568 facilitators who reached 44,447 DREAMS AGYW and 30,642 caregivers with the Furaha program. Administered pre-/post- assessment questionnaires determined that 45.6% of adolescents who completed the Furaha curriculum reported improved ability to communicate with their parents/caregivers about HIV risk behavior and 16% of adolescents reported experiencing reduced levels of harsh physical discipline. (See Activity 3.4.1 for more details on the Furaha Parenting Program.)

3.2.2.6: DREAMS intervention for out-of-school OVC girls ages 15–19

In FY19, Pact provided vocational scholarships to 4,653 DREAMS girls ages 15–17 referred by other DREAMS partners (see Activity 3.3.1 for more details on vocational scholarship support). Considering that the location of some vocational centers were far from AGYW homes, the project decided to include an option of boarding centers for AGYW interested in the vocational scholarship. To ensure the girls who attended the boarding vocational centers were safe and their needs were immediately met, Kizazi Kipya hired 66 chaperones (each chaperone on average with 55 girls), who supported the girls while they went through the vocational courses and ensured the girls were protected from abuse or any act that would put them at risk of sexual abuse, exploitation, and contracting HIV. These chaperones were women ages 35+ years who received two days training on how better to support the girls while at the centers; the training covered sessions about Kizazi Kipya and vocational scholarship support, their roles and responsibilities, qualities they need to possess, how to best collaborate with the LGAs and Vocational Education and Training Authority (VETA) centers, and steps to take in case they encounter a VAC/GBV case.

Activity 3.2.3: Prevention of sexual violence and HIV in adolescent girls and boys (non-DREAMS)

Kizazi Kipya aimed to reduce the HIV risk of the hundreds of thousands of OVC age 9-19 years who were enrolled in the project—by supporting their education as well as their access to health and social services. This involved school retention activities as well as ASRH education to build children and young people's knowledge on HIV and sexual violence prevention and their negotiation and decision-making skills to keep themselves healthy and safe as they mature.

At the start of the project, Restless Development implemented these activities through in- and out-of-school teen clubs, as well as via outreach for older adolescents. National Peer Educators helped identify and adapt clubs, structuring them to meet semi-weekly with 15-20 OVC members and elected officers to lead members through a one-year curriculum cycle. For younger members, this included the "Girls Let's Be Leaders" curriculum, an employability toolkit, and financial literacy materials. For older adolescents the curriculum included materials on the prevention of GBV, and an Information and Communication Technology for Development (ICT4D) toolkit. Where Teen Clubs needed to be established in schools, the project collaborated with community leaders and WEOs on school selection, then with LCWs/CCWs to identify enrolled OVC.

The club model proved challenging, as many schools already had established clubs and out of school adolescents were scattered among wards, making regular meetings difficult as these children had to travel to a central location. In FY19 the project redesigned prevention activities, moving away from the club model towards shorter term group-based activities. In FY19, Kizazi Kipya coordinated with CCWs to distribute materials on puberty and healthy adolescence for ages 10-19. CCWs distributed puberty books to 108,602 OVC ages 10–14 years (56,902 female, 51,700 male) and Healthy Adolescent books to 95,709 OVC ages 15–19 years (48,739 female, 43,970 male). The Tanzania-specific books provide age-appropriate SRH and HIV information in English and Kiswahili. At the same time, the project helped deliver the National ASRH curriculum to in- and out-of-school boys and girls in 11 non-DREAMS councils, as well as in four high-prevalence DREAMS councils. Project partners worked with HCWs to form community youth groups, with the HCWs delivering sessions on the ASRH curriculum. By close of project, 655 OVC groups had 14,755 adolescents (6,615 males, 8,140 females) attending sessions.

In FY20, the project adapted to updated PEPFAR COP guidance, expanding prevention via a new OVC Preventive component which targeted boys and girls age 9-14 with the PEPFAR recommended modules on the Primary Prevention of Sexual Violence and HIV. This curriculum consists of three modules on healthy relationships, healthy decisions about sex, and sexual consent. The project implemented this curriculum in 11 non-DREAMS councils with high HIV prevalence and large numbers of Kizazi Kipya OVC aged 9–14 years. Evidence-based DREAMS interventions already reached adolescent girls in DREAMS councils, and the OVC Preventive component allowed scale-up of prevention activities to councils beyond DREAMS. As part of same-sex groups, 112,733 adolescents age 9-14 gained knowledge on HIV and sexual violence prevention. This expanded programming also enabled a process for referring adolescents at high risk of HIV or violence to the

OVC Comprehensive or DREAMS components, via CSO reports of suspected abuse, neglect, or need for post-violence care. Kizazi Kipya also established and applied an SOP for facilitated referral of suspected or known CLHIV cases to ensure children received HIV testing, treatment, and inclusion in the comprehensive program.

In FY20, PEPFAR invested $100 million to address key gaps toward achieving epidemic control and ensuring children justice through faith, community, and traditional leaders in 10 countries, including Tanzania. With this funding from PEPFAR's FCI, Kizazi Kipya reached 98,057 adolescent boys age 9-14 in schools with the "Coaching Boys into Men" (CBIM) curriculum, a PEPFAR-approved evidence-based intervention that emphasizes respectful relationships, including with women and girls. The FCI funding presented an important opportunity for the project to reach larger numbers of vulnerable adolescents under OVC Preventive. Kizazi Kipya implemented FCI in 13 councils and an additional five councils under the OVC Preventive Program.

IR 3.3: Improved and expanded opportunities for developing livelihoods and employment skills and engaging in life skills education

Economic insecurity increases vulnerability and is often a cause of risky sexual behavior among youth. Kizazi Kipya encouraged out-of-school youth to return to school and gain skills for future careers, while ensuring the focus on economic security does not deter OVC from returning to school where the option is available. Kizazi Kipya supported out-of-school OVC with vocational scholarships and business start-up kits as a second chance to acquiring new skills/knowledge to engage in productive IGAs.

Activity 3.3.2: Support out-of-school OVC with vocational scholarships

In line with PEPFAR guidance for comprehensive ES programming, Kizazi Kipya supported out-of-school OVC ages 15–19 in 81 DREAMS and non-DREAMS councils with vocational training scholarships and business start-up kits. This included OVC from various vulnerable groups, including DREAMS AGYW, adolescents living with HIV, CIM, and CYLWS. Over the LOP, Kizazi Kipya supported 10,238 adolescents with vocational scholarships, and 9,183 also received business start-up kits (Figure 12).

In FY21, Pact documented the Kizazi Kipya pathway to entrepreneurship, wage employment, and asset building,[14] in the four regions of Dar es salaam, Shinyanga, Kagera, and Mbeya. The field survey involved 363 OVC ages 15–24 years, who were randomly selected from 9,565 OVC who completed vocational scholarships after vocational training creates in the lives of AGYW, sustainable 12 months after training. The survey found that nearly all of the 325 AGYW respondents completed vocational training (98%), with baking, electrical installation, motor vehicle mechanics, and welding among the most popular vocations. Although less than 50% of respondents reported having source of income prior to ES training and support, post-training, over 80% of respondents reported having an income, and most of these used the business start-up kits provided by the project. Eighty percent reported an increased monthly income after vocational training, mostly within six months after completing the course (Figure 13). Additionally, 91% of OVC who were given start-up kits engaged in IGAs, 59% of whom have started their own small businesses; the other 32% were either employed or in apprenticeship. Survey participants also reported acquiring assets with the income gained. Government representatives (DSWOs and WEOs) appreciated the support from USAID Kizazi Kipya and showed interest in sustaining these results. Lessons learned include the importance of engaging parents as well as youth.

[14] The findings and lessons are also detailed in the September 2021 *Documentation of the USAID Kizazi Kipya Project's Vocational Scholarship and Livelihood Service Model in Tanzania Survey Report.*

Figure 12: Youth beneficiaries of vocational training and start-up kits, by program type

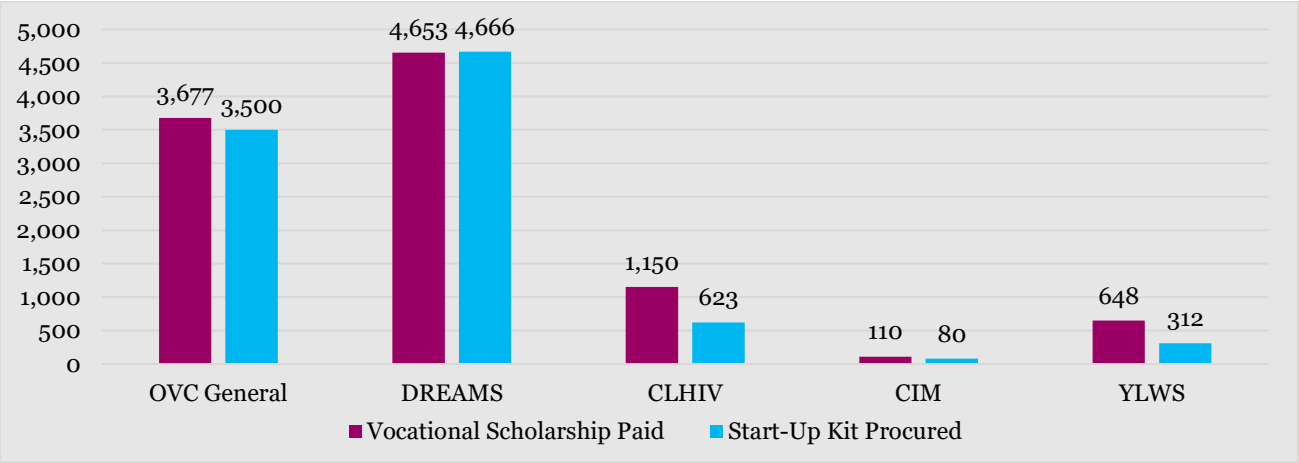
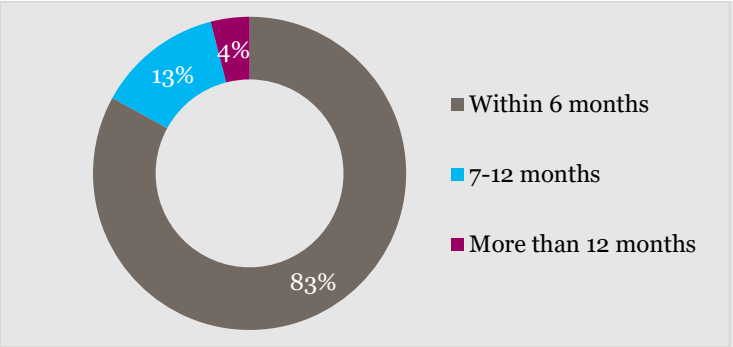


Figure 13: Proportion of duration it took for OVC to experience an increase in income after completing a vocational course (n=289)



Additionally, key lessons learned from the vocational scholarship and livelihood service model include that:

- Working closely with CCWs to identify, follow up, and support OVC contributes to the successful implementation of the vocational scholarship
- Providing transport allowances to OVC relieves stress, enables them to concentrate in college, and contributes to the higher rate of course completion and acquire a complete set of skills
- Provision of income-generating start-up kits to OVC greatly increases the chances of their engaging in IGAs
- Working closely with LGAs is key to ensure the sustainability of the project's achievements

IR 3.4: Improved and expanded child protection and other services

To prevent and respond to violence against OVC, Kizazi Kipya supported the implementation of the National Plan of Action to End Violence against Women and Children (NPA-VAWC) in Tanzania. Under this intermediate result, Kizazi Kipya ensured that CSOs in all councils had child safeguarding policies in place and implemented basic child protection interventions, including identifying cases of abuse and supporting survivors to utilize relevant services, including emergency post-rape care (e.g. PEP) for the sexual abuse cases. Given that violence against children often occurs in the home, Kizazi Kipya scaled up an evidenced-based parenting intervention described under 3.4.1 that has been shown to reduce the risk of violence, neglect, and abuse.

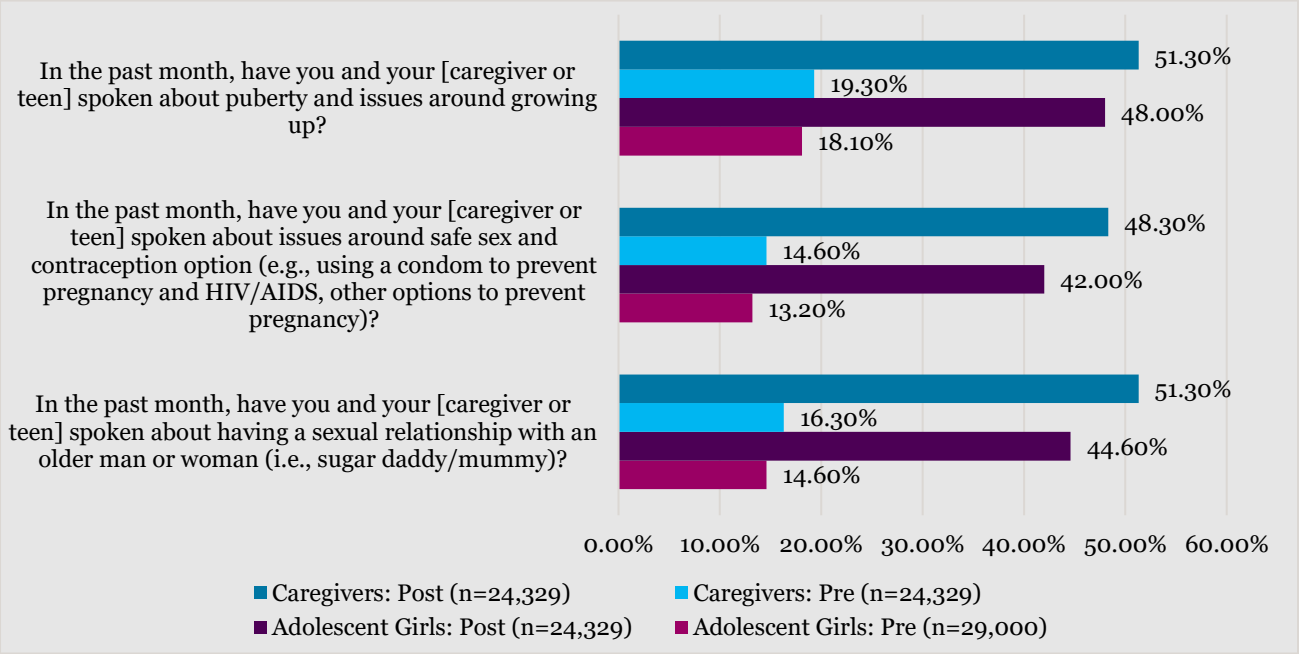
Activity 3.4.1: Conduct Furaha Caring for Families for Parents and Teens to reduce risk of violence, neglect, and abuse

Aligned with NPA-VAWC's Thematic Area 4: Parenting, Family Support and Relationships, Pact worked with CWB-SA to scale up community-based violence prevention activities using the evidence-based Furaha Teens package, an intervention aimed at reducing the risk of violence against adolescents and improving positive parenting. Evidence-based HIV-related content was added to the original curriculum by CWB-SA. Pact implemented the community-based Furaha Teen package in 17 councils (8 DREAMS councils and 9 OVC Comprehensive councils). Additionally, Pact adapted the curriculum to the mining context and delivered it in 3 CIM councils. Across the four years of implementation, Kizazi Kipya trained 1,034 Furaha facilitators, who

reached 55,484 OVC (44,447 DREAMS, 10,936 OVC Comprehensive, and 101 CIM) and their caregivers with Furaha parenting knowledge.

Pact conducted analysis on the pre-/post-assessment questionnaires to a sample of 29,900 adolescent girls and 24,329 caregivers in DREAMS councils. The assessment showed improvement in communication between caregivers and adolescents on difficult topics around sexual relationships as a measure to address HIV risks (Figure 14).

Figure 14: Outcomes of the Furaha program on adolescent-parent/caregiver communication



Pact worked with the National Institute for Medical Research (NIMR), UK Oxford University, and CWB-SA to conduct *The Furaha Adolescent Implementation Research (FAIR) Study of the Kizazi Kipya Project* that evaluated the quality of delivery and impact of the Furaha Parenting intervention to reduce VAC in Tanzania. In FY21, the team published a study, *A Mixed Methods Evaluation of the Large-Scale Implementation of a School and Community-based Parenting Program to Reduce Violence Against Children in Tanzania: A Study Protocol*, in the journal Implementation Science Communication. The study results will be presented and shared to key stakeholders in 2022.

Activity 3.4.2: Screen, refer, and follow up on cases of violence, abuse, neglect, and exploitation to DSWO and Child Protection Teams

Aligned with the NPA-VAWC's Thematic Area 6: Response and Support Services, LCWs/CCWs referred and followed up on identified cases of violence, abuse, neglect, and exploitation. LCWs/CCWs trained by the DSW Community Health and Social Services Project (CHSSP) and Kizazi Kipya on CM-identified abuse cases and provided relevant support including referrals to the DSWOs; Police, Gender, and Children Desks (PGCDs); One-Stop Centres; and/or members of Violence against Women and Children Protection Committees (VAWC-PCs). In FY21, Pact developed and used a training curriculum on violence against women and children, endorsed by PO-RALG, to train 1,865 ward VAWC-PC members (1,070 female, 795 male) on psycho-social support so they can provide basic psycho-social services to survivors of VAC and GBV.

During the five years of the project, LCWs/CCWs identified and facilitated referral of 32,411 VAC/GBV cases (17,394 female, 15,017 male; 165.3% of the five-year targets of 19,598) to the VAWC-PCs, DSWOs/ASWOs, and/or PGCDs. Of the 32,411 referred cases, 21,008 (64.8%) were neglect, 6,232 (19.2%) exploitation, 3,432 (10.5%) emotional abuse, 1,328 (4.1%) physical abuse, and 411 (1.3%) sexual abuse. Furthermore, the VAWC-PC members trained during the project implementation continued to provide psycho-social support services to survivors of VAC and GBV. Pact emphasized the importance for LCWs/CCWs to specifically inquire about GBV and VAC during household visits to ensure that any increase in cases due to COVID-19 were identified early and the affected persons were linked to services. Pact cluster staff continued working with CSOs' CMOs to follow up on the referred cases to ensure provision of appropriate services.

Activity 3.4.3: Safeguarding children

Three Kizazi Kipya staff and 14 CSO staff participated in a child safeguarding training organized by USAID and facilitated by Keeping Children Safe UK. The training aimed to ensure that USAID partners have child safeguarding measures in place for reducing the risk of and for addressing concerns related to child abuse, exploitation, and neglect that can result from personnel working with children or from the design and implementation of projects. Following this training, Pact incorporated feedback received from the Keeping Children Safe UK trainer on Pact Tanzania's Child Safeguarding Policy and worked with Pact's Human Resources (HR) Department to ensure compliance during recruitment processes. Under FCI funding, Kizazi Kipya reviewed and worked with 45 CSOs (100%) to incorporate needed updates or improvements to their Child Safeguarding Policies. CSO staff were also oriented on the revised Child Safeguarding Policies. To further ensure children were safeguarded, Pact developed an online child safeguarding training course for Pact staff, CSO staff, and community volunteers to uphold standards to protect children and youth from violence and abuse. By the end of the project, 102 Pact staff (57% of 180) took the online course to its completion and were provided with a certificate.

Activity 3.4.4: Implement recommendations from the gender analysis to ensure gender inclusivity in various Kizazi Kipya interventions

To strengthen diversified packages of services for men, women, boys, and girls, Pact conducted a gender analysis in FY19, which included a review of the project's workplan, SOPs, and gender disaggregated data for different age groups. This information was analyzed and compared to evidence-based best practices in the field to identify where the project had gaps in gender transformative interventions or gender inclusion approaches.

As a measure to address the gender-related gaps, Pact conducted a two-day all-staff training on gender equality, diversity, and inclusion within the workplace, which provided space for staff to reflect on the organization position towards gender transformation and areas for improvements. The workshop also informed staff around sexual exploitation, abuse, and harassment in the Tanzania workplace; the Pact Tanzania policies on sexual harassment; and sexual exploitation and abuse measures to be taken in case of an experience of such treatment. Pact developed a standardized Gender Transformative Approaches Manual to strengthen project staff's ability to apply evidence-based gender transformative approaches to project activities. Pact selected 24 Gender Champions and CSOs selected 137 Gender Champions, who were trained and cascaded the training to their Kizazi Kipya colleagues. Additionally, Pact organized three gender-related dialogues: Choosing to Challenge in 2021: What Does it Mean for Our Future, Contextualizing Work-Life Balance, and Quality of Life: A Case of a Career Woman. This provided a platform for all Pact staff to discuss their views on what needs to be done from the individual, family, community, and workplace to ensure strong women's inclusion in all developmental aspects. Pact provided Gender Equality, Diversity, and Inclusion Impact Awards to five outstanding champions to recognize their commitment in promoting gender equity, diversity, and inclusion among staff.

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

CYLWS and children engaged in the worst forms of labor, such as CIM, are hard to reach with health and social services. A significant proportion of these children experience higher rates than their peers of sexual abuse and are sometimes engaged in high-risk behaviors, including transactional or commercial sex, which places them at an elevated risk of HIV and other sexually transmitted infections (STIs). COFSW also run an increased risk of HIV through mother-to-child transmission. They all urgently need child protection services. The heightened vulnerabilities of hard-to-reach children are compounded by marginalization, which means these children and households are less likely to access health and social services. Meanwhile households with CYLWS, CIM, and COFSW have many of the same needs as other poor Tanzanian families. However, because of their situations, these children need different approaches to service delivery than the general population.

Working with project partners, CSOs, and local governments, Kizazi Kipya tailored its approaches and interventions to address the different groups' specific needs (Table E). Kizazi Kipya worked with RCA and IHI to ensure the needs of hard-to-reach children were well addressed. RCA focused on IR 4.1, which aimed to improve and expand services for CYLWS, while IHI and Pact focused on IR 4.2, which aimed to improve the service delivery model for children in the mining sector. IHI was responsible for conducting formative research, documenting learning, and evaluating the interventions while Pact was responsible for designing and implementing the service delivery model.

Rather than relying on volunteers to provide community CM, the project used more professional staff. For CIM, Kizazi Kipya implemented the same package of services, but adjusted the delivery, sequencing, and intensity. CYLWS received additional services to support their exit from living on the street. LCWs/CCWs and ILVs/LVs were recruited from the community to support FSW households. These services aligned with the project's objectives to reduce barriers to access and uptake of HIV services, reduce LTFU, and ensure HIV and OVC referrals were complete.

Table E: Kizazi Kipya interventions for children and youth living and working on the streets, children in mining, and children of female sex workers

Services	CYLWS	CIM	COFSW
Case management	●	●	●
Economic strengthening (e.g., WORTH-Yetu)	●	●	●
Positive parenting (Furaha)	●	●	●
CCD counseling			●
Linkages to HTS	●	●	●
Support to HIV continuum of care: ART initiation, ART adherence, disclosure support, viral load testing, multi-month dispensing	●	●	●
Nutrition assessment and referral	●	●	●
Linkages to child protection services under the NPA-VAWC	●	●	●
iCHF enrollment	●	●	●
School attendance and progression	●	●	●
Vocational training and start-up kits	●	●	
Childcare			●
Family reunification/ integration	●		
Youth associations	●		

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

The CYLWS component under Kizazi Kipya was implemented in 12 urban councils in the six major cities in Tanzania (Dar es Salaam, Mwanza, Arusha, Dodoma, Iringa, and Mbeya). Table F shows the IP in each of the cities and the DCs that were covered. Services provided by the six CYLWS CSOs reached 10,359 CYLWS and included street outreach interventions, family reunification, vocational scholarships, life skills sessions, linking of CYLWS and families to HIV testing and counseling (HTC) services, and ES opportunities as a way of expanding the safety net for them.

Table F: Coverage of services for CYLWS, by CSO and location

Implementing CSO	City	Councils Covered	Target
Babawatoto Centre	Dar es Salaam	Ubungo, Temeke, Kigamboni, Ilala, and Kinondoni	2,134
Amani Centre	Arusha	Arusha CC	1,304
IDYDC	Iringa	Iringa CC	1,261
Kisedet	Dodoma	Dodoma MC	936
Cheka Sana Tanzania (CST)	Mwanza	Ilemela and Nyamagana MC	1,740
Caritas	Mbeya	Mbeya MC and Mbeya DC	1,328
Total			**8,703**

Activity 4.1.1: Support provided to CSOs dealing with CYLWS

Under USAID Kizazi Kipya, RCA was responsible for providing technical support to all six CSOs implementing the CYLWS component, specifically in applying the three CYLWS intervention methodologies: street outreach, youth association model, and family intensive support, including CM within each of these interventions (see Activity 4.1.3 for descriptions of each methodology). The process was kick-started by developing SOPs and the differentiated CYLWS HIV package guide. In addition, RCA engaged external experts to provide further support to strengthen the family work intervention.

RCA engaged with AVIGUK[15] to capacitate project staff to use the Video Interaction Guidance (VIG) technique to ensure children, once reintegrated, remain at home and do not drop back to the streets and overall to improve the home situation for both the children and caregivers. VIG is an intervention through which a practitioner uses video clips of authentic situations to enhance communication within relationships. It works by actively engaging clients to develop better relationships with those who are important to them. It requires a practitioner to have a client-centered approach to interact and enable clients to be actively engaged in the change. The intervention was introduced to two of the CYLWS CSOs, Amani Centre and CST, to help address violence, strengthening relationships, communication, and interaction between caregivers and caregivers and their children.

RCA and the six CYLWS CSOs identified and trained 120 community champions across the six cities. The community champion initiative intended to create a safety net for children in the respective councils where the CYLWS interventions were implemented. The champions were community members that interacted with CYLWS on a routine basis and volunteered to support them by providing referrals or immediate support. In this case, trained community champions included police, Gender Desk Officers, food vendors, bus agents/conductors, motorbike drivers, security guards around bus terminals, local government officials, and small business owners. As part of the training, the champions were provided with information on various support services to which they can refer CYLWS within their councils. This approach was successful in increasing referrals, counseling support, and child-friendly services in the community, especially in Tanzanian communities where police and security officers are regarded as child unfriendly. By the end of the project, the total number of CYLWS referrals reached 1,541 (977 male, 564 female) through the community champions.

Activity 4.1.2: Headcount of CYLWS in six cities

In FY17, RCA, in collaboration with the MOHCDGEC, Pact, PO-RALG, and the six CYLWS CSOs, conducted a first-of-its-kind in Tanzania headcount exercise of CYLWS in six cities and repeated the exercise in FY20/FY21. This provided a baseline to generate information on where children were, determine their socio-demographic patterns, and inform potential programmatic approach in targeting, CM, and family reintegration needs.

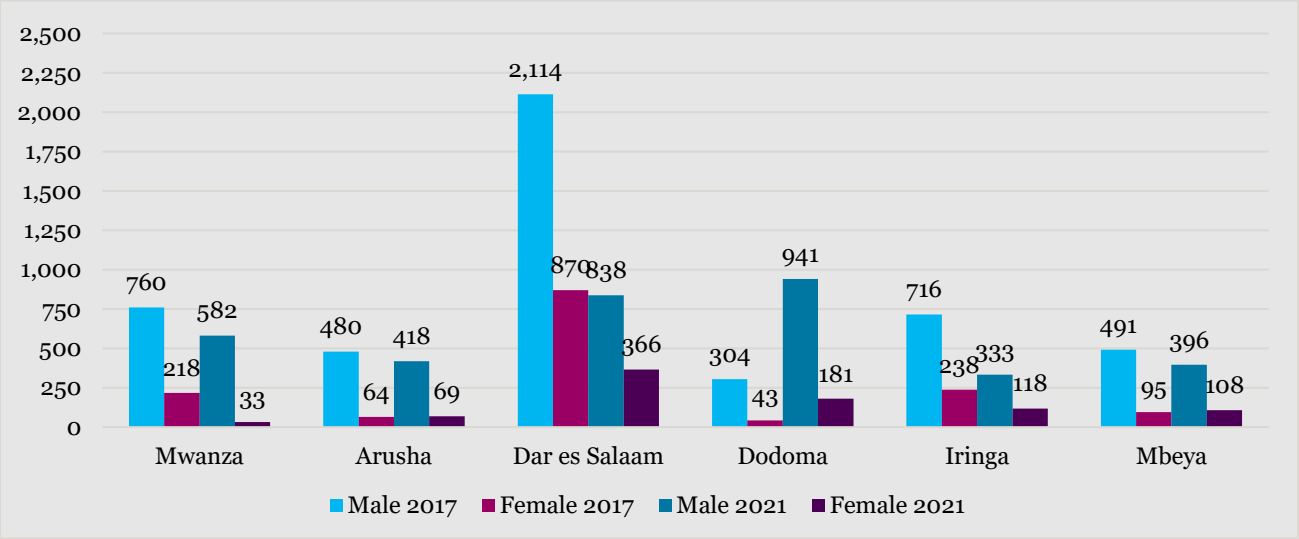
The FY17 headcount exercise resulted in a total of 6,393 CYLWS ages 0–18 (Figure 15), of which 4,865 were male, in the six cities during the day. Of these, 51% were ages 15–18, 35% were ages 11–14, and 14% were ages 0–10. Among female CYLWS, 86% were ages 15–18. At night, the numbers of children reduced significantly to around 1,385, but the ratio of males to females also reduced somewhat as compared to the day count: about a quarter of those counted during the day were female, rising to 30% at night and higher in some locations. Also, more than 50% of CYLWS were ages 15 or older; these children were less likely to be found begging and instead conducted some form of fixed or moving business.

The second phase of the headcount exercise was conducted in FY20/FY21 in the same locations and revealed a total of 4,383 during the day, of which 20% were female and 80% male. Comparing the 2017 and 2021 headcount results (Figure 15), there was an overall reduction in the number of CYLWS in the six cities, except

15 https://www.videointeractionguidance.net/

for Dodoma, which recorded a 223% increment in the number of CYLWS. This increase was hypothesized to be related to the increased business activity in Dodoma after it became the administrative capital of Tanzania

Figure 15: Comparison 2017 and 2021 CYLWS headcount, by location and gender



Activity 4.1.3: Service provision to OVC and their caregivers (OVC_SERV)

Although the initial headcount exercise came up with only 4,383 children and youth living and working on the streets (CYLWS), Kizazi Kipya partners reached 10,359 CYLWS (2,320 female, 8,039 male) through street outreach activities; these are street connected children and youth that received at least one core service. This is because the street outreach identified more street-connected children than the initial count. With support from Kizazi Kipya, CYLWS CSOs established drop-in center facilities that provided HIV-focused services, including SRH education, prevention of HIV and other STIs, GBV and VAC prevention, referral to HTS, and linkages to PLHIV support groups that enhance disclosure and continuity on ART. Services for CYLWS were packaged to also include games, counseling, literacy skills, life skills, and health and hygiene support. These centers provided facilities for cleaning and washing and provided food snacks occasionally but did not have residential (sleeping) facilities. All these activities aimed to create readiness for a child to leave street life and go back to their families or to alternative care.

Of the CYLWS reached, 1,468 (483 female, 958 male) were reintegrated into protective families (foster families and kinship relatives) and 1,051 (306 female, 754 male) were provided with emergency shelter through placement to residential center and/or fit persons. LCWs/CCWs, council SWOs, and CSO staff continued providing regular visits to these families and beneficiaries to enhance the quality of family support. 2,862 (1,125 female, 1,737 male) children were provided with educational support through school re-enrollment and materials. A further 648 CYLWS (289 female, 359 male) were provided with vocational scholarships and start-up kits. Kizazi Kipya also formed youth groups to support peer-to-peer group dynamics, improve disclosure, and address social and health needs for the youth. In total, 69 youth center-based associations groups were formed over LOP, comprising 1,878 members (870 female, 1,008 male). The youth association groups were provided with life skills education in HIV education, goal setting, hygiene sessions, SRH education, conflict management, savings and SIM banking, camping, and goal setting skills. Project staff used different approaches, such as art therapy, storytelling, and drawings, to make sure sessions were effective and interactive.

Table G: Indicator results for CYLWS services delivered

Indicator	Year 2 2017/18		Year 3 2018/19		Year 4 2019/20		Year 5 2020/21		Total	
	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
# CYLWS reached through street outreach activities	2,355	3,803	2,355	2,109	2,210	2,368	1,780	1,983	8,700	10,359
# children supported to attend vocational training	162	63	162	249	162	146	162	190	648	648
# children reintegrated with protective families	248	435	248	395	248	240	260	398	1,004	1,468

Indicator	Year 2 2017/18		Year 3 2018/19		Year 4 2019/20		Year 5 2020/21		Total	
	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
# children provided with emergence shelter	435	399	360	387	490	112	445	153	1,730	1,051
# CYLWS provided with school support	900	550	1,540	1,330	1,140	538	1,440	444	5,020	2,862
# CYLWS provided with SRH services	290	1,497	290	945	290	231	290	244	1,160	2,917
# youth supported with self-reliance training	290	604	290	320	290	54	290	29	1,160	1,007

Table H: Annual OVC_SERV results for CYLWS

Year	Target	# Achieved	% Achieved
Year 2 2017/18	4,200	4,043	96.3
Year 3 2018/19	4,390	5,995	136.0
Year 4 2019/20	4,844	3,277	68.0
Year 5 2020/21	4,828	3,658	76.0

Along with family reunification activities, Kizazi Kipya conducted HIV risk assessments with all CYWLS; those found to be at risk received referrals and an escort to health facilities for HTS and other services. The project supported all CYLWS found to be HIV-infected with ART initiation, close follow to ensure their adherence and continuity on ART and viral suppression. As a result, all beneficiaries whose status were reported as HIV-positive were linked to ART and none dropped from the treatment.

Across the six cities, 648 CYLWS (289 female, 359 male) were provided with vocational scholarships and start-up kits. As of September 30, 2021, 11% of the youth supported with vocational scholarship are employed and 53% are self-employed. In addition, 64% of all youth supported with vocational scholarships can generate income from vocational skills obtained and 36% are yet to graduate from studies. In total, 648 (359 males, 289 females) scholarships were provided, and, of the scholarships provided, most were for motor vehicle mechanics, hair dressing, food production, tailoring, welding, and electrical installation.

In FY21, the project implemented the transition plan co-designed with LGAs to strengthen the capacity of local government staff to provide and sustain services to CYLWS. Kizazi Kipya continued to advocate for government and community commitment to ensure sustained CYLWS programming. With CSOs pledging to continue supporting CYLWS within their area of operations, the project transitioned these beneficiaries to the respective LGAs. At the end of the project, RCA engaged national stakeholders, including government officials in PO-RALG and the MOHCDGEC, in a national dialogue that highlighted the special needs of CYLWS, specific programmatic actions, and the resources needed to continue addressing the root causes.

IR 4.2: Improved service model for child laborers and miners

Based on the extreme physical and health risks associated with child labor within artisanal and small-scale mining of gold and precious stones (i.e., rock crushing, exposure to hazardous working environment, and sexual abuse) and building on Pact's deep experience in the mining sector, Kizazi Kipya piloted interventions targeting CIM communities who face acute protection and HIV-related risks. Since the inception of this intervention for the CIM sub-population in FY18, Pact provided services to 1,424 community members (1,030 OVC, 394 caregivers) in targeted mining areas in Chunya DC, Songwe DC, and Bukombe DC.

In addition, the project worked to address several root causes of HIV vulnerability among this population by:

- Extending and advancing the quality of early childhood education and enhancing enrollment and retention of adolescents, especially girls, in secondary school
- Improving and expanding opportunities for developing livelihoods and employment skills and engaging in life skills education
- Supporting family reunification for those CIM who are living on the street
- Facilitating para-social worker linkages to access and monitor protection services for abused or exploited children

Activity 4.2.1: Delivery of improved service model

4.2.1.1: Stakeholder coordination, support, and feedback

The primary local stakeholder structure for CIM interventions is the VAWC-PC. The project worked closely with established government systems and structures, including VAWC-PCs, to address the needs of children living and working in mining communities. During the five years of project implementation, both Bukombe DC and Chunya DC had active council- and ward-level VAWC-PCs (Bukombe DC was trained by CHSSP and Chunya DC was supported by UNICEF), whereas Songwe DC had an active VAWC-PC at the council level only established by the government in FY19. CSOs' CMOs in Bukombe DC and Chunya DC worked with VAWC-PCs' secretariats to follow up and monitor reported VAC and GBV cases in the mining communities. By the end of the project in FY21, CSOs' CMOs participated in quarterly VAWC-PC meetings in Bukombe DC, Chunya DC, and Songwe DC. Topics covered included progress on the reported VAC/GBV cases, challenges, and solutions to improve service delivery to OVC in the target communities.

4.2.1.2: Roll out CM services to children in the mining households, including assessments

Pact adapted the Kizazi Kipya beneficiary identification and enrollment modality, but with an additional component of liaising with the mining associations around the mining areas and in consultation with key local stakeholders, many of whom were identified during the initial formative research. Pact developed a SOP on the identification and enrollment procedures, working closely with DSW and CSOs who implemented the service package for this population. The following criteria were used to identify CIM to be enrolled:

- Girls ages 10–19 years who work in direct contact with, provide services at the mines work directly with minerals who are not accompanied by their caregiver(s)/families, have been physically or sexually abused, and/or are HIV-positive
- Boys ages 0–14 years who work directly with minerals and are not accompanied by their caregiver(s)/families
- Boys ages 0–19 years who have been physically or sexually abused and/or are HIV-positive
- Girls or boys ages 0–19 years who have a sibling meeting one of the criteria above who already consented to the intervention

The identification and enrollment process included holding a stakeholders' orientation to train IPs, CSOs, LGA officials, representatives from health facilities, and local leaders. After the orientation, representatives formed teams and identified eligible children and youth in mining areas.

Pact used a family-centered CM approach to deliver services to targeted children and their caregivers in mining communities. This unique approach was instrumental in delivering relevant services while promoting the protection of children from hazardous child labor in mining. Intensive CM and HIV services provided by the project included NACS, positive parenting messages, HIV prevention, HIV risk screening and referrals for HTS, linkage and support for CLHIV, and referrals to healthcare and other social services.

Along with CM, the project worked with local governments and CSOs to address the heightened needs of CIM via the following health, education, ES, and child protection interventions. Although households with CIM have many of the same needs as other vulnerable families, the children often have higher risk of violence, and often engage in high-risk behavior themselves, including alcohol and drug use as well as transactional or commercial sex. The below tailored activities address the elevated risk of acquiring HIV, by engaging community groups in social protection efforts to improve the well-being of CIM and improve the ability of their families to mitigate these risks by supporting protective aspects such as schooling.

4.2.1.3: OVC education interventions

Through CMOs, Pact frequently monitored CIM OVC who were originally out-of-school and later enrolled in primary schools and COBET program. The project monitored school progress and attendance of 565 in-school OVC (461 in primary, 92 in secondary, and 12 in COBET). By the end of the project, Pact distributed educational subsidies to 565 OVC (286 female, 279 male) to promote school attendance and progression. Moreover, 166 OVC (62 female, 104 male) completed vocational training.

4.2.1.4: Child protection, prevention, and response

CSOs' CMOs used CM visits to identify children who were experiencing neglect, abuse, or exploitation and delivered child protection awareness messages to caregivers and children ages 10 and above on types and potential signs and symptoms of abuse. A total of 245 VAC cases (216 neglect, 9 emotional abuse, 7 physical abuse, 7 sexual abuse, and 6 exploitation) were identified and referred to DSWOs, PGCD, and VAWC-PCs by the end of the five years. The project worked with these entities to closely follow up on reported incidences to ensure abused children received timely and comprehensive support services.

4.2.1.5: Parental education

Feedback from formative research conducted for this project supported the need for parental education, particularly on issues related to the consequences of child labor in mining. In FY19, Pact trained CSOs' CMOs and DSWOs on the evidenced-based Furaha curriculum that was specifically tailored by Pact for adolescents (ages 10–17 years) and caregivers in mining communities to ensure enhanced child to parent relations exist, who subsequently trained facilitators to deliver the Furaha intervention. The project, through CMOs, reached 501 beneficiaries (215 caregivers, 286 adolescent boys and girls ages 10–17) with Furaha sessions. Furthermore, CMOs delivered positive parenting messages to caregivers in 394 households (292 female, 102 male) during home visits and to 306 caregivers (227 female, 79 male) during WORTH-Yetu groups by the end of the project. These messages aimed to improve caregivers parenting practices among mining communities, improve communication and promote teens' esteem thus responding to mitigating VAC incidences at households' level.

4.2.1.6: Economic strengthening interventions

ES interventions both respond to HIV's negative impact on household economic security and seek to prevent child labor in mining by reducing households' economic dependency on such labor. The WORTH-Yetu group members consisted of both project beneficiaries and non-beneficiaries. In the past five years, Pact supported the mobilization and formation of 27 WORTH-Yetu groups with 336 members (226 female, 110 male). Furthermore, over LOP, WORTH-Yetu groups supported 328 OVC (151 female, 177 male) with transport to access medical services, covered medical expenses, and provided scholastic materials. Nine caregivers were supported with medication, food support for their families, and transport fare to health facilities.

4.2.1.7: Health interventions

Kizazi Kipya used the CM approach to deliver services, including referrals to health and social services. During LOP, 1,019 active CIM OVC were administered with HRAQM tool: 50 (5%) reported being HIV-positive and 969 (95%) reported being HIV-negative. No OVC were determined to be at HIV risk because their status was known. Out of the 50 OVC who were reported to be HIV-positive, 100% were on ART.

Over LOP, CMOs provided NACS to caregivers. In addition, the CMOs conducted nutritional status assessments using MUAC tapes and provided nutrition counseling to 341 OVC under age five. Of the 341 OVC, 42 were malnourished, 41 were moderately malnourished, and 1 was severely malnourished; these children were provided with referrals for nutrition services. The malnourished children also received HTS, and 40 tested HIV-negative, 1 HIV-positive, and 1 did not disclose their status. To further support CIM OVC, 431 households with 991 OVCs received iCHF/iTIKA cards.

Activity 4.2.2: Implementation of operations research

In FY17, an extensive formative assessment was done for the Kizazi Kipya CIM component that assessed risk factors associated with and the pathways to child labor, the type of work performed by children, perceptions of the situation, power relations and dynamics, and the use of health and social services. This subsequently informed the design of the CIM intervention package by Pact and its partners. This package aimed to enable CIM and their caregivers to utilize age-appropriate HIV-related and other services and intended to improve care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing of the CIM and household members. The objectives of the evaluation were to quantify and qualify the unmet need for HTC among CIM and to assess the impact of the model on clinical cascade indicators, including HIV testing, ART enrollment, proportion of CIM removed from working in mines, and a few other secondary objectives.

Central to the intervention was the CM component, in which CMOs provide customized support for families using standardized tools to assess vulnerability. This aimed to reduce barriers to access and uptake of HIV services, ensure tracking to reduce interruption to treatment, and facilitate effective bi-directional HIV and OVC referrals to ensure completion. The evaluation had the following key findings:

- HIV testing improved. At endline most children reported to have ever tested for HIV (558 of 610, 91%), a 2.5-fold increase from the 36% at baseline who reported to have had a test before (221 of 610). More than 80% of children who were tested by the study at baseline, had also had at least one other HIV test after the baseline testing.
- By 2020, the majority of children who were sent for testing and further evaluation as a result of the project's HIV risk assessment form actually went to the clinic (87% of boys, 96% of girls), but very few of the already diagnosed HIV-positive CIM did so (21% of boys, 6% of girls).
- At baseline, 218 of 610 (36%) children were involved in mining. At endline, 141 of these 218 (65%) had stopped their mining activities. Girls were more likely than boys to leave or never start mining activities. The same was true for younger children compared to older children.
- Awareness about HIV/AIDS rose 22% and 23% among boys and girls, respectively. Of the children with awareness about HIV, 61% reported knowing how HIV is transmitted at baseline and 78% at endline. Less

than half of them could mention at least one way of reducing HIV risk at baseline, while two thirds could do so at endline.
- 76% of children reported that the abuse occurred less often since the project case worker had started visiting their household. This was especially true for the more severe forms of abuse.
- The percentage of children involved in generating income for their family reduced by 20% for 5–9-year-olds (to 3%), with 38% among 10–14-year-olds (to 30%) and with 17% among 15–19-year-olds (to 66%). A larger proportion of the older children who were still working for money were involved in safer forms of income generation, such as farming, vocational jobs, and small business, by the end of study.

This evaluation concluded that the CIM component of the Kizazi Kipya project was associated with improved care, health, nutrition, education, protection, livelihoods, and psycho-social wellbeing of CIM. The aim to enable children and their caregivers to utilize age-appropriate HIV-related services was partly accomplished, but practical barriers, such as transport challenges, remain for CLHIV and their caregivers. The observed positive changes were supported by evidence from process evaluation that the project activities were comprehensively and consistently implemented and were well accepted by all stakeholders, including project participants; this makes it plausible that observed changes resulted from the implemented project activities.

Collaboration with the Private Sector

From the start, Pact formulated Kizazi Kipya's corporate engagement strategy with the vision of creating synergies with the private industry to attain greater social and economic impact for beneficiaries and to contribute to the national economic growth agenda. The engagement plan aimed to specifically develop or increase the capacities of local civil society and the GOT, diversify Pact's funding portfolio, and strengthen staff capacities. In advancing this agenda, Pact prioritized its engagement with the private sector and aimed to expand opportunities for healthier and more prosperous communities.

Within Kizazi Kipya project implementation, Pact nurtured existing relationships within the OVC and HCT implementation landscape and forged new corporate partnerships at every opportunity, including with commercial banks (Absa, Tanzania Commercial Bank - TCB, National Microfinance Bank - NMB), mobile service providers (Tigo, Vodacom), and other organizations (e.g., BRAC). Pact also conducted specific scoping assessments to identify and initiate contact with potential partners to co-design innovative and impactful programs. On a monthly basis, corporate engagement and business development efforts were evaluated to discern relevant trends and pursue potential opportunities as needed. Pact also used social media, case studies, reports, media events, and webinars to track and communicate prospect partnerships as required.

Private sector partners provided services ranging from in-kind technical and material support for business youth entrepreneurs, to financial inclusion services and access to educational loans, to access to health and parenting information. Over the five years of implementation, Kizazi Kipya successfully engaged the government, non-state actors, and private entities to advance its impact agenda. Specifically, the private sector engagement plan targeted prospects in the energy sector (particularly renewable energy). Additionally, collaborations were sought with organizations working on financial inclusion, life skills improvement, entrepreneurship skills development, girl empowerment, and menstrual hygiene improvement. On the renewable energy front, Pact successfully linked WORTH-Yetu group participants with businesses working on solar products and merchandising. The project also successfully engaged VETA to provide tailor-made entrepreneurial trainings and business linkages related to motor vehicle mechanics, electrical installation, batiki-making, masonry and bricklaying, catering and food production, decorations, embroidery, hair dressing, and tailoring.

Pact also engaged with BRAC Tanzania to integrate financial management curriculum into WORTH-Yetu and engaged with commercial banks, such as Absa, Kenya Commercial Bank, National Microfinance Bank, and Tanzania Commercial Bank-TPB, to deliver financial inclusion trainings. To improve financial literacy, digital money management, and e-wallet options, Pact worked with Tigo and Vodacom and pursued the sustainable Thaminika Microfinance apex ideation to leverage the benefit and market network potential for saving and lending micro-credit groups. At every opportunity, Kizazi Kipya approached and forged impactful partnerships with the private sector and individual philanthropists to support beneficiaries for the common cause. These efforts resulted into individual donations of sunflower filter equipment to improve the quality of sunflower oil, digital money management training (by Equity bank), micro-enterprise and training in modern poultry (Silverlands Poultry Company), training in business opportunities and IGAs (Sunking Company), and modern and improved paddy farming (One Goal and Majinja Rice Production companies).

Worth noting is that private sector engagement trajectory faced one major challenge—the COVID-19 Pandemic—which impacted sector-wide growth and resilience in Tanzania. The resulting pandemic restrictions caused most private sector firms to shift their focus to existing portfolios and minimally vie for new business ventures.

Project Management

Finance

As of September 2021, Pact's total obligation was $162,425,181, of which $158,516,955 (98%) had been expended and reported in Pact's financial system, with the majority spent under the sub-contracts and sub-grants cost category. Cumulative expenditures per result area are shown in Table I.

Table I: Detailed expenditure summary

Cost Category	Total Obligated Amount	Cumulative Expenditure July 2016 - Sept 2021
Salaries	$ 20,126,104	$ 17,787,270
Fringe Benefits	$ 6,599,951	$ 5,905,356
Allowances	$ 1,402,618	$ 875,812
Travel	$ 4,070,076	$ 3,563,215
Equipments	$ 987,098	$ 375,187
Supplies	$ 4,871,099	$ 1,889,580
Consultants	$ 638,561	$ 786,120
Workshops and Program Activities	$ 7,598,287	$ 11,523,015
Subcontracts & Subgrants	$ 89,929,179	$ 91,854,923
Other Direct Costs	$ 6,939,012	$ 5,443,214
Subtotal Direct Costs	**$ 143,161,985**	**$ 140,003,692**
Overhead	$ 19,263,196	$ 18,513,263
Subtotal Indirect Costs	**$ 19,263,196**	**$ 18,513,263**
Total Budget	**$ 162,425,181**	**$ 158,516,955**

In reference to the project's results framework (Figure 1), actual project spending can be summarized per each result area as follows:

1. $42,799,578
2. $19,022,035
3. $72,917,799
4. $23,777,543

The approved budget for the close-out window (October 2021 to December 31, 2021) is $1,001,362, which will bring cumulative total spending to $159,518,317. DREAMS funding contributed $19,242,774 (12%) of the cumulative spending through September 2021, and FCI contributed $2,322,928 (1%). Pact reported a cumulative cost share of $12,911,051 (112%) of the total expected $11,496,136 from October 1, 2016, to September 30, 2021. Kizazi Kipya's annual expenditure summary is shown in Table J.

Table J: Summary of annual budget and expenditure

Financial Year	Budget	Actual Spent
FY17	$27,513,236	$17,937,509
FY18	$33,257,148	$34,805,681
FY19	$34,000,000	$31,498,980
FY20	$39,803,815	$36,558,039
FY21	$40,514,825	$37,716,749
FY22 (Q1)	$1,006,362	to be reported later as part of final financial report (date TBD)

Grants, Contracts, and Compliance

The workplans and budgets for the five consortium partners implementing Kizazi Kipya were finalized in Q1 FY2017. Similarly, Pact Tanzania started issuing grants in October 2016 to avoid disruption of services during close-out and transitioning from the predecessor USAID Pamoja Tuwalee project. Through bridge funding, Pact brought on board CSOs that were implementing Pamoja Tuwalee and conducted capacity assessments of these CSOs using Pact's Sub-Awardee Risk and Responsibility Assessment tool (SARRA) to identify risks and formulate mitigation plans prior to providing funds to them. The assessment results showed that 4 CSOs were low risk, 16 were moderately low, and 9 were moderate. Later, 48 CSOs were successfully awarded the initial contracts for the April 2017 to September 2017 period after a transparent and competitive RFA process.

Pact continued to closely support all 48 CSOs by providing technical and management support, including capacity development (CD). Extra oversight and support were provided to CSOs with large targets and budgets to ensure optimal performance. As part of the ongoing sub-award management process, Pact discovered some non-compliance issues with subs and executed remediation actions through targeted coaching and mentorship that fixed most of those. However, two major incidents related to fraudulent procurement and mismanagement of funds committed by two sub-awardees (CORDET and WISE) in Year 2 led to termination of these agreements in January 2019.

Pact also identified that approximately $183,081 in service and start-up kits did not reach intended beneficiaries because of fraud committed by another CSO, WAMATA. In December 2020, Pact terminated the contract with WAMATA, and all activities implemented by WAMATA were transferred to another capable CSO, PASADA. These non-compliance issues were duly notified to the project's Agreement Officer and the USAID Office of the Inspector General in 2020.

Pact sub-granted to 45 CSOs in FY19. The planned expansion to 25 new councils did not occur in FY19 because no PEPFAR COP targets were assigned to those councils. The project's senior management team closely monitored, frequently visited, and provided extra support to ensure optimal performance for all sub-awards, especially the "top 10" largest CSOs with the most targets and funding.

Pact continued submitting VAT refunds claims to the GOT through USAID, and to date, Pact has submitted TZS 6,291,881,770.63 worth of VAT refund claims and TZS 1,302,926,231.26 has been refunded, equivalent to 20% of the claims, as summarized in Table K below.

Table K: VAT claims submitted, refunded, and outstanding (TZS)

Year	Total claim summitted	Total refunded	Outstanding
2016	114,752,104.89	NIL	114,752,104.89
2017	454,798,042.61	278,260,765	176,537,277.61
2018	821,285,573.64	755,450,051	65,835,522.47
2019	1,011,831,662	269,215,415	742,616,246.76
2020	1,120,530,626		1,120,530,625.88
2021	2,768,683,762		2,768,683,761.76
TOTAL	**6,291,881,770.63**	**1,302,926,231.26**	**4,988,955,539.37**

Pact received, reviewed, and approved all technical and financial reports from Restless Development, IHI, RCA, and EGPAF in early FY21. These consortium partners were successfully closed, except RCA, whose close-out was delayed to late FY21 to allow effective transitioning of its target beneficiaries of CYLWS. As implementation was ongoing in Year 5, Pact embarked on a concurrent close-out of sub-awardees, including transitioning some of them to the new project, ACHIEVE. Among other steps, close-out involved initial meetings to walk partners through expectations and accountability requirements. Official sub-award close-out documentation was finalized before the end of December 2021.

Pact continued to be compliant with statutory requirements of filing monthly, quarterly, bi-annual, and annual returns with the Tanzania Revenue Authority and registrar of NGOs, including payment of annual fees to the registrar of NGOs. In addition, Pact has operated under the premise that USAID Kizazi Kipya funds are ineligible for payment of VAT, Service Development Levy (SDL), and other taxes, as detailed in the USAID-GOT 1968 Economic and Technical Cooperation Bilateral Agreement and the USAID Strategic Assistance Agreement (which was later followed by a letter from USAID to the commissioner for Tanzania Revenue Authority). However, Pact received numerous requests from sub-awards (CSOs) that do not have a charitable status to pay arrears, penalties, and interests due to the SDLs, which organizations were supposed to settle. Pact interpreted this as disallowable, and the requests have not been accepted. From the outset of the project,

Pact reminded sub-awards to process charitable status and advised them to cite the reference bilateral agreement for them to get exempted from paying project-specific levies or taxes.

Pact Tanzania has undergone an A-133 audit every year. In Years 4 and 5, Pact conducted a compliance audit (per single audit act of 1996) for CSOs that qualified for the A-133 audit for expenditures reaching a threshold of $750,000 in annual spending. No sub-award audits were done prior to Year 4 as no CSOs qualified for the audit. However, five CSOs qualified for the audits for FY19 and six CSOs for both FY20 and FY21. The USAID financial review in FY19 and FY20 for Pact Tanzania covered areas of finance, grants management, HR, and procurement and did not have major findings or concerns. In line with this, Pact Tanzania has continued to address specific gaps identified by to improve its financial and operational management systems. Further, in 2019, as part of statutory compliance, Claritas International was engaged to conduct the local statutory audit for Pact Tanzania, complementary to annual Pact audits conducted at the global level.

Pact Tanzania performed routine asset and supplies inventory reviews to ensure the project had necessary tools to deliver on the project commitments. All equipment, assets, and supplies purchased using project funds were tracked using specific lists, and functionality and need were updated by specific staff monthly by location (Pact offices, at cluster and CSO levels). As part of project close-out, Pact staff completed the verification of assets and inventories, submitted request for disposition of residual non-expendable property assets with value of less than $5,000 and received approval from USAID for the disposition of non-expendable property, under which most have been or will be transferred to ACHIEVE project and a few others donated to local CSO partners. A few furniture and office supplies that have either reached scrap value or furniture that would be damaged if moved between locations were donated to CSOs that will continue implementing OVC activities under ACHIEVE. Pact donated information and communication technology supplies that are unrecoverably damaged or with scrap value to VETA to support practical learning in related subjects. Pact will maintain these lists and document the related approval process, as required.

Human Resources

Over the five years of Kizazi Kipya implementation, Pact ensured staffing was in accordance with the required project performance needs. As such, the project headcount fluctuated over the years of implementation. The average headcount in FY17 was 110 staff, which increased to the highest average annual headcount of 147 staff in FY19 and FY20. The headcount decreased significantly in the close-out period of FY22, to 21 staff. The voluntary staff turnover (resignations) for staff was highest in FY17, with a voluntary turnover rate of 12%. However, following the implementation of a HR compensation review, the voluntary staff turnover rate went down to 9%. The project achieved a 37% female staff ratio overall, with a majority being among the Senior Management Team, where females' percentage was higher than males.

Table L: Project staffing by sex and voluntary turnover summary

Year	Male	Female	Total	Voluntary Turnover Rate
FY17	75	35	110	12%
FY18	83	50	133	9%
FY19	95	52	147	10%
FY20	94	53	147	3%
FY21	94	50	144	6%
FY22 (Q1)	15	7	21	5%

Two main transitions of key project personnel happened over LOP. Following the resignation of the first Chief of Party (COP) at the end of FY20, the Deputy Chief of Party (DCOP) assumed the acting role, up to February 2021, when the new COP was recruited. Also, the Director of Finance and Administration (DFA), separated from the project in May 2021 due to not obtaining work permit renewal, and this remained vacant up to October 2021 when the position was filled.

By September 30, 2021, the total headcount was 144 staff, with 39% based in the main office in Dar es Salaam and 61% in the 6 cluster offices in Mwanza, Dodoma, Tabora, Mbeya, and Songea town/cities. Contracts for 116 staff ended in September 2021, with the remaining on a phased transitioning plan from October to December 2021. The types of staff, cluster structures, relationship of cluster offices to the Dar office personnel, and Senior Management Team staff are well described in the project compendium.[16]

16 *Best Practices in Programming for Orphans and Vulnerable Children (OVC): A Compendium of Interventions and Lessons Learned from the USAID Kizazi Kipya Project*, https://www.pactworld.org/library/best-practices-programming-orphans-and-vulnerable-children-compendium-interventions-and.

From summer 2021 on, based on the accelerated close-out for Kizazi Kipya and to accomplish the ramp up activities of the new OVC project (ACHIEVE), Pact established an internal task force to efficiently monitor the deliverables under the two projects. This phase included bi-weekly check-in meetings with close-out team members to monitor progress and discuss issues with the Kizazi Kipya COP, Pact Tanzania Country Director, and Pact Washington, DC, team. This staffing needs taskforce included the HR Director, DCOP, COP, DFA, MERL Director, and the immediate supervisor for the position under consideration. The team was responsible for assessing, advising, and managing the ongoing staffing needs during this window, keeping supervisors, heads of departments, the COP, and the Pact Washington, DC-based country oversight team informed of the balance or pending staffing requirements.

Key COVID-19 Considerations for Effective Project Delivery

Following the COVID-19 outbreak in Tanzania, all project staff worked remotely from home after a temporary office closure in late March 2020. Pact Tanzania also established a country office COVID-19 preparedness and response team led by the Pact Tanzania Country Director. The team was charged with coordinating all COVID-19 activities for Pact Tanzania, continued to meet bi-weekly, and developed Pact-specific guidelines and workplace precaution measures for staff use to help keep staff healthy and safe.

Project staff continued teleworking based on the available information on continuing waves of outbreaks, or as assessed by the country team. Project activities strictly followed USAID guidance on social distancing, masking, and limitation of in-person activities, for which prior concurrence was always requested. All Pact Tanzania offices continued to be equipped with face masks for staff, sanitation supplies, marked office spacing, and schedules for maintaining a minimum number of staff coming to work in the office. Staff who were sick were required to work from home for 14 days until improvement, and all offices had a designated office space for any staff who fell ill while in the office. Additionally, there were assigned personnel to support medical emergencies for such staff. Despite a few who reported being ill or hospitalized, generally most staff remained healthy and safe.

In addition, Pact continued to engage in the national COVID-19 coordination activities by nominating specific representatives and participating in the various national pillars of coordination, surveillance, and research; CM and Infection Prevention and Control (IPC); WASH; lab and diagnostics; logistics; Risk Communication and Community Engagement (RCCE); mental health and psycho-social support; resource mobilization; Environmental Health and Safety; and non-state actors (NSAs). Following a successful introduction of COVID-19 vaccines in FY21, project staff accessed the voluntary vaccinations either offered through GOT channels or through the United Nations COVID-19 vaccination facility.

Monitoring, Evaluation, Research, and Learning

Kizazi Kipya reported into two complex data systems: Tanzania's National MVC_MIS and PEPFAR's Data for Accountability, Transparency, and Impact Database (DATIM). This required significant and sophisticated individual-level and longitudinal data collection and analysis. LCWs/CCWs used data to deliver CM to households, conduct assessments, and provide and track referrals to other social and health services. LCWs/CCWs submitted paper forms, then data clerks entered the submitted data into the databases. The LCWs/CCWs also submitted activity reports, which CSO M&E staff entered, cleaned, and reviewed. For instance, CMCs used LCWs'/CCWs' activity data to analyze performance and provide coaching and support. Through collaboration with clinical facilities, CSOs also generated and retrieved data around retention in care and ART adherence for beneficiaries living with HIV. Some data was collected in real-time, while other data was submitted to and used by the project to monitor CSO activities and track performance to achieve targets.

Key Kizazi Kipya Collaborating, Learning, and Adapting (CLA) activities over LOP included:

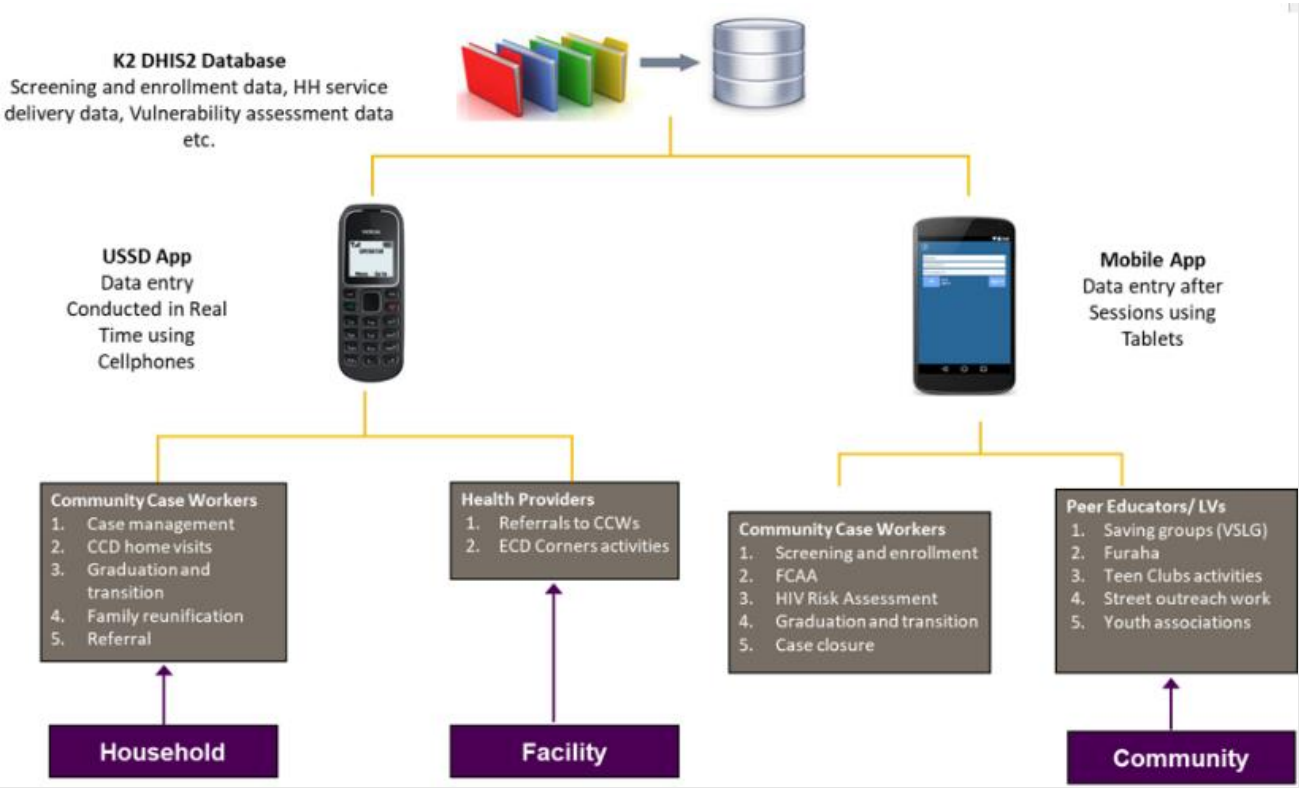
- ***Capacity development:*** Routine MER updates for Pact and CSO staff, data systems upgrades and orientation, and virtual coaching and mentoring
- ***Data quality assurance:*** Routine continuous monitoring, joint on-site support, and quarterly data quality assessments (DQAs), prioritized by council, CSO, intervention, and targets
- ***Learning from data:*** Collaborative data analyses with PEPFAR IPs, quarterly data review meetings at the LGA level, and semi-annual data summits at cluster level

Data Management System

At the beginning of the project, in FY17, Kizazi Kipya deployed an interim data collection system to capture additional beneficiary enrollment data and household-level service delivery data. The system was based on the CommCare platform and enabled CSOs' data entry by temporary data clerks using tablets. The project assigned unique identification codes (UICs) to each beneficiary after the screening and enrollment process for both new beneficiaries and those inherited from the predecessor project (Pamoja Tuwalee). The UIDs helped distinguish beneficiaries with similar or identical names and other characteristics to prevent double counting and track service layering across the various project interventions. The project adopted an algorithm for assigning the UICs that includes a combination of letters taken from the beneficiary's location (region and council) plus a random eight-digit number derived by permutation without repetition to ensure uniqueness for confidentiality purpose. In FY17, the project also introduced Quick Response (QR) codes to facilitate data entry by reducing the burden of typing beneficiary details during data entry, thus reducing data entry errors.

In FY18, Kizazi Kipya developed the project's web-based, password-protected data management system using DHIS2 platform as a data warehouse to store all projects data in a single instance and developed a USSD app, linked with DHIS2 to allow real-time data collection and submission via any type of phones, including basic feature phones. The USSD technology uses the GSM network (the same technology used to recharge airtime in phones or used for mobile money transactions), rather than internet, and allows rapid and cost-effective data entry by decentralizing the process.

Figure 16: Kizazi Kipya data management system, technology, and process



As part of strengthening the DSW, in FY18, USAID Kizazi Kipya developed features that enabled automated synchronization of beneficiaries served data from Kizazi Kipya's DHIS2 with the National MVC_MIS. An extension application programming interfaces was programmed to automate the aggregation of the individual level data collected through USAID Kizazi Kipya DHIS2 database and submitted into the MVC_MIS on monthly basis to ensure availability of the Kizazi Kipya's services delivery and referrals data on the national MVC_MIS to facilitate government decisions-making.

At the beginning of FY19, a custom native Android application for livelihood (WORTH-Yetu) data collection was developed and deployed. The application enabled management of groups and members information and to track members' funds and group cycles by LVs.

All data systems enabled robust data analysis, enhanced data validation, and used logic checks to ensure that beneficiaries received appropriate services based on age, sex, HIV status, and other crucial demographics.

To enable linkage of households to the CCW assigned to provide service in the respective location, In FY20, the project developed a beneficiary profiles management system to facilitate linkages between CCWs and the households they serve.

Quality Improvement

In FY19, USAID Kizazi Kipya rolled out the QI SOP, which facilitates establishment of QI teams at Kizazi Kipya cluster offices and CSOs with CCWs. The QI approach aimed to ensure quality services were provided to beneficiaries, thereby identifying performance gaps, defining measurable aims, and proposing and testing changes to improve services provided to OVC and households. Findings from the QI rollout indicated that application of QI is key in facilitating staff to clearly understand the project and to build a sense of ownership through identification of performance barriers and plan for improvement. In FY20, USAID Kizazi Kipya continued to strengthen the capacity of its implementers on the application of the Plan-Do-Study-Act model to improve service provision to OVC and caregivers. Implementation of QI plans resulted in increases in project's performance of key indicators across all clusters.

CD on MERL and Quality Improvement

For five years, Kizazi Kipya strengthened CSOs' MERL staff knowledge and skills on MERL to improve their capacities to carryout key MERL functions, solve problems, and facilitate achievement of the project's outcomes. As part of CD, completion of online training was a prerequisite to ensure new knowledge on mHealth is impacted to MERL staff. In FY17, Kizazi Kipya staff began scaling up training on MERL processes, indicators, electronic database, and data capture system for service delivery and bi-directional referral to CSO staff, data clerks, volunteers, and other local stakeholders to support implementation of programs. CSOs and government officials (DSWOs, DCDOs and CHACCs) received training on the MERL requirements for CM, child protection, referrals, and HIV linkages. In FY18, Kizazi Kipya conducted a training of trainers on both the electronic database, the data capture system for service delivery, and the bi-directional referral system to 24 cluster MERL and data managers. The USSD and Android apps were instrumental in improving reporting of bi-directional referrals data between CCWs at community level and service providers at service delivery points to facilitate capture and reporting of referrals issued and completed in real time. In FY19, The MERL and QI teams collaborated on developing and rolling out the QI training to clusters' and CSO's staff in the context of USAID Kizazi Kipya. Following the successful pilot of the QI SOP in Tabora and Mwanza, a total of 33 Pact cluster staff, 44 staff from six CSOs, and 40 CCWs from the Coast, Central and Southern clusters received an orientation to QI principles, dimensions and desired outcomes, QI in the context of Kizazi Kipya, QI approaches (e.g., problem tree analysis, Plan-Do-Study-Act Cycle), roles of QI teams at different levels, and the QI Performance Audit Tool. Strong QI teams at both the CSO and community levels were created with the role of monitoring implementation of the QI plan developed through monthly meetings to identify the performance gaps and taking improvement actions.

Data Quality Assurance

Throughout LOP, the project prioritized data quality assurance through DQAs and CD. The DQAs served the dual purpose of monitoring the quality of data used for project decision-making and reporting to USAID and CD for CSOs to strengthen their data management skills and systems for producing quality data. In FY17, the project received its first external routine data quality assessment (RDQA) by MEASURE Evaluation, in collaboration with Kepler. And in FY18, USAID Kizazi Kipya, in collaboration with MOHCDGEC, MEASURE Evaluation, and other partners, adapted the RDQA tool for conducting internal DQAs. Since FY18, the RDQA tool has undergone annual reviews to accommodate emerging project requirement, such as case file assessment, key indicator assessment, automated sample size determination, and random selection of households for spot checks. In addition to the internal DQAs led by Pact, in FY19, the USAID-funded Data for Development (D4D) project conducted a second external DQA in Morogoro MC, Kilosa DC, and Mjini (15 wards total) focused on the OVC_HIVSTAT indicator for FY18, assessing availability, completeness, and accuracy of reported data. These DQAs informed development and tracking of action plans for improving data quality on a quarterly basis at regional level in sampled districts. DQA findings and lessons learned were disseminated and discussed during quarterly data review meetings, attended by MERL and project staff from CSOs and at the district and ward levels.

Data Summit and Review Meetings

USAID Kizazi Kipya created an enabling environment and structures to facilitate data use for decision-making at all levels through implementation of a semi-annual data summit and data quality review meetings. Data summits aimed to review semi-annual council-level performance, discussing challenges and lessons learned. Over LOP, Kizazi Kipya convened data demand and use meetings annually at the cluster that brought together CSOs, IPs, MOHCDGEC, and regional and local government authorities, including RHMT and CHMT members and DSWOs, to review data and project performance and sharing best practices. In 2018, the project introduced quarterly data review meeting that brought together CSOs, LGAs, clinical partners, and ward representatives to review and discuss issues related to data quality, sources of errors at different levels and the best modality for data verification prior to reporting, performance progress, review of MVC_MIS data, status of ward readiness for case files transfers, the involvement of ward-level supervisors during monthly meetings, strategies on enrollment of new beneficiaries, provision of services to beneficiaries, and updating and reporting the care plans. Data summits and review meetings created a sense of data ownership to use data to inform decision-making through planning meetings and program management.

USAID Site Improvement Monitoring System

PEPFAR/USAID Site Improvement Monitoring System (SIMS)'s goals are to standardize clinical and community site quality monitoring through assessment and to score site performance on key program area elements. SIMS involves monitoring capacity at facility, community, site, and above site levels to provide high-quality HIV/AIDS services in all program areas. In FY17, USAID Kizazi Kipya had its first SIMS assessment conducted to implementing councils. In FY19, Coast cluster conducted an internal SIMS with CYLWS CSOs (Amani Center and Baba Watoto) and re-assessed five CSOs/councils that were assessed in FY18. As part of CD to CSOs, Kizazi Kipya continued to strengthen CSO staff to implement remedial actions.

Research and Learning

Kizazi Kipya's design prioritized research and learning as a core component of MERL functions. These activities aimed to inform project implementation and to contribute to the evidence-base for OVC programming in Tanzania and elsewhere across PEPFAR programs in other locations. This constituted scientific documentation of project successes and achievements to form visible and timeless footprints that the project can leave as a legacy. In FY17, Kizazi Kipya began with a baseline assessment to establish benchmarks to gauge project performance overtime. A learning agenda workshop followed to establish learning questions that comprised a set of learning priorities for the project. In FY19, the leaning agenda was revised to update existing and added new questions. In the implementation processes, a secondary analysis protocol was developed and sought ethics clearance from the NIMR—granted in FY18[17]—to ensure ethical conduct of all research activities under the USAID Kizazi Kipya project. Over LOP, Kizazi Kipya developed 34 abstracts and presented 26 at various in-country and international conferences. In FY18, selected abstracts were expanded into full manuscripts and were successfully published. Over LOP, a total of 15 manuscripts were developed, 9 were successfully published in various scientific journals, 3 were in the review stage for potential publication, and 3 were still being developed. The details of the respective manuscripts/papers and abstracts are included in Annex 1.

[17] Approval code: NIMR/HQ/R.8a/Vol.IX/3024

Environmental Mitigation and Monitoring Plan

Pact ensured that project implementation continued to be within the scope of the approved environmental documentation regulation. All environmental considerations were completely integrated into the routine implementation plan, revisited on an annual basis to minimize adverse impact to the environment.

All sub-awards and procurement documents included specific guidance to ensure CSOs, vendors, and stakeholders complied with GOT and international environmental protection requirements, legislation, and standards. Careful assessments of individual and group enterprises were done to identify environmental impacts associated with their implementation. As part of the performance delivery framework, Pact ensured that project procurement maximized environmentally friendly considerations, such as procurement of reusable sanitary kits for in-school adolescent girls (DREAMS) and training for safe disposal for the sanitary pads, including managing the generated waste in accordance with the environmental conservation principles. Pact, in collaboration with technical teams from LGAs (Agriculture Extension Officers and Environmental Conservation Officers), Small Industries Development Organization (SIDO), and machine salespersons, delivered specific trainings to equip beneficiaries with environmentally appropriate knowledge to reduce waste and ensure environmental protection. Use of environmentally friendly practices, organic manures, proper waste management, and informed selection of pesticides and livestock pharmaceuticals was covered during specific mentorship and training sessions.

In FY21, in line with the project's document retention policy (which also aligns with both USAID and GOT requirements), the project embarked on careful sorting, labelling, and packaging of physical documents to minimize quantities of physical documents and allow digitization and electronic storage of other documents as required before disposition. Pact also ensured an updated asset and inventory register across the project offices. On a regular basis, Pact approved the donation to VETA of defunct electronic supplies that either malfunctioned or were obsolete, such as old laptops, tablets, or printer parts, to support practical training at those facilities. In line with data security protocols, all hard discs and storage spaces on defunct electronic equipment were checked and data were erased or decommissioned prior to donation.s