The Community Health & Social Welfare Systems Strengthening Program

FINAL REPORT • SEPTEMBER 2020

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COMMUNITY HEALTH AND SOCIAL WELFARE
SYSTEMS STRENGTHENING PROGRAM
Final Report • September 2020

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COVER PHOTO:
Group photo of community case workers leaving a monthly meeting in Mbeya. JSI trained 18,890 case workers who conduct household visits, enabling tracking and management of HIV cases at the local community level. Photo by Erick Gibson for JSI.

TABLE OF CONTENTS

ACRONYMS 2

EXECUTIVE SUMMARY 3

PROGRAM OBJECTIVES 5

RESULTS OF THE COMMUNITY HEALTH AND SOCIAL WELFARE SYSTEMS STRENGTHENING PROGRAM 7

- The National Integrated Case Management System 8
- Multi-sectoral AIDS Committees 15
- People living with HIV Clusters 17
- Violence against Women and Children Protection Committees 21

COVID-19 RESPONSE TO SUPPORT THE GOVERNMENT 23

ANNEXES 24

- Annex 1: Evolving Scope of CHSSP 24
- Annex 2: Annual Program Achievements 26
- Annex 3: Tools and Guidelines Developed 30
- Annex 4: Challenges and Recommendations per Component 31
- Annex 5: List of all Presentations/Conferences at which CHSSP Presented 36
- Annex 6: List of Tools and Resources Developed by CHSSP 37

ACRONYMS

AGYW	adolescent girls and young women
ART	antiretroviral therapy
CBHP	Community Based Health Program
CHMT	council health management team
CCSWOP	Comprehensive Council Social Welfare Operational Plan
CCW	community case worker
CHW	community health worker
CHSSP	Community Health and Social Welfare Systems Strengthening Program
CSO	civil society organization
DSWO	district social welfare officer
GBV	gender-based violence
GOT	Government of Tanzania
GOP	Gender Operational Plan
IP	implementing partner
JSI	JSI Research & Training Institute, Inc.
LGA	local government authority
MAC	multi-sectoral AIDS committee
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MVC	most vulnerable children
MVC-MIS	Most Vulnerable Children - Management Information System
NACOPHA	National Council of People Living with HIV and AIDS
NICMS	National Integrated Case Management System
NPA-VAWC	National Action Plan to end Violence against Women and Children
NUPAS	Non-U.S. Organization Pre-award Survey
OCA	organizational capacity assessment
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PO-RALG	President's Office - Regional Administration and Local Government
PSS	psychosocial support
PY	program year
SWO	social welfare officer
TACAIDS	Tanzania Commission for AIDS
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV and AIDS
VAWC	violence against women and children

EXECUTIVE SUMMARY

Deputy Permanent Secretary of PO-RALG, Dr. Zainab Chaula (right) and Chief of Party of CHSSP, Dr. Tulli Tuhuma (left) hold a joint memorandum of understanding after signing the document in May 2018 to reach the 90-90-90 goals in Tanzania. At the center is the former Senior Technical Advisor, Paschal Wilbroad (left) and Assistant Director for Social Welfare of PO-RALG, Rasheed Maftah (right). Photo by MOHCDGEC Communications.

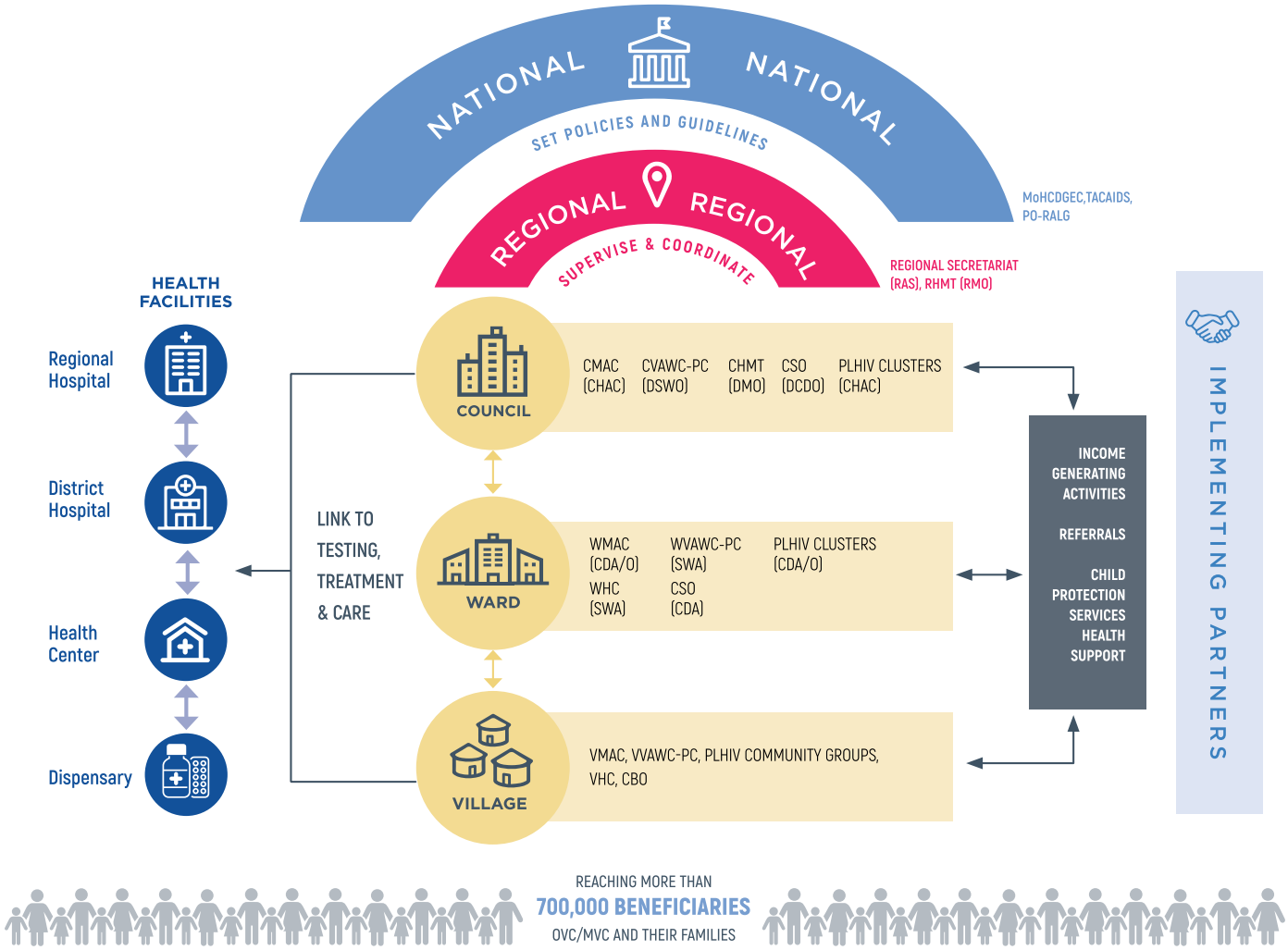
Over the last six years, the JSI Research & Training Institute, Inc. (JSI) Community Health and Social Welfare Systems Strengthening Program (CHSSP), with the United States Agency for International Development (USAID) and President's Emergency Plan for AIDS Relief (PEPFAR) support, has forged a collaboration built on trust and mutual respect with the government of Tanzania (GOT) to develop and adopt national policies to meet the Joint United Nations Programme on HIV/AIDS 90-90-90 targets. An important outcome of this collaboration is the establishment of the National Integrated Case Management System (NICMS), which strengthened the Tanzanian government's ability to identify and ensure that children who are most at risk for HIV are tested, treated, retained on treatment, and linked to integrated health and social welfare services at the community level.

Other examples of the collaboration are the National Plan of Action to end Violence against Women and Children; the Community Based Health Program implementation design; and the Council Comprehensive Social Welfare Operational Plan Guide. JSI/CHSSP helped the GOT develop and operationalize these policies, created guidelines and tools to implement the policies, and developed the capacity of local government structures and civil society organizations (CSOs) to use them. These efforts resulted in local ownership and sustainability of the policies and opened the door for other implementing partners to collaborate

with the newly capacitated government entities and CSOs to control the HIV epidemic in Tanzania.

Over the life of the program, CHSSP responded to changing priorities of USAID and the GOT. The program description shifted three times, and with each change, lessons and momentum from previous iterations were used to strengthen program implementation (see Annex 1). By the end of the program, CHSSP had sponsored training for 229 community health workers; trained 18,890 community case workers (CCWs); worked in 106 councils; built the capacity of 49 CSOs; and revitalized and supported government structures, including 3,316 multi-sectoral AIDS committees; 281 violence against women and children prevention committees; and 102 people living with HIV clusters at the council, ward, and village levels.

NATIONAL IMPLEMENTATION STRUCTURE



Despite challenges (see Annex 4), CHSSP worked at all levels of the health system to ensure HIV services reach the last mile as shown in the diagram above. The program trained a social welfare volunteer cadre of community case workers (CCWs), whose members are trusted by the communities they serve. These CCWs helped 731,327 most vulnerable and orphan children receive health and social welfare services, 444,652 (61 percent) of whom it linked to HIV testing services and antiretroviral therapy. In closing, CHSSP leaves behind a comprehensive health and social welfare system that is fully owned by the GOT (see Annexes 2 and 3).

PROGRAM OBJECTIVES

Vailet Mollel, CHSSP's social welfare and case management technical lead, briefs the Prime Minister of Tanzania, His Honorable Kassim Majaliwa, on the project's work of reducing HIV in Tanzania through the National Integrated Case Management System at a social welfare conference. Photo by CHSSP staff.

There is widespread recognition that community systems can offer tremendous support and resources for adolescent girls and young women (AGYW); people living with HIV (PLHIV); and most vulnerable children (MVC). The establishment of links between the health and social welfare sectors to strengthen community structures and systems, referrals, follow-ups, and adherence counseling contributes to an eventual AIDS-free generation in Tanzania.

The United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR) funded the six-year (2014–2020) project, which brought JSI and its partner World Education Inc. /Bantwana Initiative (WEI), to support the GOT's commitment to strengthening community health and social welfare structures and systems.

PEPFAR 3.0 provided new directions and priorities for achieving HIV epidemic control by pivoting to a data-driven approach that targets geographic areas and populations where HIV is most prevalent, and where PEPFAR can achieve the greatest impact.

CHSSP's objectives aligned with the GOT and PEPFAR goals, along with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast Track Strategy, which aimed to reach the following goals by 2020:

- 90% of all people living with HIV will know their status
- 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy
- 90% of all people receiving antiretroviral therapy will have viral suppression.

CHSSP contributed to this goal through its systems strengthening approach, in close collaboration with the President's Office – Regional Administration and Local Government (PO-RALG) and the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) through the following two objectives:

Objective 1

Higher performing human resources for community health and social welfare services. The objective included activities to expand the social welfare workforce to support AGYW, MVC, PLHIV, and their families, particularly in communities most affected by HIV. Objective 1 also focused on developing and strengthening an HIV-sensitive integrated case management system to improve linkages and referral networks across the continuum of HIV services.

Objective 2

More functional, better coordinated community structures and systems to serve priority and key populations. This objective included activities that focused on creating an enabling policy environment and strengthening coordination, partnerships, and organizational leadership and management capacity of community structures (multi-sectoral AIDS committees [MACs], violence against women and children [VAWC] prevention committees, civil society organizations [CSOs], and PLHIV clusters) at council, ward, and village levels. The objective also focused on reducing stigma and discrimination and implementing a service model to increase access to and quality of core HIV health and social welfare services for priority and key populations.

RESULTS OF THE COMMUNITY HEALTH AND SOCIAL WELFARE SYSTEMS STRENGTHENING PROGRAM

CHSSP forged a collaboration built on trust and mutual respect with the GOT to develop and adapt national policies to meet the global 90-90-90 targets. The collaboration included support from the project to the GOT to operationalize these policies down to the community level by developing and implementing the ground-breaking NICMS. The project and the government jointly created guidelines and tools to implement these policies and then developed the capacity of local government structures, volunteer social welfare cadres, and CSOs to use them. These efforts resulted in local ownership and sustainability of policies and opened the door for other implementing partners (IPs) to collaborate with the newly capacitated government entities, volunteer cadres, and CSOs to control the HIV epidemic.

BOX 1. STRENGTHENING THE CAPACITY OF CSOs

CHSSP worked to build the organizational capacity of 49 Kizazi Kipya sub-grantee CSOs. CSOs are pivotal to Tanzania's HIV response, bringing community representation to the MACs, VAWC prevention committees, and PLHIV clusters at each level of the system. CHSSP used a collaborative approach to: 1) conduct self-guided organizational capacity development needs assessments; 2) develop action plans to close capacity gaps; 3) implement action plans; and 4) monitor CSO progress and adapt action plans as needed.

CHSSP believed that well-capacitated CSOs can mobilize resources, function in the absence of international IPs and therefore support USAID's "Journey to Self-reliance" and PEPFAR initiatives to fund local partners. Through CHSSP's support, six CSOs mobilized resources, and applied for and received over 3.3 million USD in funding from donors including USAID and UKAid. Out of the six, five CSOs also received targeted support to help them pass the USAID Non-US Organization Pre-Award Survey (NUPAS), a selection tool that USAID uses to determine a partner's eligibility to manage funds.

Sihaba Nkinga, the former permanent secretary for the Ministry of Health, Community Development, Gender, Elderly and Children, signs and approves the NICMS framework in Dodoma. Photo by CHSSP staff.

The National Integrated Case Management System

Integrated case management systems coupled with a strong social service workforce can improve the access, reach, and use of proven high-impact interventions to increase HIV case finding and reduce new infections.[1] However, certain challenges hinder this, such as the lack of health workers. Data from a national social welfare workforce mapping exercise in 2012 and more recent data from a district capacity assessment documented a serious shortage of social welfare workers in Tanzania.[2, 3] Many international nongovernmental organizations have hired community volunteers, but have resulted in an ad hoc and fragmented response that fails to connect child protection, social welfare, and health services, and perpetuates a "silo effect" between clinical and community-based service providers. These challenges prevent service providers from reaching last-mile clients and entering and retaining them in the HIV clinical cascade of services.

Tanzania's HIV-sensitive NICMS fills these gaps by integrating service provision between health, protection, and social welfare sectors to improve HIV outcomes for vulnerable children and adolescents. The NICMS provides a harmonized, standardized, and systematic framework supported at the community level by CCWs. The NICMS strengthens referral networks and supports HIV status disclosure among families, contributing to improved HIV case finding, linkage to care, antiretroviral therapy (ART) retention and adherence, and viral load suppression, all of which are needed to achieve the UNAIDS 90-90-90 targets.

The commissioner for the Department of Social Welfare under the Ministry of Health, Community Development, Gender, Elderly and Children (middle), accompanied by PO-RALG (right) and USAID (left) representatives, cuts a ribbon to mark the official handover of the NICMS data collection and reporting tools developed by CHSSP, in collaboration with USAID-Kizazi Kipya and MEASURE Evaluation. The tools will be used by community case workers across the country to document and track most vulnerable children to provide health and social welfare services. Photo by CHSSP staff.

[1] "Protection, Care, and Support for an AIDS-Free Generation: A Call to Action for all Children." UNICEF, PEPFAR, UNAIDS, et al. (2014).

[2] District Capacity Assessment Report, CHSSP, 2020.

[3] Assessment of the Social Welfare Workforce in Tanzania. Ministry of Health and Social Welfare, 2012.

Leveraging best practices in MVC case management systems and building on existing structures and cadres in Tanzania, CHSSP engaged the MOHCDGEC and PO-RALG in the NICMS design process from the planning stage. The GOT created a NICMS National Task Force comprising technical experts from MOHCDGEC and PO-RALG, who worked with CHSSP and other stakeholders (including UNICEF and other PEPFAR IPs) at every stage of the development and rollout of the NICMS. The engagement of the GOT from inception increased local ownership and political will to invest in NICMS. Through a series of workshops, CHSSP leveraged its sister organization, World Education, Inc./Bantwana's (WEI) global expertise in integrated MVC/OVC case management to develop the NICMS Framework and a CCW training package. The NICMS government coordinating structure defines the system parameters and connects and coordinates all service providers working with children across the health, protection, and social welfare sectors.

Particularly, the NICMS framework outlines how to implement an integrated case management system that is comprehensive and complementary to Tanzania's national policies and other legal frameworks. The NICMS defines government coordinating structures and roles and responsibilities for implementing the system from the national to the village level. The NICMS framework has standard operating procedures for case categorization and management (including opening, transferring, and closing cases), referrals, service mapping, confidentiality, community-facility-school linkages, documentation, record-keeping, and reporting, and the process of recruiting CCWs and lead CCWs (Diagram 2). The NICMS includes a series of nine data collection and reporting forms to enable CCWs and lead CCWs to identify, track, and manage HIV cases. The NICMS also covers the qualifications and standard training requirements for social welfare professionals and paraprofessionals and community volunteers, and outlines supportive supervision practices.

The CCW training package builds confidence and skills to resolve case-load management challenges. Using a core competency approach, CHSSP developed a five-day training program for CCWs.

The training methodology is participatory, experiential, and designed on the case management cycle of case identification, intake, assessment, developing care plans, providing direct services and support, making referrals, following-up, and closing cases. To ensure the training is practical and learner-centered, the training manual included three case studies that highlight child welfare, protection, and health issues that CCWs are likely to encounter. The manual also has a strong focus on gender-based violence (GBV) prevention, adolescent sexual reproductive health, and CCW stress management and self-care.

WHO GETS TRAINED TO USE NICMS?

BOX 2. DATA ON CCW SUPPORTIVE SUPERVISION (2018–2019)

Of the trained **16,948** CCWs:

- **89%** were retained and served MVC/OVC.
- **75%** were submitting monthly case management reports to social welfare officers (SWOs).
- Most of the council SWOs from **106** councils attended monthly CCW meetings.

Of the trained **1,942** CCW supervisors:

- **75%** submitted monthly reports to councils.
- **45%** attended CCW meetings

A facilitator guides a role-playing session between a case worker and a family during a community case worker supervisor training in Mkuranga District. Erick Gibson for JSI.

CHSSP designed six short interactive e-learning videos in Kiswahili to help CCWs improve case management documentation. The videos, which are five to six minutes each, can be downloaded and viewed on smartphones by CCWs, CCW supervisors, and SWOs. CHSSP shared the e-learning videos via SMS texts and WhatsApp groups.

Supportive supervision and other forms of monitoring were used to improve CCWs' ability to use the NICMS. CHSSP conducted regular joint monitoring visits in collaboration with PO-RALG and MOHCDGEC at council, ward, and village levels. CCWs and lead CCWs gave and received peer-to-peer support and supportive supervision from CCW supervisors and SWOs. CCWs and lead CCWs attended monthly case review meetings at the community level and quarterly case review meetings at the council level, where they received coaching and guidance, discussed challenging cases, and liaised with HIV clinicians to strengthen referrals between community- and facility-based service providers. A summary of supportive supervision data from 2018–2019 is highlighted above in Box 2.

Rose Kimathi (right), listens attentively to a beneficiary narrating her struggle with HIV. Rose is one of the 18,850 community case workers in Tanzania trained by CHSSP to manage HIV cases at the grassroots level through a standardized system – the National Integrated Case Management System – which was nationalized by the Government of Tanzania in mid-2018 in collaboration with the program. Photo by Erick Gibson for JSI.

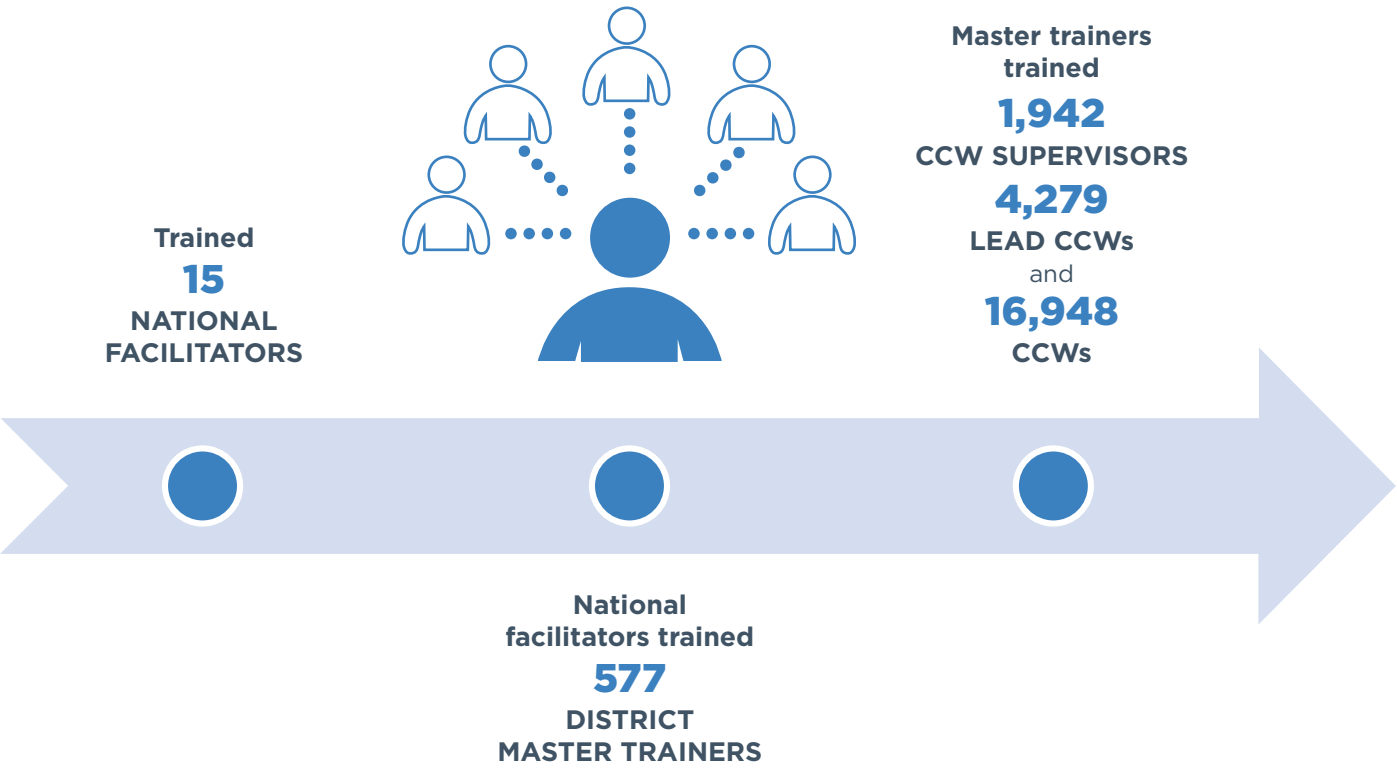
BOX 3. COUNCIL COMPREHENSIVE SOCIAL WELFARE OPERATIONAL PLANNING GUIDE

Realizing the need to operationalize policies and implement social welfare interventions in the community, CHSSP, in collaboration with PO-RALG, MOHCDGEC, and IPs (UNICEF and the Public Sector System Strengthening Program), developed the Council Comprehensive Social Welfare Operational Planning (CCSWOP) guide. The CCSWOP harmonizes and standardizes multi-sectoral planning, budgeting implementation and reporting processes for social welfare interventions at all levels (village, ward, and council).

The GOT approved the NICMS and the permanent secretaries of PO-RALG and MOHCDGEC signed the NICMS Framework and issued a circular mandating all IPs serving vulnerable children and families to use the NICMS for case management.

Over the life of CHSSP, CCWs supported 731,327 MVC/OVC and their caregivers with HIV, GBV, and wrap-around social welfare services and referrals. Of these people, 444,652 (61 percent) learned their HIV status and received HIV services. Three years after the NICMS was developed and scaled up, the GOT nationalized the system to ensure all IPs working with vulnerable populations and in social services used its data collection and reporting tools. The government also issued a circular to all councils with a mandate to budget and plan for NICMS implementation. A district capacity assessment conducted in 2020 showed that councils implementing NICMS perform better, particularly in planning, coordination, budgeting, and quality of case management. Moving forward, the national scale-up of NICMS must be closely monitored to ensure that all councils budget for and support implementation.

CASCADE TRAINING FOR NICMS



SUCCESS STORY

ACHIEVING 90-90-90 ONE HOUSEHOLD AT A TIME

Julius Mwanpashe, a JSI-trained community case worker in Mbeya, manages 14 HIV cases in his village. His role in the community is to visit households to encourage HIV testing, and if they are positive, to refer them to the needed health and social welfare services, and to continuously track their progress until they are virally suppressed. Julius became a case worker to help people in his village improve their health and remain healthy.

However, Julius explained that the role comes with its challenges. He said, "The challenges I face while doing my job, especially when dealing with HIV/AIDS are that beneficiaries are not open about their status due to fear of stigma. Beneficiaries do not trust that case workers can provide good services to them while keeping their status confidential. All this is as a result of stigma in the community."

Despite these challenges, Julius perseveres to help the vulnerable in his village, such as in one case of a young girl who was sexually abused. Julius explained that when he was conducting his usual round of household visits, he came across a girl crying. He approached her and asked her if she was unwell and she explained that she was recently sexually abused. With the sensitivity of this case, Julius immediately went to speak to her parents who requested his assistance.

Using what he learned in his JSI training on the case management system, he took her to the ward executive officer and drafted a referral form for the social welfare officer. Together, they filed a case at the nearby police station to arrest the abuser while it was discovered that the young girl was HIV positive. She received treatment at the nearest care and treatment clinic and obtained medication.

"Integrated case management training has helped me develop a capacity for identifying children's problems and dealing with them," Julius said. "Also, I now know how to write reports, fill out all the forms so that I can present them properly and accurately to my leaders."

He added, "In the past, I was providing care without sufficient education. There is a big difference now compared to the time we didn't have this systems strengthening project. I, as a community case worker, have developed a better understanding of my job and my responsibilities to better serve my community."

Julius continues to manage HIV cases in his village including tracking the progress of the young girl whose condition has improved. Julius is one of more than 18,000 volunteer community case workers trained by JSI's Community Health and Social Welfare Systems Strengthening in the country – contributing to the end HIV epidemic in the country.

"Integrated case management training has helped me develop a capacity for identifying children's problems and dealing with them," Julius said. "Also, I now know how to write reports, fill out all the forms so that I can present them properly and accurately to my leaders."

CHSSP Program Officer Halima Kaombwe (right) discusses the standing agenda outlined in the MAC guidelines with a multi-sectoral AIDS committee secretary from the Pwani Region during a supportive supervision visit. Photo by Erick Gibson for JSI.

Multi-sectoral AIDS Committees

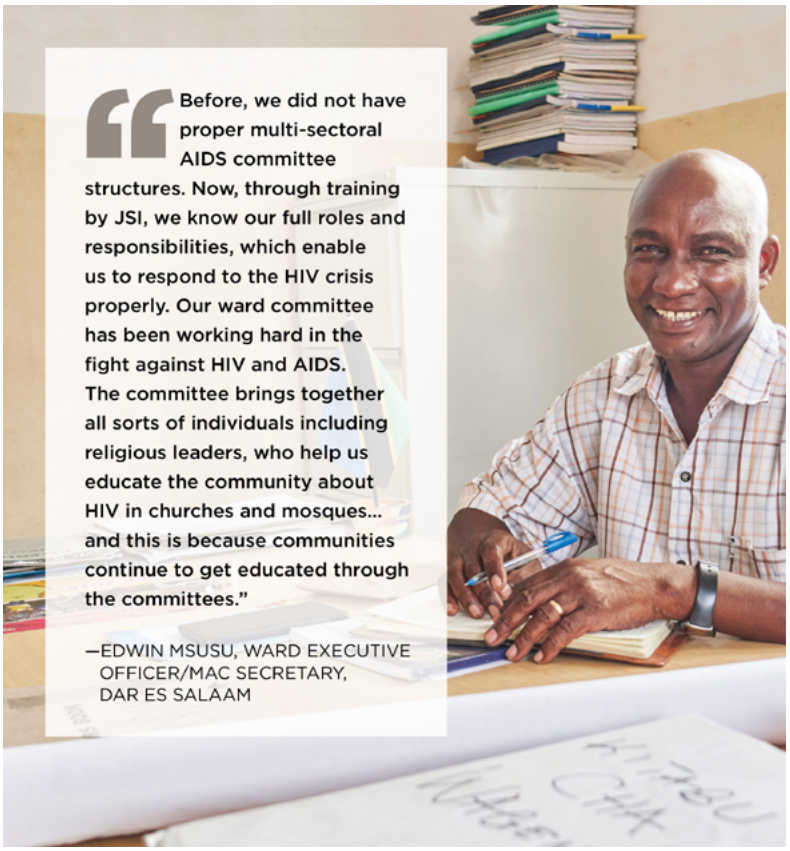
In 2003, the Tanzania Commission for AIDS (TACAIDS) established multi-sectoral AIDS committees (MACs) at council, ward, and village levels. MACs are council-level steering committees that coordinate community-level HIV response activities and increase HIV service provision (e.g., HIV testing, ART adherence support, and tracking people lost to follow up). Although TACAIDS developed guidelines for establishing MACs at all levels, a 2014 assessment found that MACs existed primarily on paper; in places where they had been established they were not fully functional and members were unaware of their roles and responsibilities.

To remedy this, CHSSP used a cascade approach to strengthen MACs by orienting council-level MAC members on their roles and responsibilities, including how to establish MACs at all levels. These members then trained ward-level members, who trained village-level members. After the orientation sessions, CHSSP distributed printed copies of the updated guidelines to MACs.

BOX 4. RESULTS OF STRENGTHENING MACs

CHSSP strengthened the capacity of **3,316** council, ward, and village-level MACs. CHSSP supported TACAIDS and the Government of Tanzania to print and disseminate 2,000 copies of the MAC guideline and copies of the National Gender Operational Plan for HIV Response (2016–2018) in Tanzania Mainland (both in Kiswahili).

CHSSP's efforts to strengthen MACs, along with other facility-level partners, enabled **106** councils to report **5,329,835** people who tested for HIV (the first "90"). Of those tested, **159,504** (3 percent) were found to be positive and initiated treatment (the second "90").



With capacity development support from TACAIDS and CHSSP, MACs are now able to:

- Use the guidelines to coordinate and manage the HIV response in their communities, with interventions that contribute to the 90-90-90 targets.
- Use the guidelines to build the capacity of MACs at lower levels.
- Develop resource mobilization strategies to raise funds to ensure self-reliance and sustainability of HIV response interventions.
- Use data from the GOT's district health information system to make evidence-based decisions and plans for HIV, MVC/OVC interventions, and reducing GBV.
- Design, mobilize, implement, and monitor community support programs at the ward level and transfer this skill set to the village level.
- Understand key gender concepts and approaches and their connection to health and HIV vulnerability. MAC members are also aware of stigma and discrimination and how gender roles and socialization processes harm AGYW, PLHIV, and MVC/OVC.
- Advocate to reduce stigma and discrimination against voluntary medical male circumcision, which has led to more than 625,000 men receiving this service.

Caroline Hezron (left), the chairperson of the Tabora PLHIV cluster, leads one of their routine meetings with cluster members. She encourages them to advocate for testing and treatment in the community, to ultimately contribute to the 90-90-90 goals in Tanzania. The Tabora PLHIV cluster is one of 102 clusters revitalized by CHSSP. Photo by Erick Gibson for JSI.

People Living with HIV Clusters

People living with HIV clusters are an important part of Tanzania's HIV response. Each cluster assists a number of PLHIV support groups, which meet in wards and villages all over the country. PLHIV clusters and support groups have a critical role in helping Tanzania reach the global 90-90-90 targets because they identify people who are at risk for HIV and link them to testing, treatment, and other services, and support them to stay on treatment once started. Established by and for community members, PLHIV clusters and support groups are trusted and well-equipped to identify people who are most vulnerable to HIV, many of whom are hidden due to stigma and other barriers. They also encourage enhanced adherence and retention on ART and promote referrals and linkages to clinical services and activities that socially and economically empower PLHIV.

CHSSP collaborated with the National Council of People Living with HIV and AIDS (NACOPHA) to strengthen the organizational and management capacity of the PLHIV clusters to support provision of HIV services and advocate for the rights of PLHIV. CHSSP also helped NACOPHA develop and finalize the PLHIV Cluster Management Handbook, which is used to manage and monitor PLHIV clusters throughout Tanzania.

CHSSP used a cascade approach to build capacity and train NACOPHA and district-level PLHIV clusters on management, supervision, resource mobilization, health promotion, and advocacy. In turn, they convey the training to ward-level PLHIV clusters and village-level PLHIV support groups. CHSSP also supported PLHIV clusters to establish a process for holding elections when leadership terms end. Seamless leadership transitions are important for ensuring that PLHIV clusters and support groups are able to fulfil their roles and responsibilities without disruption. The project also helped NACOPHA facilitate the formation of new PLHIV clusters at the district level.

BOX 5. RESULTS OF CHSSP SUPPORT FOR PLHIV CLUSTERS

The following are the results of CHSSP support:

- Clusters have the capacity to conduct quarterly action meetings on HIV prevalence rates, uptake of ART, and HIV-response-related policy updates.
- Clusters have the ability to make follow-up visits to members, who in turn help PLHIV support group members stay on treatment and become involved in income-generating activities.
- Clusters have strategies to strengthen relationships with council and district HIV and AIDS coordinators.
- Cluster leaders understand their roles and responsibilities and have the capacity to submit monthly reports to NACOPHA and local government entities.
- Clusters are able to conduct supportive supervision at all levels (e.g., ward-level clusters and PLHIV support groups).
- Clusters are able to write effective reports, document data accurately, maintain filing systems, form new clusters where needed, and create and implement action plans that identify and overcome challenges.
- NACOPHA has an updated directory of all PLHIV clusters and support groups. The directory maintains information including registration status, location, total membership disaggregated by sex, leadership contact information, and income-generating activities.
- NACOPHA has an updated directory that specifies IP location, contact details, and activities.

SUCCESS STORY

COMMUNITY GROUPS PROVIDE SUPPORT FOR VULNERABLE POPULATIONS

Living with HIV for 23 years, there are many challenges including feeling hopeless because of the inability to work and provide for your family due to stigma in the community," said **Jane Mwaliego** who resides in Arusha.

It is one of the many challenges she has faced since she became HIV-positive, but that quickly changed since the inception and support of JSI's Community Health and Social Welfare Systems Strengthening Program. One of the objectives of the project is to strengthen and revitalize existing community structures to provide better health and social welfare services to HIV-impacted populations, including structures like PLHIV clusters. The project, through NACOPHA, builds the capacity of these cadres to advocate for HIV testing and treatment at council level and ultimately contributing to end the epidemic in the country.

Jane became the chairperson of her local PLHIV cluster and she said it has become a source of comfort.

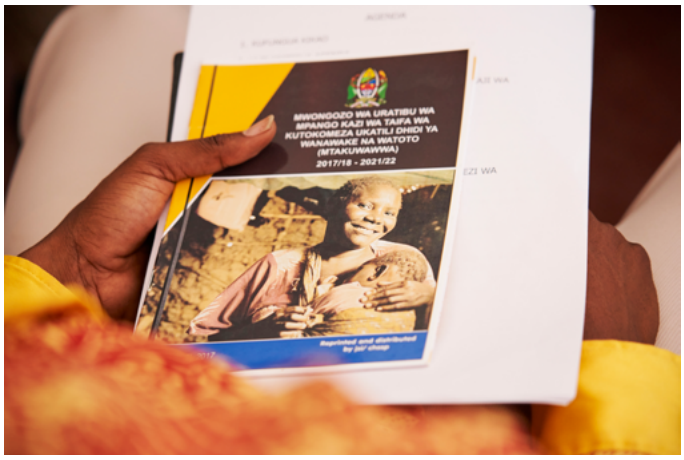
"To be in the group you have to be aware of your status. The group provides education and encourages all members to take their medication to improve their health, and they also ensure that every member consistently takes the medication and becomes virally suppressed."

The group also collectively pools together funds to generate savings and start their own income generating activities after receiving resource mobilization training by JSI. Jane said, "I have directly benefited from these groups through savings. I did not have the ability to do this before. I was able to get a loan to start a business. This has improved my financial status. For instance, I can get enough money to go get medication, money for food and for buying school uniforms for my children. Had I just stayed home, I would have been unable to save."

The group – one of 54 clusters supported by JSI in the country – has become a trusted community support group for many. Presently, though her leadership, the number of members have grown from 80 to 445 within a few years and she said it has changed her perspective on life: "The only way to deal with HIV-related challenges is to accept yourself. I have accepted my situation after being trained and enabled by JSI. I'm now aware that living with HIV is not the end of life."

"To be in the group you have to be aware of your status. The group provides education and encourages all members to take their medication to improve their health, and they also ensure that every member consistently takes the medication and becomes virally suppressed."

The VAWC committee in Chato DC is one of more than 280 committees revitalized by CHSSP works to advocate for the rights of children and women and increase awareness of GBV. Due to their activeness in the community, the committee has been able to increase the number of GBV cases within one quarter by almost double and have been able to refer those cases to the necessary services, including HIV testing. Photo by Erick Gibson for JSI.



The Government of Tanzania launched the National Plan of Action to End Violence against Women and Children of 2017-2022 (pictured). Following this launch, CHSSP, with the Government, established more than 280 violence against women and children committees at council and ward level, which have been able to link and refer more than 14,000 cases of violence against women and gender-based violence cases to appropriate services, including HIV testing. Photo by Erick Gibson for JSI.

Violence against Women and Children Prevention Committees

In 2017, the GOT launched the National Plan of Action to End Violence against Women and Children (NPA-VAWC). Recognizing the importance of an integrated HIV and GBV prevention and response to ensure that survivors of violence receive the full range of critical services, including HIV testing services and pre-exposure prophylaxis, **CHSSP supported the integration of NPA-VAWC coordinating structures** (VAWC prevention committees) into the NICMS. In addition, CHSSP, as one of several stakeholders responsible for establishing VAWC prevention committees in a defined geographical area,[4] enhanced the VAWC prevention orientation package to include linkages and referrals as outlined in the NICMS. This provided a clear pathway to link survivors of GBV to integrated comprehensive services including HIV, legal, counseling, social protection, and social welfare.

CHSSP trained 52 VAWC prevention committee master trainers who in turn established a total of 281 VAWC prevention committees in 52 councils and 229 wards.

[4] CHSSP was responsible for operationalizing the VAWC prevention committees in 52 PEPFAR high-priority councils.

BOX 6. SUPPORTIVE SUPERVISION OF VAWC PREVENTION COMMITTEES

CHSSP developed a council-level supportive supervision tool to monitor core VAWC prevention committee functions including:

- Composition of members per NPA-VAWC guidelines.
- Regular convening of quarterly meetings.
- Regular submission of quarterly reports to local government authorities (LGAs).
- Cascading of structures to ward and village levels by the council-level VAWC prevention committee.
- Supportive supervision visits by the council level to the ward and village VAWC prevention committees.

Data from the CHSSP supportive supervision visits in the councils indicated that of **52** councils in which VAWC prevention committees were established, **96** percent had appropriate composition; **82** percent had established lower-level VAWC prevention committees; **72** percent had conducted supportive supervision visits to lower-level VAWC prevention committees; and **60** percent were submitting regular reports to PO-RALG and other authorities.

COVID-19 RESPONSE TO SUPPORT THE GOVERNMENT

In January, the world witnessed the COVID-19 outbreak. The pandemic has wreaked havoc on every aspect of society, including but not limited to health, livelihoods and other socio-economic activities, education, culture, social services, and politics. In addition to its physical health scourge, COVID-19 has brought fear, anxiety, and other psychosocial maladies.

Psychosocial support (PSS) is a critical aspect of pandemic mitigation, so CHSSP shifted its scope of work accordingly. In collaboration with PO-RALG and MOHCDGEC, CHSSP developed a series of instructional videos and guides on COVID-19 and PSS, and distributed them to regional and council SWOs in 81 councils. CHSSP developed a PSS instructional guide and provided training to SWOs, CSO representatives, and CCW supervisors, and oriented CCWs on PSS. Training materials included a PSS assessment tool, a COVID-19 care plan, a PSS service provision form, and PSS training PowerPoint presentations prepared and facilitated by PO-RALG.

BOX 7. SUPPORT PROVIDED TO THE GOVERNMENT ON PSYCHOSOCIAL SUPPORT:

- Conducted PSS training for **438 SWOs** and CSO representatives in 81 councils.
- Conducted PSS training for **1,358 CCW** supervisors.
- Oriented **4,191 CCWs** to PSS.
- Printed and distributed **5,372 simplified PSS orientation guides** for CCWs in **22 councils**.

ANNEX 1: EVOLVING SCOPE OF CHSSP

For the first year of the program (November 2014–December 2015), CHSSP included four partners: JSI; National Association of Social Workers (NASW); WEI; and Initiatives, Inc. During this iteration of the program, geographic focus was in 10 regions covering all councils and had a strong focus on the Community Based Health Program (CBHP) and the development of standardized community health worker (CHW) training.

The second phase of the program (December 2015–May 2017) included three partners: JSI, WEI, and Initiatives Inc., and the geographic focus shifted to 42 councils in PEPFAR-defined scale-up districts. Work with the CBHP and CCWs continued, but with the removal of NASW as the program no longer supported the Tanzania Association of Social Workers or Association of Schools of Social Work in Tanzania (ASSWOT). In this phase, CHSSP capacity-building support for CSOs was initiated.

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Sarah John, a community development officer in the Shinyanga region of Tanzania, discusses sustainable HIV strategies in her community during a multi-sectoral AIDS committee meeting, which has been revitalized through the support of CHSSP. With capacity building training that the program has provided to the committee, Sarah is a change maker in her community as she managed to educate 25 groups of adolescent girls on HIV/AIDS and encouraging them to get tested to know their status and enrolling them into "clubs for children" to teach them how to handle stigma and discrimination. Photo by Erick Gibson for JSI.

BOX 8. CHSSP SUPPORTED THE CBHP IMPLEMENTATION DESIGN AND TRAINING OF CHWs FROM PY1 TO PY3

Community health workers are essential to expanding access to essential health services. In 2014, the MOHCDGEC developed the CBHP Policy Guidelines, which called for the creation of a salaried CHW cadre. Following the policy development, the government drafted a National CBHP Strategic Plan 2015–2020 and a CHW training curriculum. However, the program soon faced challenges because questions remained about how to implement the CHW program, the services CHWs would provide, and how responsibilities for community health service delivery and management would be scaled in Tanzania's decentralized health system. A clear program implementation design was needed to bring the new cadre and associated community health interventions to fruition.

In response, CHSSP provided technical and financial support to the MOHCDGEC Health Promotion Services (HPS) Unit to develop the CBHP implementation design. CHSSP and HPS implemented an approach founded on: 1) fostering strong government ownership through consultation, input, and review of representatives from a broad range of government departments; 2) using human-centered design to ensure the needs of communities and districts were reflected in the design; and 3) providing professional resources and high-quality technical support to facilitate consultations and document development. The process resulted in an approved design, signed on March 29, 2017, that was widely accepted by all stakeholders. Following the signing of the document, CHSSP helped HPS orient 30 regional CBHP coordinators and 61 district CBHP coordinators to recruit CHWs, support their training, ensure effective village participation in CHW selection, integrate CHW data into the health management information system, and implement the CHW program. Between October 2017 and September 2018, CHSSP also sponsored 229 CHW students from 16 PEPFAR priority councils who graduated from the program and were deployed in their respective districts.

ANNEX 2: ANNUAL PROGRAM ACHIEVEMENTS

YEAR	ACHIEVEMENT
2014/2015	Program set up
	Prepared CHW program design
	Reviewed MAC guideline and curriculum
2015/2016	Finalized MAC guideline and curriculum
	Printed 1,200 copies of MAC guideline
	Printed 500 copies of the National Multi-Sectoral Framework 2014–2018
	Oriented 22 council MACs to MAC guideline
	Oriented 70 ward MACs and 56 village MACs to MAC guideline
	Disseminated the National Gender Operational Plan (GOP) for HIV Response 2016–2018 in 15 councils
	Introduced community collaborative model in 2 councils (Ilala and Kyela)
	Revised training package for MVC committees to include HIV
	Revitalized MVC committees in 10 councils
	Oriented district SWO in 25 councils on roles and responsibilities
	Trained 2,542 para-social workers and 432 para-social worker supervisors in 14 councils
	Finalized CBHP program design
	Oriented council health management teams (CHMTs) in 20 councils to CBHP program design and policy guideline
	Oriented 67 CBHP coordinators in 12 councils to CBHP program design and policy guideline
	Developed CHW training materials
	Sponsored training for 229 CHWs
	Orientated CHMTs to the formation of ward health committees in 14 councils
	Strengthened the organizational and managerial capacity of 6 CSOs to contribute more effectively to linkages and referrals along the continuum of the HIV response
	Conducted capacity assessment of 15 PLHIV clusters

2016/2017	Revised MVC identification guideline
	Developed National Guideline for Early Identification and Intervention for Children with Disabilities
	Disseminated the National GOP for HIV Response 2016–2018 in Tanzania
	Disseminated National Multi-Sectoral HIV & AIDS Stigma and Discrimination Reduction Strategy 2013–2017
	Developed HIV-sensitive NICMS
	Developed NICMS training materials and data collection/reporting tools
	Trained 15 NICMS national facilitators
	Trained 449 district master trainers from 84 councils on NICMS
	Trained 14,293 CCWs and 1,267 CCW supervisors from 68 councils on NICMS
	Trained 1,737 lead CCWs and 304 CCW supervisors from 10 councils on NICMS
	Revitalized 32 council MACs, 160 ward MACs, and 800 village MACs
	Revitalized 21 council MVC committees, 24 ward MVC committees, and 100 village MVC committees
	Trained 50 CSOs on financial management and Quickbooks software
	Installed Quickbooks software for 11 CSOs
	Trained 30 CSOs on resource mobilization
	Adopted and revised organizational capacity assessment (OCA) tool
	Conducted OCA for 8 CSOs
2017/2018	NICMS Framework approved by GOT
	HIV-sensitive CCW training manual approved by GOT
	CCW practical handbook approved by GOT
	Printed and handed over NICMS data collection forms (set of 9 tools) to GOT
	Procured and disseminated NICMS working tools, 777 bicycles, and 772 file cabinets in 79 councils
	Disseminated 62,027 NICMS-branded materials (T-shirts, bags, ID holders, and caps) in 79 councils
	Incorporated NICMS into NPA- VAWC training materials
	Trained 52 NPA-VAWC master trainers from 26 regions
	Established and trained council VAWC prevention committees in 52 councils
	Translated, printed, and disseminated 540 copies of the Swahili version of the National GOP for HIV Response 2016–2018 to 54 councils
	Translated, printed and disseminated 1,000 copies of the Swahili version of the MAC guideline in 54 councils

	Translated and printed 1,000 copies of the Swahili version of MAC curriculum in 54 councils
	Trained 10 national MAC curriculum trainers
	Trained 292 trainers in 54 councils on MAC curriculum
	Conducted "data demand and use" sessions for 292 people in 54 councils
	Trained 292 ward MAC members from 54 councils on resource mobilization
	Conducted OCA assessments with 41 CSOs
	Provided resource mobilization training to 54 PLHIV clusters
2018/2019	Developed content on GBV and adolescent-friendly reproductive health services and incorporated it into NICMS training manual
	Trained 111 district master trainers on NICMS
	Trained 2,655 CCWs and 675 CCW supervisors on NICS
	Developed 6 instructional videos on NICMS for CCWs to improve case management documentation
	Developed tool for district capacity assessments and conducted assessments in 32 councils
	Developed the CCSWOP guide
	Distributed 3,068 copies of the NICMS Form 3 in 79 councils
	Established and oriented of 229 ward VAWC prevention committees to NICMS
	Established/revitalized 52 council MACs and 283 ward MACs
	Conducted supportive supervision in 106 council MACs
	Printed and disseminated 1,000 copies of the MAC guidelines in 52 councils
	Built the capacity of 49 CSOs according to OCA action plans
	Conducted NUPAS assessment with 5 CSOs
	Developed and disseminated cluster management handbook in 81 clusters in collaboration with NACOPHA
2019/2020	Distributed 33,666 copies of NICMS data collection tools in 81 councils
	Distributed 678 file cabinets in 81 councils
	Distributed branded materials to CCWs (3,287 t-shirts, 859 caps, 611 bags, and 449 ID holders)
	Built capacity of 3 councils based on assessment results
	Developed PSS training videos

	Trained 438 SWOs and CSO representatives in 81 councils on PSS
	Trained 1,345 CCW supervisors in 81 councils on PSS
	Oriented 4,191 CCWs in 22 councils to PSS and COVID-19
	Distributed 5,372 copies of simplified PSS orientation guide to CCWs in 22 councils
	Orientation and installation of QuickBooks to 7 CSOs
	Conducted mock NUPAS to 7 CSO
	Built the capacity of 49 CSOs based on OCA action plans
	Distributed branded materials to PLHIV clusters (65 caps and T-shirts)
	Distributed 70 filing cabinets to 70 PLHIV clusters
	Reviewed CPHP and operational guideline to incorporate the social welfare component and NICMS
	Printed and distributed 1,000 copies of the 2014 MAC guideline to 244 wards and 727 villages
	Introduced and mentored 5 clusters on “Konga Bora” (i.e., Best PLHIV Cluster initiative)
	Distributed 252 copies of MAC guideline in 7 councils

ANNEX 3: TOOLS AND GUIDELINES DEVELOPED

YEAR	GUIDELINE/TOOLS
2015/2016	MAC guideline and curriculum
	CBHP program design
2016/2017	**CHW tools:**
	CHW facilitator's guide
	CHW practicum guide
	CHW supervision guidelines
	Student manual
	Assessment plan
	Practicum procedure book
	Job aids on case management
	NICMS Framework
	NICMS training package materials and data collection/reporting tools:
	CCW Training Manual
	CCW Practical Handbook
	NICMS Tools:
	National MVC Registration Form (Form 1)
	Screening and Enrollment Assessment Form
	Care Plan Form
	HIV Risk and Assessment Form
	National MVC Monthly Summary Form (Form 3)
	National MVC Referral Form (Form 6)
	Case Closure Form
	National MVC Monthly Service Tracking Register Form (Form 2)
2017/2018	Translated, printed, and disseminated Swahili version of National GOP
	Translated, printed, and disseminated Swahili MAC guideline
2018/2019	Translated and printed Swahili version of MAC curriculum
	PLHIV cluster management handbook
2019/2020	PSS training package for COVID-19

ANNEX 4: CHALLENGES AND RECOMMENDATIONS PER COMPONENT

While CHSSP's mandate, partners, and geographical focus shifted over the six years of the program, it leaves behind many important nationally recognized policies and programs. It is imperative that national and local governments, donors, and IPs work to strengthen and scale CHSSP's achievements. Below is a list of the challenges that CHSSP encountered, by area, and recommendations for overcoming them.

SOCIAL WELFARE	
Challenge	**Recommendation**
There is a high risk of CCW dropouts in the absence of NICMS implementing partners supporting CCW daily tasks.	GOT should monitor use of CCWs by other partners and ensure adherence to community-based health and social welfare operational guidelines, and provide CCWs with a career path/educational opportunities and non-monetary incentives.
There is a need for the social welfare system to rely on additional volunteers who cannot be absorbed by the government employment criteria.	GOT should develop criteria for volunteers and ensure that the CBHP policy and guidelines are strictly followed.
Some councils are reluctant or don't allocate funding for printing the tools that are necessary for NICMS implementation.	Increase advocacy for council management teams to allocate resources for social welfare services. The government through the district social welfare officer (DSWO) at the council level should allocate a budget to cover NICMS activities.
There are not enough SWOs at lower levels (ward and village) to respond to the CCW assignments.	Develop and maintain a database of trained CCWs and their supervisors that other MVC/OVC programs can use to provide services. The government should encourage revisions of scheme of service for social welfare cadres to include social welfare assistance.
Extension officers at ward level who trained as CCW supervisors are over-stretched because they have duties in addition to their assigned NICMS roles.	Hire more social welfare staff at council and ward levels.

Most Vulnerable Children - Management Information System (MVC-MIS) is not optimally used for decision making.	The Council Health Management Information System focal person should be the council custodian of the data and engaged in uploading data into the MVC-MIS. • Train DSWOs to analyze data and use the MVC-MIS for decision-making. • DSWOs should ensure data/reports from MVC-MIS are presented during CHMT meetings. • Each council should fill gaps identified by data quality assessment.
Council Comprehensive Social Welfare Operational Planning Guide	
Challenge	**Recommendation**
CCSWOP guide implementation has not been scaled.	Develop and finalize the CCSWOP guide implementation strategy. The government should roll out the plan across all councils to facilitate planning for social welfare activities.
SWOs lack skills on advocacy and resources mobilization.	The government should provide training and mentorship to build the capacity of SWOs on advocacy and resource mobilization.
Decisionmakers lack knowledge of social welfare issues.	Orient decisionmakers to social welfare issues.
Because social welfare activities cut across many sectors, it is difficult for SWOs to obtain an adequate (or any) budget from the council's own source.	SWOs should advocate the importance of implementing CCSWOP and social welfare activities to decisionmakers.
People don't know how to use the new social welfare planning and reporting tools.	Councils should provide training and mentorship on use of tools.
Social welfare interventions that are planned and implemented in other sectors, like education, needs to be coordinated and monitored.	Full implementation of CCSWOP will ensure coordinated social welfare interventions across all sectors.

VIOLENCE AGAINST WOMEN AND CHILDREN PREVENTION COMMITTEES	
Challenge	**Recommendation**
Competing priorities on the available council budget hinder implementation of NPA-VAWC from the council to village level.	The government should recognize the NPA-VAWC as a standing committee to ensure budget allocation at council level. Give committees skills to mobilize local resources.
VAWC prevention committees at village level are not fully functioning.	Councils should revitalize the VAWC prevention committees, particularly at village level, and monitor and ensure their functionality. Councils should allocate a budget to support VAWC prevention committee quarterly meetings at council, ward, and village levels.
NPA-VAWC does not include all non-protection measures.	The government should revise the NPA-VAWC (2017/18–2021/22) to accommodate other non-protection interventions for MVC/OVC.
NPA-VAWC reporting tools to gather data/information from village level do not exist.	The government should develop NPA-VAWC reporting tools to gather data/information from village level.
Case management referral system is not functioning well.	The national and local government should strengthen the case management referral system to capture cases at all levels.
PLHIV Clusters	
Challenge	**Recommendation**
Most PLHIV clusters do not have office premises within the councils, which makes it difficult for them to coordinate and implement activities.	Encourage councils to offer space to PLHIV clusters.
PLHIV clusters are not using all council-level resources.	Council HIV/AIDS coordinators should link PLHIV clusters with other partners within the council to access resource and skills support and continue to implement PSS and stigma-reduction activities at community level to increase testing, ART uptake, viral suppression, and retention among PLHIV.

Although PLHIV clusters are recognized at council level, councils do not directly support them and they have no allocated budget to execute activities.	PLHIV clusters should continue to work with council HIV/AIDS coordinators and get funding to initiate and support income-generation and economic-strengthening activities with PLHIV support groups.
CIVIL SOCIETY ORGANIZATIONS	
Lesson	**Recommendation**
CSOs depend on funds from donors and lack resources to operationalize strategies.	Provide CSOs with further resource mobilization capacity-building sessions.
Some CSOs have weak leadership.	Donors/IPs should strengthen CSO leadership capacity through mentorship and collaboration with other CSOs.
CSOs lack funding to support marketing and documentation activities.	Donors/IPs should ensure CSO budgets and plans for marketing and documentation activities.
Most CSOs lack technical capacity in different areas like human resources, program management, and financial management.	Donors/IPs should build the overall organizational capacity of CSOs based on gaps identified through organizational capacity assessments.
There is a lack of coordination between CSOs and LGAs.	Strengthen coordination mechanisms for all CSOs within councils and ensure linkage with other systems (health, education, social welfare, etc.).
CSOs are not involved in council-level planning and implementation.	CSOs should share their plans with councils and councils should help them coordinate strategy planning and execution.
MULTI-SECTORAL AIDS COMMITTEES	
Lesson	**Recommendation**
There is no formal orientation plan for new MAC members.	MACs should develop standard orientation materials for all new members.
Councils do not directly support ward and village MACs.	MACs should advocate for councils to include ward- and village-level activities in council budgets.
High turnover of MAC members at all levels due to frequent government transfers, title changes, and other political and social reasons hinders consistency in implementation of HIV prevention and response efforts.	Advocate for minimum MAC tenures and increase awareness of MAC function and role in Tanzania's HIV response.

Resource constraints hinder MAC functions, including regular meetings and activities.	Continue to build the capacity of MACs to mobilize resources and conduct economic strengthening activities and quarterly meetings, and implement activities.
MAC activities are not fully coordinated with health facility activities.	Continue to strengthen coordination between MACs and health facilities to implement HIV activities in order to increase the availability of data.
IP COORDINATION	
Lesson	**Recommendation**
Some councils lack IPs because some organizations do not implement activities in far/remote areas.	The government should locate IPs across all regions, including remote areas to avoid saturation of partners in centrally located/urban areas. Councils should invite all partners that serve in a particular council to attend IP meetings, even if they don't implement their interventions in the council.
IPs do not include gender awareness/ activities in their programming.	IPs should strengthen coordination of gender issues at council level by emphasizing gender challenges in council plans.

ANNEX 5: LIST OF ALL PRESENTATIONS/ CONFERENCES AT WHICH CHSSP PRESENTED

CONFERENCE NAME	TOPIC	TYPE OF PRESENTATION
The African Regional Child Trauma Conference	Strengthening Protection of Women and Children through NICMS: A Case of Selected Councils in Mainland Tanzania	Oral
American Public Health Association (APHA) 2018	Revitalizing MACs in achieving the PEPFAR 3.0	Poster
APHA 2019	Capacitating MACs to Improve the HIV Response in Tanzania	Poster
Third Annual M&E Best Practice Conference - Mzumbe University	Routine data use for planning and evidence-based decision-making highlights the impact of gender responsive programming	Oral
Stakeholders Dissemination Conference on HIV and AIDS in Tanzania: Achieving and Sustaining HIV Control in Tanzania	NICMS	Oral
ICASA Conference 2017	Capacitating MACs to Give Voice to Most Vulnerable Children and People Living with HIV in Tanzania	Poster

ANNEX 6: LIST OF TOOLS AND RESOURCES DEVELOPED BY CHSSP

Resources for Community Case Workers (NICMS)

- Technical Brief: Designing an HIV Case Management Systems for Vulnerable Children
- CCW Training Manual (Swahili)
- CCW Practical Handbook (Swahili)
- NICMS Framework (English)
- MVC Identification Guideline (English)

Data collection and reporting tools

- National MVC Registration Form (Form 1)
- Screening and Enrollment Assessment Form
- Care Plan Form
- HIV Risk and Assessment Form
- National MVC Monthly Summary Form (Form 3)
- National MVC Referral Form (Form 6)
- Case Closure Form
- National MVC Monthly Service Tracking Register Form (Form 2)
- National MVC Registration Form (Form 1) - Zanzibar
- National MVC Monthly Service Tracking Register Form (Form 2) - Zanzibar
- National MVC Monthly Summary Form (Form 3) - Zanzibar
- National MVC Referral Form (Form 6) - Zanzibar
- HIV Risk and Assessment Form - Zanzibar
- Case Closure Form - Zanzibar

Job aids

- Child assessment tool (Swahili)
- Bi-directional referrals for HIV services (Swahili)
- Case management job aid (Swahili)
- General health and social services referrals (Swahili)
- MUAC tape (Swahili)
- Responding to cases of abuse-neglect (Swahili)

Videos and supplementing documents

- NICMS instructional videos - Overview & Facilitation Guide
- Instructional Video 1 - National MVC Registration Form (Form 1)
- Instructional Video 2 - Care Plan Form
- Instructional Video 3 - National MVC Monthly Summary Form (Form 3)
- Instructional Video 4 - National MVC Referral Form (Form 6)
- Instructional Video 5 - Case Closure Form
- Instructional Video 6 - National MVC Monthly Service Tracking Register Form (Form 2)

PSS Training Resources

- Care Plan Tool for CCWs
- Training video package
- Training presentations by PO-RALG
- PSS assessment tool for CCWs

  PSS service provision form for CCWs

PLHIV Cluster Resources

- Technical Brief: Strengthening Community Structures - People Living with HIV Clusters
- PLHIV Cluster Management Handbook

CSO Resources

- Technical Brief: Strengthening the Capacity of Civil Society Organizations
- Organizational Capacity Assessment report 1
- Organizational Capacity Assessment report 2

MAC Resources

- Technical Brief: Strengthening Community Structures - Multi-sectoral AIDS Committees

CHSSP Resources

- CHSSP Fact Sheet
- CHSSP Booklet

Videos

- Overview of the Community Health and Social Welfare Systems Strengthening Program
- Eradicating HIV in Tanzania through Community AIDS Committees
- Connecting HIV+ Communities to Support Groups in Tanzania
- Connecting Vulnerable Children to Health Services: One Case Worker's Story
- The National Integrated Case Management System Overview
- VAWC Committee Impact
- Abdallah's Story: How One Child's Life Changed with Support from a Case Worker
- Ensuring the Health of HIV Positive Community Members
- Fatuma's Story: How One Case Worker Linked a Family to Live-Saving Services

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