CHRISTIAN SOCIAL SERVICES COMMISSION (CSSC)

MALARIA COMMUNITIES PROGRAM-MCP

ANNUAL PERFORMANCE REPORT, 2008

List of Acronyms

ACT	Artemisinine-based Combination Therapy
ADDOs	Accredited Drug Dispensing Outlets
ANC	AnteNatal Care
ALu	Artemether 20mg/Lumefantrine 120mg
CCHP	Comprehensive Council Health Plan
CDC PMI	Center for Disease Control
CDD	Consultancy and Development Division
CHMT	Council Health Management Team
CHW	Community Health Worker
CORPs	Community Own Resource Persons
CSSC	Christian Social Services Commission
DMO	District Medical Officer
DNO	District Nursing Officer
DOT	Directly Observed Treatment
DRCHC	District Reproductive & Child Health Coordinator
FANC	Focused Antenatal Care
HMIS	Health Management Information Systems
IPT	Intermittent Presumptive Treatment
IPTp	Intermittent Presumptive Treatment of Malaria in Pregnancy
IEC	Information, Education, Communication
ITN	Insecticide Treated Bed Net
IRS	Indoor Residual Spraying
IMA WH	Interchurch Medical Assistance World Health
JHU COMMIT	John Hopkins University Communication Information in Tanzania
MEDA	Mennonite Development Agency
MIP	Malaria in Pregnancy
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
NACP	National AIDS Control Program
PMI	President's Malaria Initiative
PNFP	Private Not for Profit
PSI	Population Services International
QI	Quality Improvement
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
SP	Sulfadoxine- Pyrimethamine
TFDA	Tanzania Food and Drugs Authority

A. The main accomplishments

CSSC-MCP first year of program implementation, 450 people were trained / oriented in malaria prevention and control. The project worked in two districts with public (government and faith based organizations) as well as private health care providers, religious and community leaders of Mbinga district and Songea Rural district in Ruvuma region, the southern part of the United Republic of Tanzania.

Currently 48 (100%) of health facilities in Songea district and 44 (64%) in Mbinga District have at least one health care provider trained in FANC. Rural communities' engagement in malaria activities has steadily increased; MCP has oriented over 190 Accredited Drug Dispensing Outlets (ADDOs) and Community Health Workers (CHWs). The ADDO Dispensers are now actively managing non-severe malaria using ACTs. Both groups are providing malaria prevention messages. All 144 trained health facilities in the two districts are equipped with latest malaria guidelines[1], IEC materials, providing malaria intervention-ITN Vouchers, SP for IPTp and ACT (ALu) as the first line course for treating non-severe malaria.

S/No	Activity	Target Group	Areas of Training/capacity Building	Targeted Number	Numbers Reached
1.	FANC[2] Training	Frontline Health care providers in ANC[3] Clinics	Health education on malaria prevention, IPTp[4] and Case Management	50 health care providers from 20 Health facilities	51 health care providers from 50 Health facilities
2.	Malaria Advocacy Meetings	Community leaders (religious and village leaders), women groups and health facility owners	• Advocacy for uptake of malaria prevention interventions	200	205
3.	Refresher training on Malaria	ADDOs[5] and CHWs[6]	• Malaria control including Malaria signs and symptoms recognition • Accurate treatment • Prevention strategies (IPTp and ITN)	200	193
	Total Trained				**449**

[1] Ministry of Health and Social Welfare, *National Guidelines for Malaria Diagnosis and Treatment, 2006,* NMCP 2006.
[2] FANC=Focused Antenatal Care
[3] ANC=Antenatal Care
[4] Intermittent preventive treatment of malaria in pregnancy
[5] ADDOs= Accredited Drug Dispensing Outlets
[6] CHWs= Community Health Worker

Capacity building:

During the year under review, CSSC-MCP planned four activities that directly addressed objective one of the programme. The focus was to strengthen the capacity of health care providers (public, PNFP, CHWs, etc.) in project targeted districts to implement effective malaria control interventions.

Baseline Survey and Mapping was conducted to collect detailed demographic and health data and established the baseline indicators for the programme. This activity identified stakeholders/partners, other resources, prioritised areas for capacity building and established baseline programme indicators. In the course of carrying out the activity, the team imparted the surveying skills to the district stakeholders as well as the CSSC-MCP team. As far as the mapping is concerned, CSSC and the MoHSW have collaborated for the past several years on the creation of a Mapping Task Team with a signed Memorandum of Understanding (MoU). Data collected from the baseline survey is incorporated into already existing and expandable map values and created essential tools for the management of this program.

Two **Focused Antenatal Care (FANC) Trainings** took place during the year under review, the aim of these trainings were to build capacity in integrating malaria intervention strategies in RCH provision. A total of six trainers were identified and utilized to conduct trainings in the two programme districts. A total of 50 health facilities (25 each district) provided 51 RCH health care providers for the trainings. In Songea rural district FANC-trained coverage is 100% while in Mbinga district coverage is at 60%. The programme trained 59.5% (25/41) of health facilities in Songea Rural compared to the original planning of reaching 6/41 or 14.6%. In Mbinga, the training covered 36.8% (25/68) of health facilities. Original plans were to reach only 14/68 or 20.6%.

The CSSC-MCP at community level has embarked into **Public Private Partnership (PPP)** where dispensers from every ADDO in the two operational districts were brought together into a working relationship with the CHWs and these cadres received five refresher trainings on malaria control in programme districts. Both of these groups are in the closest proximity to the community in health care provision. The aim is to continuously revitalize and consistently merge their efforts in malaria intervention strategies at the community level. A total of 193 dispensers and CHWs (65% females and 35%males) were trained. In Songea rural district, all the villages were covered while in Mbinga district the programme covered all wards.

Focused Collaboration with PMI partners and other in-country collaborators such as NMCP, MSH, TFDA, IMA WH and JHU COMMIT on capacity-building efforts throughout the first year of the program have been recorded.

Advocacy:

As malaria remains one of the major threats to the life and livelihoods of people throughout the rural areas of this programme, advocating for prompt treatment, uptake of SP for IPTp by pregnant women and a greater expansion of the availability of ITNs and ACTs has been an essential feature of the CSSC-MCP approach in the first year of operation. In the first year districts (Songea Rural and Mbinga), the programme has held advocacy workshops with a wide variety of community and religious leaders and other stakeholders including women groups, local NGOs and CBOs, CORPs as well as health facility owners. Their existence in the communities and aspiration to understand better the causes, treatment and prevention of malaria and the turnout of over 200 people in the categories noted above achieved more than 100% of the targeted number of participants.

Coordination:

Coordination of this programme took place on two levels: first level - among the district health officers and other relevant personnel who have a very important role to play at the higher level of decision-making, especially in terms of encouraging collaboration and partnership; and the second level - among a wide variety of community actors and stakeholders including ADDOs, CHWs, CORPs and the ever-expanding community-based civil-society organizations which are increasingly having an impact on Tanzanian community life. The programme reached its targeted goals for numbers of stakeholders involved in this primary and essential work of coordination; participants were encouraged to see these workshops and seminars as forums to discuss the best practices and opportunities that exist within themselves. In addition, stakeholders were further encouraged to identify the gaps and challenges that are present in the roll-out of the programme and to delineate strategies to meet these obstacles in the years to come.

Uptake of Malaria Interventions and Behaviour Change Communication:

Change in behavior does not come overnight. The evaluation of the first year programme has shown that community members have been paying attention to their religious leaders and community workers and that there is a greater understanding of the importance of integrating approaches to malaria, especially for the all important twin categories of pregnant women and children below the age of five years. The messages focuses on increasing ITN use and net re-treatment campaigns, early ANC attendance and uptake of SP for IPTp, and recognition of malaria danger signs and symptoms and prompt health seeking behavior and correct treatment with ACTs.

Other PMI partners (such as NMCP, JHU COMMIT, JHPIEGO ACCESS, MEDA and World Vision) have developed wide varieties of excellent information, education and communication materials which were created in partnership with community stakeholders. Rather than duplicate these efforts, the programme has actively sought to acquire these materials from PMI partners and has distributed a total of 15,314 assorted malaria IEC materials throughout the operational area.

Local traditional entertainers have been mobilized and some malaria interventions messages have been imparted to them. These groups are continuing to spread the malaria intervention messages within the communities. Together with their verbal messages, IEC materials are also being disseminated by them.

Quality Assurance and Improvement:

The CSSC-MCP is using the FANC platform in addressing malaria, both at facility and community levels. Using the baseline survey findings, areas for capacity building were identified and prioritized. In collaboration with the district authorities within the programme area, health workers as well as community health workers whose areas for capacity building were earmarked by the programme were selected using the district database and criteria. They were further grouped, trained and or received refresher trainings on malaria control interventions using the nationally approved training materials and guidelines.

The FANC training encompasses elements of ANC quality improvement in aspects of infection prevention and control as well as client flow. Trainings of frontline health workers in provision of RCHs were conducted using the national materials that were developed by RCHS in collaboration with JHPIEGO ACCESS Tanzania.

Within the training materials, there are also ANC essential equipment and supplies lists, forms for ordering and supplying the ANC materials as well as for client care, record keeping and reporting formats. Moreover, there are self-assessment and client feedback forms. All trainings have both pre and post test questionnaires. There is an ANC performance assessment and quality improvement (QI) tool with a set of 41 performance standards.

These FANC trainings were conducted by national trainers that were trained using the Trainer of Trainers FANC materials. The majority are based at district level. Two trainings were conducted with a total of 51 RCH health care providers trained.

The ADDOs dispensers and CHWs were grouped together for the first time and their knowledge on malaria control interventions updated. Justification for bringing them together was based on their proximity to the community that they serve. Having no refresher training materials for this group, a technical working group (TWG) was established to guide the process of developing the materials and testing them before use with CHWs and ADDOs.

The TWG consists of technical capable individuals from organizations that had worked before with the targeted groups or had a policy understanding of malaria training. The members of the TWG represented the NMCP, MSH, TFDA, IMA World Health and coordinated by CSSC-MCP.

At district level, an orientation to the developed materials was made to Malaria Focal Persons and District Pharmacists. Thereafter, these were trainers of the refresher trainings. All the trainings were conducted under the observation of a member from RHMT. A total of five refresher trainings were conducted and each of the training had a pre- and post-test.

Sustainability:

Planning of CSSC-MCP activities has been based on and aimed at complementing the national efforts to fight malaria. The implementation of CSSC-MCP activities started with a formal introduction of the CSSC-MCP to the MoHSW, the NMCP and the in-country PMI team. While this was found to be an appropriate step in introducing the programme officially to the policy makers (MoHSW and NMCP), it also gave us an opportunity to provide feedback after their support during the proposal writing phase.

CSSC being a MoHSW strategic partner, the Chief Medical Officer, Dr Deo Mtasiwa shared his views that the planned programme could be expanded to an entire region for the purpose of ensuring verifiable impact, rather than having only two districts of Mbinga and Songea rural in Ruvuma region for year one. This was observed following the fact that in year two, CSSC-MCP was already going to shift its focus to other regions while maintaining just the previous two districts (out of five total) in Ruvuma region. On a very positive note, contact with PMI partners allowed the CSSC-MCP to familiarize itself with the local situation and enlist collaborators easily.

Similarly, the CSSC-MCP made a protocol visit to year-one programme districts of Mbinga and Songea Rural in Ruvuma region. This trip allowed the team members to introduce the MCP to the CSSC stakeholders. The stakeholders included the Regional and District Authorities and Religious Authorities in the region. The team also managed to analyze the presented needs of the programme districts which were articulated in detail by the baseline survey.

Joint organization and execution of all activities such as training, advocacy and coordination workshops as well as supportive supervisions took place under the guidance of district authorities; the CHMTs. Indeed, the authorization and guidance of the RHMT facilitated our enhanced collaborations and access to both districts. In all forums, the programme used strategies advocated for by the NMCP and the National Malaria Operational Plan. The advocacy meetings, FANC trainings as well as refresher trainings for ADDOs and CHWs have integrated IPTp, ITNs and ACTs.

Active community human resources such as ADDOs, CHWs and their village leaders were engaged in meetings and refresher trainings. The CSSC-MCP involved key stake holders at national, regional, district, sub-districts and household levels in particular, to ensure local ownership of the project. Activities that are geared towards changing of community behavior like prompt care-seeking and recognition of early signs and symptoms are going to remain within the community as acquired new knowledge and skills within the household have been imparted to relevant groups.

Status Matrix

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
Objective 1: Strengthen the capacity of health care providers (public, PNFP, CHWs, etc.) in project target districts to implement effective malaria prevention and control interventions				
	29.8% (34/114) of health facilities, programs and personnel data gathered and analyzed from the mapping exercise and the baseline survey Nine personnel categories[7] identified and their needs for orientation and/ or training # and type of district level resources identified	**1. Conduct mapping and baseline survey to identify and gather information about the various stakeholders in the programme districts**	1. Baseline survey conducted and existing mapping data updated Baseline survey report completed Updated mapping data in place	
	Fifty-one FANC providers and 46% (50/109) health facilities' providing RCH services trained in FANC/MIP (including	**2. Identify ACCESS Trainers within the Project areas and utilize their skills for**	2. ACCESS trained trainers identified. Three trainers in Songea and	There were more than the needed trainers identified. The identified trainers

[7] Categories include Clinical Officers, Qualified Nurses, Maternal and Child Health Aide (MCHA) for FANC Training, ADDO Dispensers and Community Health Workers for Malaria Refresher Course and Religious and Community Leaders, Women Groups, Community Owned Resource Persons and Civil Society Oranisations for Advocacy and Sensitization on Malaria.

Project objectives	Indicators (include current measurement or result)	Key Activities (as	Status of Activities (including outputs)	Comments
	counseling pregnant women on ITN use, taking SP for IPTp, and malaria treatment with ACTs for under fives) 59.5% (25/41) of Health Facilities in Songea Rural have received FANC training (Planned 6/41 or 14.6%) 36.8% (25/68) of Health Facilities in Mbinga have been trained on FANC (Planned 14/68 or 20.6%)	**the planned FANC/MIP Training in the two project districts.** **3. Conduct district based FANC/MIP training for front line health care workers within the project districts**	two trainers in Mbinga. **3.** Two FANC Trainings conducted to a total of 51 frontline RCH service providers	worked together with one National trainer. Some of the trainers in Songea rural also were used to train in Mbinga district. Currently 100% of Health Facilities in Songea Rural have received FANC training and 60% of Health Facilities in Mbinga have been trained on FANC
	One hundred and ninety three (193) CHWs/ADDOs Oriented/ trained on Malaria interventions particularly ITNs, ACTs and IPTp in Mbinga and Songea Rural Districts	**4.** Empower local partners working on malaria through training of CHWs and ADDOs on correct identification of malaria signs and symptoms, malaria in pregnancy and home-based management of fever for children under five years of age.	**4.** Two trainings for ADDOs and CHWs were conducted in Songea rural and three in Mbinga district. These reached 193 local partners working on malaria.	

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
Objective 2: ***Empower and mobilize key stakeholders (religious and community leaders, health leaders and facility owners, CHMTs, etc.) to sensitize and advocate to community members for correct usage and adoption of ACTs, ITNs and IPTp.***				
	Thirty five (35) facility owners reached for advocacy and sensitized on ITNs, ACTs and IPTp	**5. Conduct advocacy and sensitization meetings for Public (government and FBO) and private health facility owners**.	One advocacy meeting for Facility Owners from Mbinga and Songea Rural districts; reached 35 people, (i.e. 87.5%, (35/40)	All facilities (42 in Songea Rural and 73 in Mbinga are providing Malaria interventions that include Health Education, ITN vouchers, SP for IPTp and Treat malaria using ACTs)
	Eighty (80) Religious and Community Leaders advocated and sensitized on malaria interventions, i.e. ITNs, ACTs and IPTp.	**6. Conduct advocacy and sensitization meetings for Religious and Local Community Leaders.**	Two advocacy meetings for **Religious and Local Community Leaders** from Mbinga and Songea Rural districts held; reached 80 leaders (i.e. 100% of the planned target)	

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
	Eighty nine (89) persons belonging to local NGOs, CORPs and women groups reached for advocacy on ITNs, IPTp and ACTs.	**7. Conduct advocacy and sensitization meetings for CORPs, local NGOs and women's groups.**	Two advocacy meetings for **CORPs, local NGOs and women's groups** from Mbinga and Songea Rural districts held; reached 89 people, (i.e. 111% of the targeted 80)	
	20% of villages with sensitized Religious and community Leaders and other change agents reaching out to communities with malaria preventions/intervention messages (i.e. ITNs, ACTs and IPTp.	**8. Community mobilization on malaria interventions through sensitized religious and Community leaders, CHWs, ADDOs, CORPs, local NGOs, women's groups**	Two support supervisions conducted to 14 villages (5%) with sensitized religious/community leaders and other change agents	This will be determined in the mid-line survey planned to be conducted in Year 3.
	53.5% of under fives suspected to have malaria receiving ACTs within first 24 hours in Mbinga district	**9. This is contributed by a number of activities such as: FANC Trainings, Supportive supervision, ACT National Technical Working Group meetings**		**Mbinga ADDO based Database** (Among the under fives seen by the ADDOs?)
	65% of general population suspected to have malaria receiving ACTs within first 24 hours	**10. same as 9 above**		**Mbinga ADDO based Database**

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
	in Mbinga district			
	90.3% of pregnant women who received ITN vouchers during ANC in Mbinga district 2742 and 67% (2742/1362*3)[8] of vouchers redeemed in Mbinga 1761 and (1761/529*3) 111% of vouchers redeemed in Songea Rural			**MEDA Database (Last 3 months performance)**
Objective 3: Facilitate coordination among key malaria stakeholders/partners to improve reach of malaria interventions (ACTs, ITNs and IPT).				
	Two (2) Coordination meetings conducted for policy makers, health professionals, facility owners and key partners at district level.	**11. Conduct Coordination meetings bringing together the key players involved in malaria activities that**	Two Coordination meetings conducted in Songea and Mbinga districts. A total of 60 stakeholders met (this is 100% of the planned participants)	

[8] Source: MEDA calculated as Total returned last 3 months divide by monthly target for returned vouchers *3

Project objectives	Indicators (include current measurement or result)	Key Activities (as	Status of Activities (including outputs)	Comments
		include the DMOs, district pharmacist, district nursing officer, district RCH coordinator, malaria focal person, health facility heads, key providers and facility pharmacists.		
	Two (2) Coordination meetings conducted for identified Local Partners (i.e. PNFP, local NGOs, Women's groups, CORPs, CHWs and ADDOs in the project district s	**12. Conduct coordination meetings with various stakeholders in project districts to streamline and strengthen malaria activities and to provide a regular forum for the dissemination of best practices.**	Two coordination meetings have been conducted. These coordination meetings targeted Community based malaria stakeholders working at grassroots. A total of 57 (95% of the planned targeted stakeholders) in Songea Rural and Mbinga districts met.	
	114 health facilities equipped with key malaria documents and key personnel oriented for ANC	**13. Identify, acquire and distribute key malaria documents (e.g. National policy and guidelines, IEC materials, radio spots and documentaries for local stations) to project districts personnel and then to**	370 national malaria guidelines disseminated 60 national infection prevention guidelines A total of 15314 IEC materials were accessed and disseminated	

Project objectives	Indicators (include current measurement or result)	Key Activities (as	Status of Activities (including outputs)	Comments
		the community.		
	# of days with SP stock-outs in the last month (in ANC)	**14. District level coordination meetings** **Support Supervision of CSSC-MCP activities** **National Technical Working Group on ACT forums**	More than 85% of district health facilities were present during coordination meeting. Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	This indicator has been a challenge to extract. It is not collected at facility level and hence not routinely reported to the districts.
Objective 4: ***In collaboration with the key malaria stakeholders and partners, conduct a CSSC-led BCC campaign to improve the uptake of ACTs, ITNs and IPTp.***				
	3,153 out of 6,511 (48.4%) of women attending ANC Clinics within the first trimester of pregnancy in Songea Rural district. 8,764 out of 16,412 (53.4%) of women attending ANC Clinics within the first trimester of pregnancy in Mbinga district.	**15. Facilitate community mobilization campaigns on malaria (using local drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	More than 85% of district health facilities were present during coordination meeting. Similarly, local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	Health Report for Songea rural and Mbinga districts

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
	45% of pregnant women who receive IPT in Songea Rural district 63.7% of pregnant women who receive IPT in Mbinga district	**Facilitate community mobilization campaigns on malaria (using local drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	More than 85% of district health facilities were present during coordination meeting. Similarly, local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	
	% of pregnant women who receive IPT at first ANC visit	**Facilitate community mobilization campaigns on malaria (using local drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	More than 85% of district health facilities were present during coordination meeting. Similarly, local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	The information is intermittently recorded in HMIS register Book 6; hence unable to analyze and report this information
	45% of pregnant women	**Facilitate community**	More than 85% of district	

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
	who receive 1st course of IPT under direct observation in Songea Rural district 63.7% of pregnant women who receive 1st course of IPT under direct observation in Mbinga district	**mobilization campaigns on malaria (using local groups, drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	health facilities were present during coordination meeting. Similarly, local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	
	28% of pregnant women who receive 2nd course of IPT under direct observation in Songea Rural district 43.6% of pregnant women who receive 2nd course of IPT under direct observation in Mbinga district	**Facilitate community mobilization campaigns on malaria (using local groups, drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	More than 85% of district health facilities were present during coordination meeting. Similarly, local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits 11 out 14 (78.6%) facilities had no SP for the past three months.	
	% of pregnant women who report sleeping under an ITN the	**Facilitate community mobilization campaigns on malaria (using local groups, drama groups,**	More than 85% of district health facilities were present during coordination meeting. Similarly, local community	This information is not routinely collected at health facilities

Project objectives	Indicators (include current measurement or result)	Key Activities (as outlined in the Workplan)	Status of Activities (including outputs)	Comments
	previous night at 2nd ANC visit	**etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	groups shared their status of activities re BCC on malaria control interventions at their areas	and due to limited budget; this was not collected by CSSC-MCP.
	100% of ANC clinic offer Malaria Health Education to clients	**Facilitate community mobilization campaigns on malaria (using local groups, drama groups, etc.) and distribute malaria IEC materials (specifically on IPTp, ITNs and ACT)**	More than 85% of district health facilities were present during coordination meeting. Local community groups shared their status of activities re BCC on malaria control interventions at their areas Two support supervisions conducted. During supervision visits, 14 out 14 (100%) facilities are offering Malaria Health Education to clients. CSSC MCP took part in the World Malaria day. Working with other partners	CSSC-MCP allowed offering of malaria health education with updated knowledge that was coupled with IEC materials disseminated during the different forums.

B. Factors that have **impeded progress** toward achievement of objectives

Financial constraints have been a major factor contributing to slow progress and eventual realization of the planned activities. Like many local organizations, the CSSC-MCP found it quite difficult to advance funds to the programme and then have these funds returned through the original "Reimbursement method". This constraint was communicated to USAID Washington; the PMI office in Dar es Salaam was also made aware of this effort. After some discussion, the programme was approved to utilize the "Draw-down method" through a modification of Assistance signed on 7th July 2008.

The non-availability of funds prior to the activity affected and delayed a number of other activities adversely such as supportive supervision by the district coordinators. This was combined with a lack of comprehensive supervision tools at the initiation of the programme which contributed to a less than optimum degree of viable supportive supervision at the district level.

At the end of one year of activities, it appears that the staff numbers envisaged for this programme are not sufficient to avoid overloading the Program Director with a large burden of work. It has been found that both a part-time programme officer and part-time programme accountant are inadequate to provide the administrative support essential. This is a forbidding challenge as the programme enters its second year and the numbers of operational districts and consequent increase in responsibilities on the part of all officers increases exponentially. Together with the in-country PMI team, this issue should be addressed as a first priority and a solution found before bottlenecks occur.

Another constraint has been the late approval of the work plan and budget for year one. This forced the programme to start implementation of its activities in the second quarter of the first year. However, rather than concentrating its efforts exclusively in certain areas during the initiation period, the programme went ahead and confidently scheduled all activities to take place consecutively and to ensure that all work was done within the three-quarters of the financial year remaining.

Lack of IEC materials to address IPTp uptake has been a serious challenge especially when an important objective of CSSC-MCP is to increase IPTp use by pregnant women and other malaria prevention and treatment interventions. Indeed, it cannot be denied that there are inadequate supplies of other IEC materials on the wide plethora of relevant malaria strategies. The major resolution of a forum facilitated by JHU COMMIT and its partners was not sufficient in this area, and a firm commitment was made by all, individually and in collaboration, to find the ways and means of increasing both the quantity and quality of IEC materials across the wider malaria intervention spectrum.

One of the most serious impediments to the success of the CSSC-MCP effort in the operational districts has been the continual and, up to the present, ongoing challenges of continuous stock-outs of SP. The CSSC and the management of the programme have vast experience in supply chain management in Tanzania over many years and are working very hard with the MoHSW, Medical Stores Department and all relevant agencies to address this problem. The SP stock-outs threaten to derail carefully crafted and administered malaria strategies such as increased update of IPTp.

C. Technical Assistance

What areas of TA have been required?

- Planning
- Survey, Mapping, Monitoring and Evaluation
- Financial Management strengthening
- Capacity Building (Training)
- IEC materials

What type of TA has been received and from who/where?

Planning

Work planning: In year one, CSSC-MCP received technical assistance from USAID Washington that focused on guiding the work plan. This timely boost was obtained when Ms. Jamie Beck visited the CSSC-MCP office and worked with the programme team to develop a revised work plan which received final approval. The initial draft was developed by the programme team with timely reviews and suggested amendments from IMA WH.

Survey, Mapping, Monitoring and Evaluation

Baseline survey and Mapping:
Technical assistance in this area was provided by the WEMA consultancy group which planned and executed the survey and then prepared the final report for submission. Additional TA was provided by IMA WH which has in place with CSSC an already established national health assets mapping protocol and signed Memorandum of Understanding with the MoHSW.

Supportive Supervision:
The programme M & E element in its initiation stage received support from Dr. Peter McElroy (CDC PMI/Tanzania). His inputs allowed the team to inform its baseline survey process.

Monitoring and Evaluative Tools:
Technical assistance in the creation of tools for integration of the programme indicators and the follow up of activities through a standardized M&E process has been provided in an on-going manner by IMA WH. As mentioned previously, collected data can be incorporated into existing data sets in order to expand layers of health assets mapping and provides additional tools for planners and managers in the CSSC-MCP programme. In addition, clear maps with highlighted areas of importance or progress are of great assistance in making presentations both regionally and nationally.

Financial Management

The visit of USAID Washington, Branch Chief, Mr Harry Pimpong, contributed towards a strengthening of the programme financial system. During his visit to the CSSC he carried out a “pre-award financial system assessment” It is anticipated that continued assistance on areas of weakness shall be followed by this Branch of USAID as this will not only build the

capacity of the commission but also improve accountability of funds from the American people. CSSC-MCP is still waiting for his trip report.

Capacity Building

Malaria refresher trainings required an engagement of short term technical assistance (STTA) from a local consultant with a track record of developing high quality training materials. To ensure the quality of the output, a TWG was established to guide the processes.

Programme Branding

The CSSC-MCP program received Branding Basics training from USAID Tanzania. CSSC-MCP is implementing the branding strategy that complies with the MCP/PMI branding and marking plan in line with the guidelines provided by USAID.

What is still needed?

There is a strong recognition of the need for technical assistance to improve and develop financial procedures and standards which are in accordance with USAID requirements. It is hoped that the report by Mr. Harry Pimpong will guide in this process and that this report is shortly made available to the CSSC-MCP.

D. Not Applicable

E. PMI Team Collaboration in country

Please see the table (below) which outlines the collaboration with PMI and its partners in Year One of the programme.

Name PMI partner	Event	Months	Comment
• MSH • JHPIEGO/ACCESS • NMCP • PSI	CSSC-MCP protocol visits	October, November and December 2007 and January 2008	The visits allowed the team to introduce the programme and create strategic linkages that avoids duplication. Also for the purpose of building sustainable interventions
JHU/COMMIT and PSI	JHU/COMMIT project-stakeholders consultative meeting	March, 2008.	At the end of the meeting CSSC-MCP made a commitment of ensuring that IEC materials that are going to be obtained from JHU/COMMIT shall
MSH /TFDA	CSSC-MCP Technical Working Group Meetings for Training Materials development	30th May, 9th July and 26th September 2008.	In these different forums, the team achieved to have in place training guides for the trainees and trainers. The quality assurance elements were built in as a proposal from the same group of experts.
John Snow Inc. (JSI) Deliver	JSI Making Medical Injections Safer Consultative Meeting	17th April, 2008	FBOs were made aware of the availability of free Auto Destructible syringes that were going to improve delivery of Malaria treatment strategies at facility level.
PSI	PSI and CSSC-MCP coordination meeting on IEC materials CSSC-MCP Meetings at district level	February, 2008 4th and 10th September 2008	The meeting allowed the CSSC-MCP team to be aware of the available IEC materials on ITNs. Heads of health facilities were updated on the ongoing PSI BCC activities
All PMI partners (chaired by NMCP)	PMI Partners' monthly and consultative meetings	October, November, December 2007 and January, February, March, April, May, August 2008	CSSC-MCP made a presentation of an overview including the programme objectives in the month of February, 2008. In the month of August the CSSC-MCP team made a presentation on the programme progress.
JHPIEGO/ACCESS	JHPIEGO country office visit	April, 2008	The programme received updated FANC training materials (April, 2008 draft), Job aides
MEDA	CSSC-MCP Meetings at district level	4th and 10th September 2008	Heads of health facilities were updated on the ongoing MEDA supply chain of vouchers activities.

F: Work plan Matrix

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Objective 1. Strengthen the capacity of health care providers (public, PNFP, CHWs, etc.) in project target districts to implement effective malaria prevention and control interventions					
Conduct baseline survey to identify and gather information about various stakeholders in year 2 program districts	% of health facilities and programme whose data is gathered and analyzed from the mapping exercise and the baseline survey # of personnel categories and their needs for orientation and/or training identified	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms More than 90% of households with a pregnant woman and/or	January 2009-April 2009.	Jhpiego/ACCESS, NMCP, MEDA, PSI,	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
	at facilities and communities[9] level # and type of district level resources identified	children under five will own at least one ITN 85% of government health facilities have ACTs available for treatment of uncomplicated malaria; and			
Collaborate with ACCESS program to Identify FANC trainers in the new program districts	6 district based trainers identified and prepared for FANC training	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms More than 90% of households with a pregnant woman and/or children under five will own at least one ITN	January – February 2008	Jhpiego ACCESS, CHMTs	Masasi and Lindi rural

[9] Clinical Officers, Qualified Nurses, Maternal and Child Health Aide (MCHA) for FANC Training, ADDO Dispensers and Community Health Workers for Malaria Refresher Course and Religious and Community Leaders, Women Groups, Community Owned Resource Persons and Civil Society Oranisations for Advocacy and Sensitization on Malaria

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Conduct FANC/MIP training to 50 healthcare providers, from 25 selected facilities in Masasi and Lindi rural	50 health workers trained on FANC/MIP	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms More than 90% of households with a pregnant woman and/or children under five will own at least one ITN	April 2009-June 2009	IMA WH, Jhpiego/ACCESS, CHMTs	Masasi and Lindi rural
Empower local partners working on Malaria through refresher training of CHWs and ADDOs on correct identification of malaria signs and symptoms, malaria in pregnancy and home management of	160 CHWs/ ADDOs from Masasi district trained 120 CHWs/ ADDOs from Lindi rural district trained	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their	May 2009 – July 2009	IMA WH, MSH, TFDA, CHMTs, NMCP, JHU/COMMIT	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
fever		symptoms More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of pregnant women will have slept under an ITN the previous night;			
Facilitate year 1 trained healthcare providers with data collection, recording and reporting on malaria interventions in Mbinga and Songea rural districts.	60% of year one conducted activities are monitored and furnish the programme with updated data on Malaria interventions.	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms More than 90% of households with a pregnant woman and/or children under five will own at least one ITN	October 2008 , January 2009, April 2009 and July 2009	Faith Based Collaborators in the Districts, CHMTs	Mbinga and Songea Rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
		85% of children under five will have slept under an ITN the previous night; 85% of pregnant women will have slept under an ITN the previous night;			
Collaborate with other PMI partners to empower FBO health facilities on needs fore casting, ordering and report using Integrated Logistic System (ILS)	50 Staff from FBO health facilities trained in ILS 50% of FBO health facilities access Malaria control commodities	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms 85% of government health facilities have ACTs available for treatment of uncomplicated malaria	January 2009 to July 2009	FBO Health facilities, NMCP, JSI Deliver, MSD, TFDA, IMA WH	Mbinga, Songea Rural, Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Objective 2: Empower and mobilize key stakeholders (religious and community leaders, health leaders and facility owners, CHMTs, etc.) to sensitize and advocate to community members for correct usage and adoption of ACTs, ITNs and IPTp.					
Conduct advocacy and sensitization meetings on community based malaria prevention and treatment activities for Religious and Community leaders	120 Religious and community leaders advocated to and are sensitizing 40% members of their communities on malaria interventions	More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of pregnant women will have slept under an ITN the previous night; 85% of children under five will have slept under an ITN the previous night; 85% of women who have completed a pregnancy in the last two years will have received	March 2009-April 2009	CHMTs, Faith Based Collaborators in the Districts,, Villages Government	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
		two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms.			
Conduct advocacy and sensitization meetings on community based malaria prevention and treatment activities for health facilities owners (FBO, Public & Private)	40 facility owners sensitized	85% of government (and FBO) health facilities have ACTs available for treatment of uncomplicated malaria 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms. More than 90% of households with a pregnant woman and/or children under five will own at	March 2009-April 2009	CHMTs, Faith Based Collaborators in the Districts,, Village Government	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
		least one ITN			
Conduct advocacy and sensitization meetings on community based malaria prevention and treatment activities for CORPs, Local NGOs and women's groups	120 members of Local NGOs and CBOs, CORPs and Women's groups sensitized 90 villages in Masasi and 50 villages in Lindi rural with sensitized groups actively spreading malaria prevention and treatment messages	More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of government (and FBO) health facilities have ACTs available for treatment of uncomplicated malaria 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms.	March 2009-April 2009	CHMTs, Local NGOs and CBOs , Local Women groups, Village Government	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Objective 3: Facilitate coordination among key malaria stakeholders/partners to improve efficiency of malaria interventions (ACTs, ITNs and IPTp)					
Conduct malaria coordination meetings bringing together the key players involved in malaria activities that include: The DMOs, district pharmacist, district RCH coordinator, malaria focal person, health facility heads, MCP district coordinator, etc	4 Malaria coordination meetings conducted by September 2009.	85% of government (and FBO) health facilities have ACTs available for treatment of uncomplicated malaria 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms. 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy. 85% of pregnant women will have slept under an ITN the previous night;	February 2009, July 2009-August 2009	CHMTs, MEDA, PSI, NMCP, World Vision, GTZ, Faith Based Collaborators in the Districts	Mbinga, Songea Rural, Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
		85% of children under five will have slept under an ITN the previous night;			
Carry out supportive supervision to ensure work follows year one training guides		85% of government (that include the CSSC registered facilities) health facilities have ACTs available for treatment of uncomplicated malaria 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms. 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy.	October 2008 , January 2009, April 2009 and July 2009	CHMTs, Faith Based Collaborators in the Districts	Mbinga and Songea Rural,

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Conduct coordination meetings with private not for profit (PNFP), public facilities and community networks working on Malaria in project districts	4 Coordination meetings conducted for identified actors in each project district by September 2009	More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms. 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy; 85% of pregnant women will have slept under an ITN the previous night; 85% of children under five will have slept under an ITN the previous night;	July 2009-August 2009	CHMTs, Local NGOs and CBOs, Local Women Groups, ADDO Associations, Village Government	Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
Objective 4: In collaboration with key malaria stakeholders and partners, conduct a CSSC-led BCC campaign to improve uptake of ACTs, ITNs and IPTp					
Identify, procure and disseminate key malaria documents (national policy and guidelines including IEC materials and local radio and documentaries) to project districts personnel and then to the community.	100 health facilities equipped with key malaria documents and key personnel oriented 10,000 IEC materials on malaria control disseminated to the community	More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of pregnant women will have slept under an ITN the previous night; 85% of children under five will have slept under an ITN the previous night; 85% of government (that include the CSSC registered facilities) health facilities have ACTs available for treatment of uncomplicated malaria 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy	October 2008 – September 2009	NMCP, JHU/COMMIT, Jhpiego/ACCESS, World Vision, Faith Based Collaborators in the Districts, Tanzania Broadcasting Corporation (TBC)	Mbinga, Songea Rural, Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
		More than 90% of households with a pregnant woman and/or children under five will own at least one ITN			
Identify and reproduce user friendly IEC Materials that are currently unavailable in circulation e.g. IEC on IPTp	10,000 user friendly IEC materials reproduced and disseminated to targeted population	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy More than 90% of households with a pregnant woman and/or children under five will own at least one ITN 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms.	October 2008-September 2009	NMCP, Jhpiego ACCESS, JHU COMMIT, PSI, World Vision,	Mbinga, Songea Rural, Masasi and Lindi rural
Facilitate community mobilization campaign on malaria using local drama groups, traditional	20% of villages in the project districts with local congregational	More than 90% of households with a pregnant woman and/or children under five will own at least one ITN	October 2008 – September 2009	Faith Based Collaborators in the Districts, CHMTs, Village	Mbinga, Songea Rural, Masasi and Lindi rural

Objective/Activity	Outputs	Related PMI Target	Timeline	Key sub-partners	Location
dances, road shows and distribute malaria IEC materials	and village local development groups sensitized on Malaria control strategies interventions and assisting the programme in disseminating IEC materials	85% of pregnant women will have slept under an ITN the previous night; 85% of children under five will have slept under an ITN the previous night; 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms. 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy		Authorities, Local NGOs and CBOs	