THE PROFILE OF HEALTH PROMOTION TANZANIA

This document summarizes the capacity, systems, policies and experiences that Health Promotion Tanzania brings in public health programs, governance and advocacy. It was updated in June 2017:

Contact: ed@hdt.or.tz. Website: www.healthpromotiontanzania.org. Tel: +255222772264

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INTRODUCTION

Health Promotion Tanzania (HDT) is a local non-government organization (NGO) registered in Tanzania ten years of experience in managing HIV/TB programs, community system strengthening and innovative sustainability of Community Health Workers. Since its establishment, HDT partners with communities to develop interventions that improve health of poor families in Tanzania including taking care of Most Vulnerable Children. We operates at both grassroots and national level in five priority regions: Dar es Salaam, Kagera, Geita and Ruvuma, where we have physical presence. In addition, we also have partnership with RHMT for advocacy for RMNCH and Nutrition in Tabora, Kigoma, Cost region and Mara regions.

For the past 13 years, HDT has been addressing community based health promotion issues and Social Accountability at community level and capacity building and advocacy at National level. At National level, we have been addressing advocacy issues in areas of HIV/AIDS, TB, RMNCH, and Nutrition among under-five, pregnant women and among PLHIV.

ORGANIZATIONAL CAPACITY

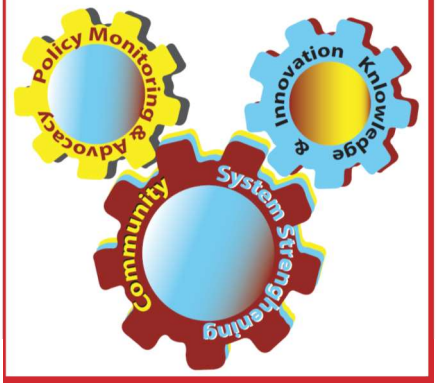
Health Promotion Tanzania is an indigenous organization, legally registered in Tanzania bringing 13 years of experience in managing HIV/TB programs, community system Strengthening and innovative sustainability of Community Health Workers. We have headquarters in Dar es Salaam and physical presence in Kagera and Geita and Ruvuma regions. Below we summarize six elements of our Capacity that qualify us and distinguish us from other organizations.

VISION AND MISSION

Vision: A responsible and healthy society

Mission: *Through a results-based approach we will pioneer and promoting innovative community based health systems and standards that deliver sustainable health.*

HDT PILLARS



Governance and Leadership: We have an efficient structure and leadership. The supreme body is the Board of Directors who by Memorandum of Understanding provides leadership and overall direction. The board directly supervises Executive Director who is supported by a team of Senior Managers (4) to perform day to day functions. Managers manage the day to day business of staff in different functional units as indicated in the chart above.

ORGANIZATION STRUCTURE

At the Headquarters, HDT has adequate and secured office infrastructure 372 Square meters capable of housing at minimum 18 officers at any one time. The office is fitted with Local Area Network-full time internet service and adequate broadband modem that serve as back up for mobile staff. There are both central printers and photocopy machine that are networked to provide the most efficient printing and scanning of documents. The office is furnished, ventilated with outside 12-seater garden that allows staff to refresh their mind in the mid of work and accommodate non-official yet refreshing discussions. We have a 12-seater board room secured with projector and automatic screen all designed to allow knowledge management and organizational learning. We have a shaded-secured 4 vehicle parking lot that is used for office cars and extra parking space able to accommodate up to ten cars for staff and visitors. Our Regional Offices too, are provided with minimum level of equipment and environment to suit their performance at work; that is Office equipment and furniture. All Officers use laptop computers to allow their flexibility to work.

Policy and Strategy: We have clear organizational structure and guiding set of policies for establishment (MEMART[1]), Staff handbook[2], Transport and Travel policy[3], Financial and Accounting manual[4], Project Management guidelines[5], M&E operational Manual etc. We have Five year strategic plan (2017-2022), which is guided by the Vision and mission as articulated in the information sheet above.

Human Resource: We are ready to implement public health projects in areas of HIV/TB, RMNCH, and Nutrition including community system strengthening for the aforementioned areas. Health Promotion is managed by highly skilled Human Resource, being led by the Executive Director who is a medical doctor with Masters in Business Administration specializing in acquisition of leadership skills. He brings 15 years' experience in managing public health project and managing institution. Program Manager Ms. Peta Mhoma the Community System Strengthening holds Masters of Science in Nutrition and Rural Development. She brings ten years' experience in managing community projects, lecturing and as a consultant. Finance and Administrative Manager-Agnes Kisala with CPA-Tanzania. The Acting Program Manager Knowledge and Innovation Mr. Vitus Msangazi holds Masters in Public Health brings intensive research and monitoring and evaluation experience.

Human Resource Management is guided by staff handbook which provides for rights and responsibilities of staff, core values, code of conduct, policies and procedures, Standard Terms and Conditions of employment and staff welfare. We conduct quarterly performance review and annual appraisal which determine staff motivation. We have both contract staff, Service Level Agreement contract and Volunteers, giving opportunities for young cadres to acquire skills in their areas of specialist. We have online staff management system, where planning and reporting is online; allowing state of the-art access to staff to do list and progress of every activity available at http://staff.healthpromotiontanzania.org/ . This system not only encourages self-discipline, but also allows managers to manage staff from a distance hence being able to manage multiple task.

[1] MEMART registration with BRELA and got certificate of compliance for NGO as per NGO Act

[2] Provides for regulations, staff conduct, Standard of conduct, Policies and procedures, Standard Terms and Conditions, Staff welfare

[3] Provides institutional commitment on Vehicle use and management, security, vehicle disposal etc

[4] Provides commitment on Accounts Administration, Budget controls and reporting, Assets management and stocking, Authorization and Controls, Grants Management, Audit and procurement

[5] Provides to officers our commitment, protocols for implementers from pre-implementation to implementation, Data Verification, Reporting and sharing, list of Don'ts such as bribes, fraud, over-pricing etc

Result Based Planning and Management: We are Result Based Management [6] Organization; which begins with Result Based Planning[7]. We run a very efficient online console secured system for program and finance management system http://fp.healthpromotiontanzania.org/ that provides various levels of access with advanced security features. The system monitors indicators and targets over a period of time to inform Contingency Planning and Accountability. It also allows summarization of data into the dashboard for every project, and consolidates reports as it compares planned targets and actual implementation at any given time. The system uses visual analogue color-codes to indicate performance against targets. The performance could be *Action required, Alert, Moderate performance, Good progress.*

Security features of the system:
Access controls: *Restricts unauthorized access.*
Access levels: *Defines who accesses what.*
Auditing: *Creates and keeps audit trail showing activity done*
Secure configuration: *Automatic backup performed daily.*
Error prevention: *Three trials with wrong login allowed.*

Our Monitoring and Evaluation of SMART indicators and targeted results are used to (1) adjust activities and interventions and (2) hold duty bearers accountable. We collect data, we undertake Data Quality Verification, and work with local level to synthesize and interpret data and make use of them at local level. We aggregate the data from the field, develop and publish Program Updates every Quarter for our stakeholders; we use the data from the field to carefully study the respective policy and develop policy briefs that have successfully impacted on policy reviews and formulation in public health and HIV. For all our programs, we develop Monitoring and Evaluation Plan. Health Promotion Tanzania maintains custody of all data as they flow from the field to LGA and donor.

Partnership and Networking: Since its inception, HDT has always prioritized serving at the grassroots and the rural communities which are governed by the local government authority (LGAs). Currently, HDT across its programmatic interventions works with 72 Districts located in the regions of Dar es Salaam, Coast, Kagera, Shinyanga, Mara, Geita, Ruvuma, Tabora and Kigoma. In all districts, HDT has developed and maintained a communication network with relevant LGA officials. This has extremely made HDT's work easier because LGA


Tanzania Communication and Development Center (TCDC)
Presents This
Certificate of Recognition
To
Health Promotion Tanzania (HDT)
For effectively working with Local Government Authorities to implement TCCP - TCDC project activities
16th day of March 2015
Executive Director

[6] RBM= We focus resources on achieving expected results

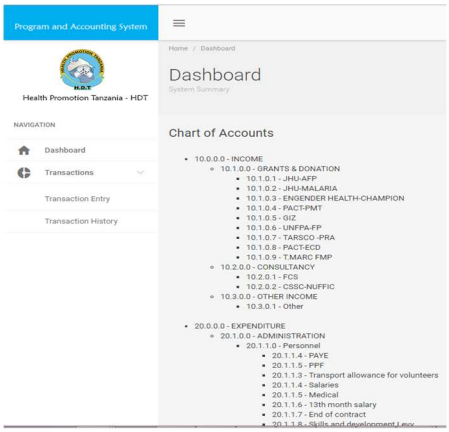
[7] RBP= We refer to sum of interventions is sufficient to achieve the expected result

officials provide adequate support in terms of resources, information, internal reflections and local experience.

HDT's programs and approaches have been tailored in regard to LGA perspective in order to leverage the support from LGA structures and respective officials. HDT's experience with LGAs ranges from working with structures, departments and individuals who are referred to as decision makers. Among the structures and committees that have for a long time enhanced HDT's success at LGAs include: Regional Health Management Team (RHMT), Council Health Management Team (CHMT), District Social Services Committees, Ward Development Committees (WDC), Ward Health Committees, Village Government Committees, Village Health Committees and Facility Governing Committees. It is this kind of coordination that has in fact yielded healthier relationships between HDT and LGA officials at all levels. During the entire period of working with the LGAs, HDT has observed and maintained ethics, protocols and conduct.

Consequently, Tanzania Communication and Development Centre (TCDC) in 2015 awarded HDT a certificate of recognition for effectively working with the LGAs (Biharamulo);

Financial Grant Management and Procurement: Health Promotion Tanzania has 13 years' experience of successful managing multiple donor funded projects including her sub grantees. As seen in the organizational structure, we have both program and financial approval in any transaction, to make minimum three levels of approval. We have succeeded to manage more than USD 10 Million to implement various activities in community health, psychosocial and economic support to most vulnerable groups. We have policies and procedures in place to guide activities and ensure staff accountability. There is a clear separation of duties among financial staff and are in line with procedures stipulated in financial guidelines. We run online Financial Reporting System that runs on accrual basis which conforms to the International Financial Reporting Standards (IFRS). As explained earlier this system will enable us to monitor all disbursement, and balances at every time. The Financial statements prepared by using online Financial Reporting System are highly reliable. Regular internal and external financial reporting is carried out (e.g. monthly, quarterly, annual and as appropriate). Reports are presented and discusses by the Senior Management Team (SMT) on a monthly basis and decision are made (e.g. to review budget plans). Annual internal and external audits are carried out and the results of audits are made available to all concerned.



We use agreements, technical assistance contracts, service contracts and purchase orders to acquire goods and services. Each contract and agreement is subject to procurement regulations. All anticipated expenditure are authorized through an annual purchasing plan, prepared by the Accounting Officer at the

same time as the budget and approved by the board as part of the annual planning and budget process. Purchases are carried out through competitive pricing and transparent comparison of several offers. An inventory of material, equipment and assets is maintained and regularly updated.

Approaches in Community Interventions

After several years of community interventions, HDT realized that the best way to successfully achieve them is empowering the communities to be responsible for their own health. This requires sharing relevant information to achieve shared vision; followed by imparting them with skills to support each other. To achieve this, we use Community Systems Strengthening. ***Community Systems*** refer to community-led structures (CBO, FBO, groups of PLHIV, women, youth e.t.c.) through which community members interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Therefore, ***Community Systems Strengthening*** is all about empowering beneficiaries and leaders to address the challenges and needs affecting their communities. From 2013, the focus for HDT has been maternal and child health, and therefore interventions are geared towards improving health of mother and child.

Of importance to note also, HDT has been careful to ensure there is mechanism for sustainability of interventions. Therefore, as much as possible HDT has sought for mechanism to ensure interventions focus on sustainability. The following have been the approaches employed:

Our model for Community Engagement

Our model for engaging communities is to building resilience and sustainable systems for health[8] that will be the foundation to achieve healthy lives and wellbeing for all ages (SDG-3). Our strategic plan is in sync with Health Sector Strategic Plan IV, Global Fund strategy 2017-2022 and NMSFIII. Our systems for public health programming are designed to reach "***last miles***"; it focuses on people, not issues or diseases. We aim to offer intergraded services[9] that address individual's multiple health needs. We involve communities in identifying, report and responding to emergency health threats. Our policy and strategy hinges on attaining universal health coverage through (1) Strengthening community systems, (2) support and invest in RMNCAH, (3) Skills transfer among health Care Workers, (4) strengthening data quality, analysis and use in health sector.

Our Community engagement offers two prong approaches that is – the leadership and members of the communities through different structures. The engagement of community leaders aims to gain their acceptance and commitment to be part of implementation. This includes mobilizing the community, identification of community volunteers and overseeing implementation of the interventions. On the other

[8] We define Systems for Health differs from health systems in that systems for health do not end at clinic, but run deeply into communities and can reach those who do not always to health clinics particularly the vulnerable and marginalized.

[9] We refer for instance to breaking the barriers that traditionally prevented HIV patients from being tested for TB or receiving prophylaxis for TB. We will work with ministry responsible for health and UNICEP to integrate service delivery platforms for Maternal and Child Health.

Dispensary Building at Mumuhamba Village

hand Members of the community are engaged to be aware of the interventions and/or be part of the implementation.

Between April 2011 and April 2012, HDT engaged in construction of Mumuhamba Dispensary at Mumuhamba Village, Ngara District in support of improving access to medical care among rural communities. The project involved meeting the District Council Officials, meeting Ward and Village Leaders, and the Village Leaders convened a general meeting to introduce the project and gain community commitment to support the project. This is an example of the process in engaging the community. In this particular project, community members committed to gather stones, prepare gravel and provide manpower during the construction worth 1.5 million Tanzanian shillings; while HDT provided financial support to facilitate construction of the facility.

Another example was on Participatory Rural Appraisal that was conducted between February and May 2014; where HDT engaged a community at Bukiriro Village, Ngara District, Tanzania with an aim of improving sexual reproductive health services in the community. The meeting brought together 13 participants from three groups – Community Leaders, Health Providers and Community Health Volunteers. During the meeting, challenges that derail access to SRH services were identified, prioritized and possible solutions discussed. Finally the meeting proposed re-establishment of Community Based Distribution Program for family planning commodities (condoms and pills) through community volunteers namely Community Based Distributors (CBDs). This was regarded as one of the best ways to strengthen Primary Health Care where CBDs will address misconception and sensitize for family planning use. CBDs will also improve access to family planning services by providing condoms and pills in the community setting, but also relieving the users from walking long distances to the facility for the same, and minimizing unnecessary congestion at the Health Facility. As a result, health centers we worked with recorded double uptake for family planning modern methods.

Community Volunteers/Champions

To build strong and sustainable resilience in community, we use the community volunteers; identified by the community themselves, trained to impart health service provision skills, and empowered with

allowance to compensate their time on monthly basis. Community health volunteers are now commonly used and are identified with different names depending on duties performed. HDT has worked with Community Change Agents (CCAs) at the Ward level who are responsible to educate and sensitize the community towards health seeking behavior in Malaria, HIV/TB and family planning. Community Based Distributors (CBDs) who facilitate access to FP commodities and managed to establish community and sustainable means to remunerate the distributors while recording double the number of FP users; Community Health Workers (CHWs) who have mobilized community meetings and home visits in promotion of RMNCH services.This strategy has been very useful since community members tend to have confidence in their fellow members.

Current community based Project Experience:

Civilian Comprehensive HIV Prevention (CCHP): Started in March 2016 and targets Priority Population (adolescent girls and young women, 15-24 years) and Key Population (female sex workers and people who inject drugs) with Prevention of HIV infection, Community Based Health Services (CHBS), Voluntary Counseling and Testing (VCT) and Care and Treatment (CTC). The project makes use of community volunteers namely Peer Educators among all the target groups and Community Based Health Service (CBHS) providers. Through community volunteers the project has been able to mobilize HIV testing and counseling among risky individuals within the target groups, link those who test HIV positive to CTC and TB diagnostic facilities, and recover lost to follow-up back to anti-retroviral therapy and TB.

At the end of June 2017, this program managed to test and provide results to 7,595 people for HIV status and reinstated a total of 1308 PLHIV to CTC who were Lost to Follow up.

Developing Social Pact for RMNCH and Nutrition in Tanzania

In partnership with Graca Machel Trust, HDT will in August and September 2017 develop SOCIAL PACT bringing together CSO, Private Sector, public sector who works on RMNCAH and Nutrition in Tanzania. The program aims at increasing visibility of and resources for nutrition in the country. This is a three years program funded by Graca Michel Trust (GMT). The RMNCH+N program also focuses on revitalizing nutrition interventions through increased funding and improved policy environment at both levels – local and national. It is set to build on past investments and on-going activities in reproductive and child health advocacy, leadership development, knowledge generation, and innovative nutrition programming. The project's thrust is to contribute towards strengthening investments in nutrition as a way towards attaining national and Global nutrition Goals.

Maternal and Child Survival Program (MCSP) now BORESHA AFYA: Implemented between in 2016, MCSP aimed at increasing access and coverage of quality reproductive, maternal, newborn and child

health through Community Health Workers (CHWs) and a predecessor of BORESHA AFYA project which has started in lake zone.

CHWs have successfully made visits to 40,575 pregnant women, newborn children and their mother's right after delivery; where 1503 referrals were provided. CHF enrollment increased from 1,947 to 9,091 in Biharamulo and 2,094 to 6,559 in Ngara between 2015 and 2016; this indicates improved health seeking behaviors for the people around these areas. Capacity building to village health committees was also conducted to support community health workers in their localities. A total of 13,910 people were reached with health education during ***'ghulio za afya[10]'*** and cinema shows. All these initiatives finally recorded reduced maternal and child mortality, average of 9 to 2 (maternal), 18 to 12 (neonatal) and 9 to 6 (infant) for Ngara and Biharamulo where HDT implemented the project.

Tanzania Capacity for Communication Project (TCCP): Started in April 2014 and ended in September 2016, TCCP is USAID funded project visualizing a country where people take charge of their own health, thus creating healthy households, individual changes in health leading to healthier families and communities. Its areas of focus include HIV prevention and reproductive health maternal and child health. Community members in Biharamulo were reached with health education and behavioral change messages on reproductive health, TB, Malaria, HIV and Family Planning. In total 816 people received reproductive health education, 275 on Family Planning, 888 on HIV, 1722 and 703 on Malaria and TB respectively. These achievements were made through community volunteers at Ward level recognized as Community Change Agents (CCAs).

Pamoja Tuwalee (PT) embedded with Early Childhood Development (ECD): Aimed at improving livelihoods and community support for Most Vulnerable Children (MVC) while ECD targeted MVCs who are under five years and living with HIV. The project was implemented between October 2012 and September 2015.

In collaboration with Empowerment Workers (EWs), HDT mobilized 103 caregivers in WORTH groups to utilize cash contributions to register for CHF; 250 children in child clubs were sensitized as a part of psychosocial support; 210 under five children were immunized as a result of sensitization made by empowerment workers; and 6 children (4 girls and 2 boys) are being supported for curative services including ART; and ECD knowledge was shared to 67 WORTH groups.

The program was successfully linked to TASAF III and 597 caregivers for MVC benefited from this initiative; 359 caregivers owned farms, cattle and/or renovated their homes and 1633 increased in voluntary savings.

[10] Gulio la Afya is a market health place which is an integrated service provision that is done jointly with CHMT to provide ALL available health services to communities ranging from HIV, Malaria diagnosis and treatment, ANC, PMTCT, HTC, CTC, TB test using Gene expert, Family Planning, NCDs test and health check.

Families Matter! Project (FMP): Focused on parents and caregivers of 9-12 year-olds to promote positive parenting practices and effective parent-child communication about sex-related issues and sexual risk reduction. A total of 6230 parents were reached with this project in Shinyanga and Dar es Salaam, whereby 6288 children benefited directly from the project and 8435 more children were reached indirectly. Community members account for improved behaviours among their children and parent to child communication especially on issues regarding sexuality, family planning and violence against children. This was phase II of the project that was implemented between February 2013 and March 2015, where community volunteers mobilized parents to register and attend all six sessions of the trainings.

Participatory Reflection and Action (PRA): Aimed at supporting the community to identify strategies for improved accountability for reproductive, maternal and child health. The process identified revitalization of family planning services provided by Community Based Distributors (CBDs) to be a priority to address RMNCH challenges. The project also identified mechanism for sustainability of services where, the village government committed to include remuneration to CBDs in their monthly budget.

Revitalization of CBD program in Bukiriro now recorded contribution of nearly 70% of the total family planning users (condoms and pills). Generally there was an increase in FP services uptake in the village; from a monthly average of 61 (January to March 2014) to 124 by the end of 2014; 122 in 2015 and 134 in 2016. There has also been an increased commitment, especially among Village Leaders and Health Committee members which in return has improved the relationship between community representatives, CBDs and health workers. This results in greater trust in the health system at community level, greater accountability on the part of the health workers, and improved access to and quality of health services.

Improving access to medical health care to rural based communities: The project was implemented between April 2011 and March 2012 with the focus of improving access to medical care particularly to mother and child by building a dispensary close to communities who by then had to walk over 10km to access health services in Mumuhamba village. The village has a population of around 5,076 people and among the population 54% are women. The project was a collaborative one between the community, the District Council and development partner (Health Australia and Tanzania) though HDT. Commitments made between the partnership include the following roles:

Community shall collect local building materials such as stones, gravel, water and manpower;

HDT/HAT shall provide resources for construction, training of village health and facility governing committees, and installation of basic furniture for the Dispensary;

The District Council shall provide resources for construction of latrines, staff houses, their recruitment and medical supplies.

This project is a good example to emulate since it tells about the potential community has towards its own health and provides an opportunity for the community to own the project. The project was fully accomplished in April 2012, where the Dispensary and its basic furniture were handed over to the District Council.

Improving Livelihood and Community Support for people living with HIV (PLHIV) and most vulnerable children (MVC): The project was supported by Elton John AIDS Foundation (EJAF) and implemented between November 2011 and April 2012. Interventions included nutritional support to ill people living with HIV, empowerment of the same after recovery with income generating activities, provision of home based care services to all chronic ill patients by Community Home Based Care (CHBC) providers, provision of school materials and school fees for most vulnerable children (MVCs), and empowerment of parents and guardians of MVCs with income generating activities. As the name of the project tells, the project managed to improve health and livelihood of PLHIV with a documentation of the following changes:

109 PLHIV (92.4%) who received nutritional supplement for four months have increased weight and 113 PLHIV (95.8%) have reduced frequency of illness (utmost once every two months);

All income generating activities for PLHIV are in good progress. 85% of the visited projects are generating income and therefore support livelihood of PLHIV;

401 PLHIV (33%) of 1,211 PLHIV reached by support groups were ready to disclose their HIV status. This indicates improved self-esteem and reduced stigma and misconception among communities.

Concerning improved access to basic needs for MVC (through their caring families), the following changes were recorded:

An average of 250 (85%) among 294 caring families visited are implementing their income generating activities well and livelihood has improved. Among them, 70.7% (208) are managing two meals per day while 0.7% (2) manage three meals per day;

There is record of improved attendance and performance among MVC supported with school uniform and bursaries. 64% have improved scores from a range of 17-50% at baseline to 60-98% at the end of the project.

Board Members for Health promotion as of 2016

No	Name	Professional	Contacts
1	Feddy Mwanga	BSc Nursing, MA, MPH	Tel: +255 754 475 185

	Chair		FMwanga@engenderhealth.org
2	Christine Mwanukuzi-	Sociologist-Gender MA, MPH	Tel: +255 754 781 198 mwanukuzi-kwayu@unfpa.org.
3	Ms. Lucy Aloyce Tesha	Jounalism BA, MA Ds	+255 787 930430 lucietesha@gmail.com
4	Dr. Bwijo Bwijo	Public Health Specialist MD, MPH	+255 784 530 325 bwijo.bwijo@undp.org
5	Dr. Amos Kawha	Research Scientist MD, MPH, PhD	+255 784 465 758 akahwa@hotmail.com

Address:
Executive Director
Health Promotion Tanzania
P.O.BOX 65147 DaR Es Salaam
Tel: +255 22 2772268/86
Email: ed@hdt.or.tz
Website: www.healthpromotiontanzania.org