Tanzania

Operational Plan Report

FY 2012

Operating Unit Overview

OU Executive Summary

CONTEXT

Tanzania faces many economic and social development challenges which are further exacerbated by a generalized AIDS epidemic and other communicable diseases. The United Nations Development Programme (UNDP) rated Tanzania 162 out of 177 countries in their annual Development Index, a metric reflecting that Tanzania's combination of life expectancy, literacy, educational attainment, and GDP per capita ranks in the lowest decile worldwide and amongst the lowest in African countries.

According to the 2010 UNAIDS report on the Global AIDS Epidemic, adult HIV prevalence in the country is estimated at 5.6% and an estimated 1.4 million Tanzanians are living with HIV/AIDS. An estimated 86,000 HIV/AIDS related deaths in Tanzanian each year, resulting in disruption of family structures and an increase in the estimated 1.1 million HIV orphans and vulnerable children (OVC) in Tanzania. According to the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS), there continues to be a significant difference in the prevalence among urban (9%) and rural (5%) areas of the country. The data also reveal significant gender differences in HIV prevalence. Overall, male prevalence in 2007-08 was 5%, while female prevalence was 7%. HIV prevalence is higher for women than men in every age group except 35-39.

In Zanzibar, the HIV/AIDS epidemic is concentrated, with HIV prevalence estimated at 0.6 percent in the sexually active population (THMIS, 2008). Recent studies of most-at-risk-populations (MARPs) have estimated HIV prevalence for injecting drug users (IDUs), female sex workers (FSWs), and men who have sex with men (MSM) at 16.0%, 10.8%, and 12.3%, respectively.

Compared to earlier years, results from the 2010 DHS suggest some successes in the response to HIV/AIDS but also highlight remaining deficits. Knowledge of AIDS is widespread, with 99% of respondents having heard of AIDS. Less than half of those respondents, however, have a comprehensive knowledge of HIV/AIDS transmission and prevention methods. Tanzanians are increasingly aware of opportunities for testing and learning their HIV status. Thirty percent of women and 25% of men were tested for HIV in the year preceding the survey, figures that are much higher than those recorded in previous surveys. Prevalence of male circumcision among men aged 15-49 increased five percentage points from 66.8% (2007-08 THMIS) to 72.3% (2010 DHS), with significant regional variation.

While analysis of the 2010 DHS suggests slight decreases in HIV risk behaviors, low rates of condom use during high-risk sex as well as high rates of multiple concurrent partnerships, transactional, and

cross-generational sex persist. Gender-based violence (GBV) is also a serious problem contributing directly and indirectly to HIV transmission in Tanzania. The 2010 DHS provides the first nationally representative data on GBV. More than one-third (39%) of Tanzanian women age 15-49 have experienced either physical or sexual violence. Twenty percent of women have ever experienced sexual violence and 10% report that their first sexual intercourse was forced. The data show significant regional variations, with women in Zanzibar the least likely to have experienced any type of violence. Data from the 2011 CDC/UNICEF Violence against Children study in Tanzania show that children are also experiencing high levels of violence. Overall, more than a third of female respondents and over 20% of male respondents experienced sexual violence between the ages of 13-18. The prevalence of reported physical violence among females and males aged 13-18 was very high, at 77% and 73%, respectively.

Deficits in resources, governance, and health systems complicate Tanzania's ability to adequately respond to HIV/AIDS. Tanzania's health programs are highly dependent upon donor funding. Foreign funds account for 97% of the Mainland's HIV/AIDS response, of which 90% come from the combined efforts of PEPFAR (74%) and the GFATM (16%). Health budgetary allocation as a percentage of total government funding was 12.9% (short of the 15% Abuja Declaration target); moreover, funds are not always disbursed annually to planning levels. In addition, the country grapples with a weak health infrastructure; a shortage of healthcare workers; high levels of stigma; cumbersome government procurement systems; weak management and strategic planning at all levels; poor accountability; and corruption.

Despite systems and leadership challenges, the country has made some progress in defining a policy and strategy framework to guide stakeholders in the response to HIV/AIDS. Among many key documents, the principal reference points are the National Multi-Sectoral Framework on HIV/AIDS (NMSF 2008-2012), Zanzibar National HIV Strategic Plan II (ZNSP II, 2011-2016), and the Health Sector Strategic Plan III (HSSP 2009-2015). The Five-Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009-2013 between The Government of the United Republic of Tanzania and the Government of the United States of America (Partnership Framework, or PF) defines the roles and responsibilities of the URT and USG/T in addressing HIV/AIDS and is aligned with these key documents.
USG/T supports the URT's capacity to lead and manage its national response to HIV/AIDS through six strategic goals that are outlined in the PF:

1. Service maintenance and scale up;
2. Prevention;
3. Leadership, management, accountability and governance;
4. Procurement and commodity distribution;

5. Human resources; and
6. Evidence-driven strategic decision making.

PEPFAR support to Tanzania has enabled a dramatic increase in the number of adults and children accessing ART, with 289,000 individuals receiving treatment in 2011. During FY 2011, a total of 3.1 million individuals received HIV testing and counseling. 58,200 pregnant women received prevention of mother-to child transmission of HIV (PMTCT) services including ART, and 368,000 OVC received support.

Although USG/T is by far the largest single contributor to the national HIV/AIDS response, other stakeholders play key roles. In particular, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) provides a substantial amount of funding for HIV and AIDS interventions in Tanzania, including commodities procurement and systems strengthening activities. Other actors include the U.N. Joint Programme and the Governments of Canada, Belgium, Denmark, Japan, Netherlands, Norway, and Sweden. USG/T participates and leads much of the ongoing communication and coordination among all stakeholders, often with the URT as convener. This collaboration is essential for the promotion of country ownership and to ensure that the USG contribution is fully leveraged. USG/T representatives actively participate in several dialogue structures bringing government, donors, and civil society together, including the Tanzanian National Coordinating Mechanism (TNCM) the Joint Technical Working Group on HIV/AIDS (JTWG), and the Donor Partners Group on AIDS (DPG-AIDS). Most information sharing and joint decision-making takes place within these multilateral fora to be inclusive of all donors, though USG/T also engages bilaterally with URT to address specific, urgent, and high-level policy issues relating to the PF.

PEPFAR FOCUS in 2012
Through the 2012 COP, USG/T continues to support achievement of the six PF goals while promoting greater capacity among Tanzanian actors to manage and support the national response to HIV/AIDS. In particular, USG/T priorities this year include:

Goal 1: Service Maintenance and Scale up

- Continuing scale up of ART with prioritization of HIV-positive pregnant women and TB patients co-infected with HIV
- Closely coordinating with GFATM to support systems strengthening activities and commodities procurement aligned with ART scale up, particularly in light of the cancellation of Round 11 and the prospective approval of Phase II of the Round 8 grant.
- Enhancing focus on quality improvement in all clinical services
- Scaling up 3I's and integrating into PMTCT, VCT, pediatrics, and congregate settings in addition

to scaling up provision of ART in TB clinics
• Improving food security and nutritional status of PLHIV and OVC through household economic strengthening activities, links with Feed the Future, and NACS and PMTCT acceleration
• Strengthening linkages between facility and community-based services
• Improving identification of and access to services for children affected by HIV through integration of OVC, MNCH, PMTCT, and pediatric AIDS interventions (EID and PITC)
• Piloting and scaling up of community-based child protection models, including efforts to safeguard adolescent girls

Goal 2: Prevention
• Continuing gradual transitioning of responsibility from USG/T to URT for blood and injection safety
• Supporting scale up of combination prevention interventions by improving partner coordination and undertaking evaluations to expand the evidence base
• Increasing HIV testing and counseling service uptake, especially among couples via the PMTCT platform, and improving linkages to care
• Continuing to accelerate expansion of voluntary medical male circumcision (VMMC)
• Expanding sites serving people who inject drugs (PWID) and establishing new programs to serve sex workers (SW) and men who have sex with men (MSM)
• Rolling out positive health dignity and prevention (PHDP) in facilities to complement community-based PHDP efforts
• Alleviating the vulnerability faced by young girls and women continues to be a cross-cutting programmatic focus built into the various prevention strategies, regardless of the target population.

Goal 3: Leadership, Management, Accountability, and Governance
• Strengthening district systems for budgeting, planning, monitoring, and reporting to ensure financial accountability and prioritized programs matched to disease profiles of a given geographic area
• Increasing mentoring, technical assistance, and management capacity building to local governments and civil society organizations tasked with developing, delivering, and managing care services for PLHIV and OVC
• Increasing USG/T's collaboration with the private sector and supporting improved dialogue between URT and the private sector
• Building capacity among parliamentarians, the media, religious leaders, and the National Council of People Living with HIV and AIDS (NACOPHA) (national umbrella organization of PLHIV) to effectively participate in the national response

Goal 4: Sustainable and Secure Drug and Commodity Supply

- Continuing gradual transitioning of responsibility from USG/T to URT for procurement
- Redesigning the sales and order system and distribution model to accommodate the massive increase in site deliveries
- Working with the MOHSW to improve the national logistics and procurement systems for appropriate ordering and distribution of laboratory commodities, supplies, and equipment
- Improving warehouses through redesign, use of pre-fabricated storage products, and improvement in standard operating procedures and security systems
- Building capacity of the Tanzania Food and Drug Authority to monitor the quality of health commodities

Goal 5: Human Resources

- Scaling up pre-service training and investments to increase training throughput
- Strengthening districts to better manage and retain the workforce and implementation of performance-based management to improve health workers' productivity
- Reforming policy to optimize the available workforce, including through task shifting
- Developing a national social welfare workforce strategy and continuing roll out of para-social work model
- Strengthening the skills and numbers of community care providers and facilitating referrals between community-based and facility-based health services
- Increasing numbers of trained laboratorians

Goal 6: Evidence-based and Strategic Decision Making

- Co-funding with other donors the health sector's M&E strengthening initiative
- Continuing gradual transitioning of responsibility from USG/T to URT for management of centralized data, including implementation of a national Health Management Information System integrating HIV/AIDS into routine health care systems
- Developing the evidence base for combination prevention through impact and outcome evaluations
- Providing technical assistance to HIV surveillance activities pertaining to ANC, MARPs, and drug resistance
- Implementing the PEPFAR Records and Organization Management Information System (PROMIS) in order to report to OGAC and provide closer data collaboration with URT counterparts to better inform planning and decision making processes

Supporting Tanzania's three Global Health Initiative (GHI) focus areas is also a priority for USG/T and is achieved through many of the activities mentioned above. Specifically, USG/T in 2012 COP will contribute to each GHI intermediate result as follows:

- USG/T will support increased access to quality integrated services with focus on maternal, newborn, and child health, family planning, and reproductive health (IR1) by increasing the number of pregnant women who are initiated on ART, improving linkages and referrals between HIV program areas, strengthening PLHIV support groups in facilities and communities, integrating family planning into HIV/AIDS care and treatment services, and introducing point of care CD4 testing.

- The health systems strengthening priorities for the HIV/AIDS response are the same as those needed to assure sustainable health services on a broader spectrum. Therefore, USG/T support inherently will contribute to improved health systems to strengthen the delivery of health care services (IR2). More specifically, USG/T will continue to strengthen human resources for health to support efficient and high-quality service delivery; improve integration and effectiveness of M&E systems; strengthen governance, management, financing, and accountability in advancement of national policies and systems; and improve health support systems, including for commodities and laboratories.

- USG/T will contribute to improved adoption of healthy behaviors including healthcare-seeking behavior (IR3) by supporting early uptake of preventive health services including couples HTC, PMTCT, ART, and male circumcision; empowering women and adolescent girls to increase their access to preventive and curative services, including those addressing gender-based violence, with support from spouses, families, and communities; strengthening the legal and regulatory environment in support of gender equity; and building capacity within government and civil society for effective social and behavior change communications activities.

Additionally, the 2012 COP contributes to the realization of all seven of the GHI principles:

1. Support country ownership. Strategies to promote country ownership are included in all USG/T technical areas and are key how USG/T conducts business with URT and civil society.

2. Build sustainability. This principle is closely tied to country ownership and is also a central goal for PEPFAR, with cross-cutting applications in all PF goal areas.

3. Promote research and innovation. Goal 6 of the PF addresses this principle by committing to build Tanzanian capacity for research and evidence-based decision-making. The principle also applies to the way that USG/T strives to make programming decisions in all areas.

4. Increase impact through strategic coordination and integration. USG/T is striving to improve its information sharing with URT and other stakeholders to leverage strategic opportunities and increase country ownership. USG/T is also working internally and with the URT to improve integration across

service platforms and program areas.

5. Improve metrics, monitoring, and evaluation. This principle is addressed through capacity-building activities under Goal 6 of the PF as well as being mainstreamed in all goal areas.

6. Focus on women, girls, and gender equality. Gender is a cross-cutting lens which USG/T strives to apply to all program areas to ensure equitable access to services, increase healthy norms and behaviors, and promote women and girl's empowerment for improved health and development outcomes. The focus on women and girls is particularly strong through the gender-based violence initiative, the HIV prevention portfolio, the PMTCT platform, and in OVC and home-based care programming.

7. Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement. This principle is reflected in many USG/T activities, including work with URT to ensure effective stewardship of and coordination with GFATM resources and efforts to revitalize private sector engagement in the national response to HIV.

The reduction of mother-to-child transmission (MTCT) is also a cornerstone of USG/T efforts to halt the spread of HIV in Tanzania. USG/T supports
the Government of Tanzania's pledge to the global MTCT elimination agenda and will ensure that its resources through PEPFAR contribute to the initiative. Specifically, the elimination agenda aims to reduce the number of new pediatric HIV infections by 90%, and reduce population-level rate of MTCT to <5%. In addition, the initiative seeks to reduce in HIV incidence in reproductive age women (15-49 yrs) by 50%, reduce unmet family planning need to zero among all women, and see a 90% reduction in HIV-associated maternal deaths and 90% reduction in infant (<1) and under-five (<5) HIV deaths. USG/T will work with the Government of Tanzania to reach the stated goals by 2015 through the PMTCT acceleration plan. USG/T will also support the systems and metrics needed to measure the reduced rate and numbers of new HIV infections among women of reproductive age and children. The ultimate, but achievable goal is to eliminate new pediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV. The reduction of mother-to-child transmission (MTCT) is one of the key cornerstones of USG/T efforts to halt the spread of HIV in Tanzania. USG/T supports the Government of Tanzania's pledge to the global MTCT elimination agenda and will ensure that its resources through PEPFAR contribute to the initiative. Specifically, the elimination agenda aims to reduce the number of new pediatric HIV infections by 90%, and reduce population-level rate of MTCT to <5%. In addition, the initiative seeks to reduce in HIV incidence in reproductive age women (15-49 yrs) by 50%, reduce unmet family planning need to zero among all women, and see a 90% reduction in HIV-associated maternal deaths and 90% reduction in infant (<1) and under-five (<5) HIV deaths. USG/T will work with the Government of Tanzania to reach the stated goals by 2015 through the PMTCT acceleration plan.

PF/PFIP MONITORING

The USG/T team continues to use the Partnership Framework Implementation Plan (PFIP) as a guiding document for all technical interventions and systems and capacity development priorities. While engagement with URT and civil society representatives has been ongoing throughout PFIP development and in the initial stages of execution, 2011 marks the first year that the two parties have agreed upon a formal monitoring tool to jointly assess progress. In 2011, USG/T submitted a draft tool to TACAIDS for preliminary consideration and then to the JTWG for full vetting. The tool was accepted and the first quarterly update was issued to the members of the JTWG in June 2011. Both USG/T and URT complete the tool, which provides narrative updates on key technical and policy developments as well as ongoing challenges. URT reported that they found the tool so useful that they plan to use it internally to augment some of their current data gathering mechanisms. A yearly update on the quantitative indicators included in the tool is expected in December 2011. The brief list of indicators includes service outcomes as well as measures of transition to greater country ownership.

In recent months, USG/T has also intensified its communications with partners about the PFIP and its relevance to their ongoing work. In March 2011, USG/T convened a partners meeting with 400 attendees, representing not only international and local partner organizations, but also national and local government bodies and civil society. URT speakers emphasized the importance of the PFIP in terms of both its content and the process by which it was developed to pull USG/T into greater alignment with URT priorities. Partners were provided with an overview of implementation plans under the six PF goals and engaged in dialogue regarding their contributions to these ongoing efforts. As a result of the meeting, partners have been able to more explicitly link their program plans for 2012 COP to the expected contributions in the PFIP.

The 2012 COP development process began with each interagency technical team reporting out on notable progress towards PFIP 2013 achievements, changes in URT's politics and priorities, changes in PEPFAR guidance, and emerging evidence either reaffirming or demanding reconsideration of PFIP expected achievements. Overall, the results show that the USG/T program remains on track to deliver on PFIP commitments.

COUNTRY OWNERSHIP

The process of developing and monitoring progress on the PF has significantly enhanced engagement between USG/T and URT on the national response to HIV/AIDS. The two parties meet prior to each government's budgeting submission to assess progress on the PFIP. The USG/T team also convenes an annual policy dialogue with the URT, representatives of civil society, and other donors to present the latest COP. Additional dialogue takes place within multilateral fora, such as quarterly TNCM and JTWG

meetings.

With the delay of 2012 COP, the high-level policy meeting to endorse the COP took place fairly early in the COP planning cycle (October 25, 2011). Additionally, USG/T staff engage frequently with URT technical counterparts under the auspices of the URT's HIV/AIDS technical working groups. These technical exchanges allow URT stakeholders to broadly articulate priorities for USG/T programming and for USG/T staff to indicate whether these priorities conform to the PF, planned funding levels, and PEPFAR policy directives.

At the outset of PF negotiations, URT questioned the potential for true country ownership if USG/T funds were not channeled through government systems. USG/T noted that project funding would be the modality throughout the life of the PF, though increased allocations through URT channels would be possible if existing Government mechanisms performed well. USG/T plans to increase activities implemented directly through host country government systems and local organizations. New initiatives planned in 2012 COP will include the use of Fixed Amount Reimbursement Agreements (FARAs) with local government entities, direct grants to districts, and potential direct funding to MSD for drug/commodity procurement. USG/T also plans to continue to increase direct funding to local civil society organizations (CSOs) and explore direct agreements with Tanzanian academic institutions. USG/T is also striving to more effectively share program and financial information with URT bodies to promote effective coordination and planning.

In addition to providing a structure for enhanced engagement, the PF provides general guidance on how URT can exercise greater country ownership, as well as how USG/T can support this evolution. One of the key themes of the PFIP design team was to articulate strategies in support of sustainability and transition to country ownership in every goal area. USG/T now looks to move beyond broad agreements on transition to the articulation of jointly developed plans that support such movement in all technical areas.

The four key challenges in reorienting the USG/T portfolio toward greater country ownership include: (1) defining an investment strategy that aims toward ambitious targets but at the same time recognizing what is beyond indigenous capacity; (2) reconciling occasional mismatches between URT and USG/T priorities, (such as with some of the PEPFAR centrally-funded initiatives), and (3) ensuring that USG/T’s commitment to deliver PFIP expected achievements, including those to facilitate greater country ownership, is matched by URT accountability for the same.

The USG/T team has begun the process of defining benchmarks for country ownership within each technical area. Perhaps the most forward thinking has occurred in the area of blood and injection safety,

where transition papers have been shared with URT, resulting in a government-chaired transition working group to push transition in compliance with the PFIP. Creating a high-level formal working group on country ownership on transition is being considered to develop dialogue with both URT officials and USG headquarters staff.   There is also a need to ensure that mentoring and development of local USG/T staff continues to receive high priority. Finally, the continuing shift to local implementation may require a different set of capabilities than those represented in the current USG/T staff structure.

The four dimensions of country ownership specified in the COP guidance are addressed below.

1. Political ownership/stewardship: URT has established a national architecture that includes guidance documents such as the National Multisectoral Strategic Framework on HIV/AIDS as well as documents specific to sub-areas of the response, such as the National Multisectoral Prevention Strategy.   However, URT frequently has difficulty in prioritizing among the very broad set of strategies.   At the same time donors and civil society representatives collectively have multiple priorities that can confuse URT prioritization.

URT is a fairly effective convener of dialogue and most stakeholders try to share information.   URT provides regulatory oversight (i.e. service provision, training, procurement) because these activities cannot move forward without URT acceptance, but exercise much less oversight over community-based activities (e.g. behavioral prevention interventions). USG/T encourages our implementing partners to share financial and program information with district officials to facilitate appropriate planning and oversight at the local level.   USG/T also supports capacity building efforts with district governments to enhance their ability to effectively manage the local-level response.

The URT does not necessarily speak with a united voice on matters pertaining to HIV.   NACP and TACAIDS, for example, are typically at odds regarding the appropriate proportion of investments dedicated to treatment versus prevention.   Bringing them together under the auspices of the Partnership Framework to exchange views and come to consensus on next steps was a positive step in the immediate term. USG/T is providing capacity building to TACAIDS to support it as the current secretariat for the TNCM.

2. Institutional and community ownership: USG/T is engaged in multiple activities across program areas to build ownership of the HIV/AIDS response among governmental and non-governmental entities. Examples include: public-private partnerships to strengthen the for-profit private health sector engagement in the national AIDS response; organizational development activities targeted toward local civil society organizations including advocacy bodies, service providers, and networks of PLHIV; capacity building efforts at the district government level; and, efforts to strengthen the planning, decision making,

and evaluative capacity of central government institutions such as departments within the MOHSW and TACAIDS.

Likewise, continuing efforts to implement the PROMIS system will allow improved sharing of PEPFAR program data and will further empower local institutions with better data to plan. At the national level USG/T is supporting URT to develop its first national Health Financing Strategy, which should enhance URT's ability to account for existing investments and effectively plan for the future. Though URT contributions to the health portfolio continue to run short of their Abuja commitment, URT has initiated plans for an AIDS Trust Fund where the government and other interested local entities can contribute to fund the HIV/AIDS response. The Trust Fund is in it nascent stages, but could provide a substantial support should it be successfully implemented.

3. Capabilities: Technical capacity to manage the national response to HIV varies widely by program area, but remains modest. All prevention, care, treatment, and systems support areas require deeper capacity to assume full local ownership without the potential loss of service/intervention quality or accountability. Blood and injection safety are two areas where Government is most capable for taking over responsibility by the end of the PF. However, the URT will need to increase its financial contributions to the area of blood and injection safety as well as finding sources of support other than PEPFAR.

While no technical area operates fully independently of international support, Tanzania has experienced modest gains in the technical and management capabilities of local organizations to deliver effective services and interventions. Several former sub-partners have graduated to prime partner status under the PEPFAR program. Former Track 1.0 programs, in particular, have gone through a highly successful transition process to local ownership. Another area of success has been the Rapid Funding Envelope, a multi-donor support mechanism that has mobilized more than $18 million from the private sector and donor community to strengthen more than 120 medium and small civil society organizations involved in the response to HIV/AIDS. The USG/T team expects to see an increase in the number of local partners managing HIV programs, though the pace of this development partly will be slow given the enormous capacity building needs. In terms of individual technical capabilities, efforts on the part of URT, USG/T, and other partners to scale up supportive supervision, mentoring, and pre-service training have enhanced URT's ability to deliver services.

Local organizations have also made progress in collecting and using information for strategic decision-making. USG/T has supported Tanzania in the development, execution, and dissemination of national-level surveys such as the TDHS and THMIS, and URT authorities have readily made this data available to public, private, and civil stakeholders. USG/T is also facilitating the consolidation of aggregate data collection systems in line with the National District Health Information System. This data

warehouse will enhance the accessibility and use of information by government and non-governmental program planners.

4. Accountability: Tanzania suffers from corruption with negative impacts on the ability of health providers to provide services. The country rates a low 2.7 on a scale of 1 to 10 by the Transparency International Corruption Perceptions Index (2010). Nonetheless, USG/T and the URT have collaborated on several sector specific strategies to increase the accountability of government health care systems. For example, USG/T has supported improved procurement systems and security protocols to reduce stock loss due to inefficiencies and theft. USG/T has also enhanced the capacity of district governments to use a transparent and participatory approach to program planning, budgeting and accounting. USG/T also is supporting the use of performance-based funding at the facility level and of performance-based management of health workers. Finally, USG/T is working at the community level to increase client demand for high-quality services.

CENTRAL INITIATIVES

Tanzania is fortunate to receive funding for several central initiatives, each of which complement country programming through the COP and bolster USG/T efforts under the PF. Updates on these programs are below.

1. GBV Initiative

Tanzania received $7 million for the first year of programming under this three-year initiative. Agencies are moving money to partners according to their internal management processes and all implementing partners began implementation in October 2011. In addition, formative efforts have already begun, such as: (1) development of national GBV policy and technical guidelines and associated tools and training; (2) assessment of capacity among GBV prevention partners, development of good practice guidelines, and planning for a training on minimum standards for GBV prevention programming in Tanzania; and (3) preparation for a national media campaign to promote awareness of GBV and appropriate individual and community-based responses. The USG/T team also anticipates moving forward with a centrally-managed GBV evaluation effort in the coming months.

2. NACS Integration with PMTCT Acceleration

USG/T successfully submitted its NACS/PMTCT integration plan to OGAC in November 2011 and completed internal planning at the end of September. Central funds in the amount of $4 million will go toward increasing integration of NACS/PMTCT services to all women and under-five children in selected districts within the Dodoma region. Emphasis will be placed on building the capacity of selected district councils to ensure sustainable provision of integrated NACS/PMTCT services by the URT in the areas of planning, budgeting, coordination, supervision and ordering of essential nutrition supplies. NACS services

will be delivered in a comprehensive package linked to PMTCT within existing platforms rather than as a stand-alone activity. The approach will address both preventive and clinical nutrition services. To enhance the policy environment for execution of district-level activities, USG/T also will support modest efforts at the national level to address key policy issues.

3. NACS Integration with Economic Strengthening, Livelihoods and Food Security
USG/T submitted a draft of its NACS/ES/L/FS integration plan to OGAC in November 2011 and is awaiting feedback from the PEPFAR Food and Nutrition Technical Working Group. USG/T has proposed to use these funds, which amount to $875,000, toward three objectives: (1) build households' resilience and reduce economic vulnerability, (2) increase households' capacity to manage and cope with shocks, and (3) integrate economic strengthening interventions with nutrition assessment and education services in HIV/AIDS programming to ensure a continuum of care among OVCs and PLHIV on ART.

4. NACS Integration with Nutritional Care
USG/T submitted a draft of its NACS/NC integration plan to OGAC in November 2011 and is awaiting feedback from the PEPFAR Food and Nutrition Technical Working Group. USG/T will seek to improve the quality of life to women and children, particularly HIV positive mothers, HIV-exposed children, and other vulnerable children during the first 1000 days of life, and improve the quality and effectiveness of the ART, PMTCT, and community support programs. USG/T will use central funds in the amount of $3 million to target PLHIV on ART, and OVC primarily during the first 1000 days of life. General NACS counseling services will be delivered through groups both at facility and community levels, and specific counseling will be delivered tailored to individual needs. The objectives are to build leadership and capacity at District Councils to scale-up and manage NACS services; to increase access to NACS services by scaling the NACS approach and promoting universal application of NACS tools; and to strengthen referrals and linkages through wraparounds with broader development initiatives.

5. Implementation Science
Through the Public Health Evaluation (PHE) mechanism, USG/T is engaged in eight rigorous evaluations spanning several program areas. Two studies are in progress to test the effect of novel interventions in treatment settings on behaviors and health outcomes of HIV-infected adults. "HIV Prevention for People Living with HIV/AIDS: Evaluation of an Intervention Toolkit for HIV Care and Treatment Settings" is a group-randomized multi-country trial, currently in the final round of data collection, with expected completion in December 2011. "Positive Change Agents" is a two-year, step-wedged study of an affirmative inquiry intervention in the piloting phase. With baseline data collection planned for September 2011, the "Strengthening HIV Test Access and Treatment Uptake Study: Project STATUS" evaluation will provide evidence on the comparative outcomes of various provider-initiated HIV testing and counseling modalities. The "Evaluation of Outcomes, Costs and Cost Effectiveness of HIV Testing & Counseling

Modalities in Tanzania" PHE, expected to submit for protocol review and approval in October 2011, will document the cost-effectiveness of a range of HIV testing and counseling approaches. Several clinically-centered evaluations are also underway. Phase one of an ART costing study was successfully completed in 2009, and data collection for phase two is in progress. "How to Optimize PMTCT Effectiveness (HOPE) Project" is the only evaluation currently on hold. Tanzania supports the multi-country "Identifying Optimal Models of HIV care approaches in Sub Saharan Africa" PHE, ongoing through 2014. The "Impact of Primary Drug Resistance on Virological Failure of First-line Regimen in Tanzania" PHE is in the analysis phase, with expected final reports in December 2011.

6. Combination Prevention Research
In line with OGAC guidance, USG/T has redesigned its prevention approach to include a comprehensive set of mutually reinforcing biomedical, behavioral, and structural interventions. However, a full combination prevention strategy has not been implemented at scale and its impact on HIV incidence is yet to be established. The Iringa region of Tanzania provides a unique opportunity to conduct a definitive trial to evaluate whether combination HIV prevention efforts jointly implemented by governmental and non-governmental partners can reduce HIV incidence at the population level. Through the receipt of $15 million OGAC central funds, USG/T will evaluate the impact of an integrated set of biomedical, behavioral and structural prevention interventions to reduce HIV incidence in the Iringa region. Complementary cross-sectional surveys and HIV assessments will be conducted among MARPs (15-39 year old female SWs, male truckers, and MSMs). Both individual and community-level exposure and utilization data of HIV prevention services will be measured to conduct dose response analyses. Cost data will be collected and used to determine cost-effectiveness of the combination prevention package. Epidemiological and programmatic data generated by the evaluation will be used for continuous quality improvement and course corrections not only to achieve better programming for all Tanzanians affected by HIV and AIDS, but to also inform HIV and AIDS programming globally.

7. Medical Education Partnership Initiative (MEPI)
The overall goal for this initiative is to provide direct support to African institutions to transform medical education in Sub-Saharan Africa, strengthen and build clinical and research capacity and thereby strengthen human resources for health. The expected outcome is to have an increased quality and quantity of health care workers and faculty trained and retained in their home counties to practice and conduct research and better respond to the HIV/AIDS epidemic and related co-morbidities. The five-year Tanzanian MEPI program is being implemented through a partnership between Kilimanjaro Christian Medical Centre (KCMC) and Duke University. The project has a total budget of $10M and started in August 2010. Since its inception, there has been a lot of success, including increased capacity of KCMC to enroll students from 120 to 150 students over five years. The institute has also been able to improve faculty capacity in teaching methodologies through introduction of e-learning, team-based learning and

other methodologies through faculty development workshops, faculty performance evaluations, an innovation and teaching award program, and satisfaction reports. Retention of health care workers is being addressed through career tracking database development, alumni engagement, and career counseling on local opportunities. The integration of a research component into the medical school curriculum is addressing capacity building in research, in addition to the enhancement and expansion of community-based research activities and strengthening of the research administrative capacity.

8. Pink Ribbon Red Ribbon (PRRR)
PRRR is an innovative public private partnership to combat cervical and breast cancer - two of the leading causes of cancer death in women - in developing nations in Sub-Saharan Africa and Latin America. Led by the George W. Bush Institute, PEPFAR, Susan G. Komen for the Cure, and UNAIDS, PRRR will expand the availability of vital cervical cancer screening and treatment, especially for high-risk HIV-positive women, and also promote breast cancer education. In December 2011, USG/T submitted an expression of interest to PRRR for $3 million and is currently in consultation with OGAC on finalizing the proposal. The approach is building on past PEPFAR investments and will provide focused support to secondary preventions activities over the next three years. Timely opportunities to address cervical cancer needs in Tanzania include: (1) enhancement of efforts in community advocacy and awareness; (2) provision of equipment and establishment of systems for their routine maintenance; (3) strengthening of laboratory and pathology capacity with a focus on development of quality assurance systems; and (4) support to the Ocean Road Cancer Institute (ORCI), to ensure long-term sustainability of efforts, and three key strategically located referral care institutions to serve as training and mentorship hubs (future centers of excellence) in cervical cancer case management within their respective zones. The goal of the project is to screen 80% of HIV positive women in care and treatment at USG/T-supported regional and district hospitals, for cervical cancer.

9. GFATM Collaboration
In February 2012, OGAC approved the $2 million proposal from the USG/T to the Global Fund Collaboration Initiative. USG/T looks to use this funding to bolster the grant management and oversight capacity of the TNCM, Zanzibar Global Fund Country Coordinating Mechanism (ZGFCCM) management units, and the Principal Recipients (PRs) in the URT to encourage better collaboration between the GFATM and PEPFAR, and to improve grant performance. Activities would cover short-term assistance on immediate skills building of staff in accounting, dashboard use, procurement, and monitoring and evaluation. TNCM and ZGFCCM members need to be provided with clear roles and responsibilities as related to their function. Decisions need to be documented and followed up, and new members need to be supported in their roles. This activity supports two PFIP goals, Goal 3 (leadership) and Goal 6 (evidence-based decision making). The main objective is to have each CCM take on a more pro-active role in planning and coordinating its GFATM grant application, implementation and reporting processes

rather than responding to requests from the GFATM Secretariat. Activities would also include long-term assistance to promote the professionalization of the management units and increase the ability of USG/T, URT, TNCM, ZGFCCM and PRs to plan together and collaborate in grant implementation.

10. Global Health Service Partnership (GHSP)
With financial and technical support from PEPFAR, the Peace Corps is initiating the GHSP in partnership with the Global Health Service Corps, a U.S.-based not-for-profit. The GHSP will recruit, screen, orient and deploy nurses, physicians and other health professionals to serve one year assignments as adjunct faculty in medical or nursing schools abroad. GHSP volunteers will also provide clinical care ancillary to their clinical education tole and are to be fully integrated with faculty at assigned receiving educational institutions. In Tanzania the GHSP will field 9-12 nursing and medical education volunteers.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	1,200,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Adults 15-49 HIV Prevalence Rate	06	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV	160,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Deaths due to HIV/AIDS	86,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV						

infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	1,812,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS	1,400,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS	1,300,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV	730,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

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Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	Service Maintenance and Scale Up: Reduce morbidity and mortality due to HIV & AIDS and improve the quality of life for PLHIV and those affected by HIV & AIDS		
1.1	Maintain care, treatment, and support services existing at initiation of Framework	P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
		P1.3.D	P1.3.D Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site
		C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting
		C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment
		C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth
		C5.1.D	C5.1.D Number of eligible clients who received food and/or other nutrition services
		T1.1.D	T1.1.D Number of adults and children with advanced HIV

			infection newly enrolled on ART
		T1.2.D	T1.2.D Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]
		T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy
		H1.1.D	H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
1.2	Expand prioritized care, treatment, and support services, dependent on available resources	P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
		C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting
		C1.1.D	C1.1.D Number of eligible adults and children provided with a minimum of one care service
		C2.1.D	C2.1.D Number of HIV-positive adults and children receiving a minimum of one clinical service
1.3	Ensure existing and additional care, treatment, and support services adhere to a minimum quality standard and package	T1.1.D	T1.1.D Number of adults and children with advanced HIV infection newly enrolled on

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	of services		ART
		T1.2.D	T1.2.D Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]
		T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy
		H1.1.D	H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
		H1.2.D	H1.2.D Number of testing facilities (laboratories) that are accredited according to national or international standards
		H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
2	Prevention: Reduce new HIV infections in the United Republic of Tanzania		
2.1	Increase access to prioritized and evidence-based HIV prevention interventions that focus on behavioral and biomedical drivers of the epidemic and on underlying structural factors that influence HIV transmission and vulnerability	P5.1.D	P5.1.D Number of males circumcised as part of the minimum package of MC for HIV prevention services
		P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the

			minimum standards required
2.2	Increase the efficacy of prevention programming through appropriate alignment of resources and prioritized interventions targeting key drivers of the HIV epidemic	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
2.3	Develop/create an enabling environment for effective and sustainable prevention programming	P12.5.D	P12.5.D Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV pilot indicator)
3	Leadership, Management, Accountability, and Governance: Provide well-coordinated, effective, transparent, accountable, and sustainable leadership and management for the HIV & AIDS response		
3.1	Ensure the implementation of prioritized, costed HIV & AIDS plans based on the NMSF and HSSP III	H2.1.N	H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period
		H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
3.2	Improve governance systems responsible for HIV & AIDS programs (accountability, transparency, and information flow)	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
3.3	Support a decentralization by devolution strategy for HIV & AIDS-related issues	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources

4	Sustainable and Secure Drug and Commodity Supply: Strengthen procurement and supply management systems of HIV & AIDS-related commodities		
4.1	Strengthen logistic management systems to provide drugs, supplies, and commodities for the management of HIV & AIDS patients through the supply chain	P6.2.N	P6.2.N Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available
4.2	Ensure the procurement of all quality drugs, supplies, and commodities based on the MOHSW Procurement Plan and associated schedule	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
4.3	Reduce proportion of equipment that is out of service	H1.1.D	H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
4.4	Strengthen logistic management systems to support the procurement of non-medical supplies and commodities, and medical supplies used outside of clinical services	H1.1.D	H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
		H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
5	Human Resources: Ensure human resources capacity necessary for the achievement of quality health and social welfare service at all levels		
5.1	Increase production of health workers, social workers, and personnel in allied health services from training institutions	H2.1.D	H2.1.D Number of new health care workers who graduated from a pre-service training institution within the reporting period
		H2.2.D	H2.2.D Number of community health and para-social workers

			who successfully completed a pre-service training program
		H2.1.N	H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period
5.2	Increase number of qualified human resources strategically posted and retained; reduce vacancy rates	H2.2.D	H2.2.D Number of community health and para-social workers who successfully completed a pre-service training program
		H2.1.N	H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period
		H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
5.3	Optimize manpower to address health and HIV & AIDS needs	H2.2.D	H2.2.D Number of community health and para-social workers who successfully completed a pre-service training program
		H2.1.N	H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period
6	Evidence-based and Strategic Decision Making: Improve use of relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision making		
6.1	Strengthen and coordinate multi-sectoral M&E systems to ensure quality vertical	P6.2.N	P6.2.N Percentage of health facilities with HIV

	and horizontal flow of information and use of data by HIV and AIDS, health, and social service sectors		post-exposure prophylaxis (PEP) available
		H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
6.2	Increase national capacity to implement key national and sub-population surveys, studies, and evaluation activities	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
		H2.1.N	H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period
6.3	Improve measures of HIV incidence	P1.1.N	P1.1.N Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
		C1.1.N	C1.1.N Number of eligible adults and children provided with a minimum of one care service
		T1.2.N	T1.2.N Percent of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)
6.4	Adopt best practices in evidence-based and strategic decision making	P6.2.N	P6.2.N Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available

Engagement with Global Fund, Multilateral Organizations, and Host Government

Agencies

In what way does the USG participate in the CCM?
Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
7+ times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
7+ times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.
Yes

In any or all of the following diseases?
Round 11 HIV, Round 11 TB

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?
Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.
Round 8 (R 8) Phase 1 has almost entirely been disbursed. The remainder of the funding is being withheld pending additional supporting information by the Medical Stores Department. With Tanzania in the process of changing the guidelines for earlier treatment, however, Phase II funds from R 8 will most likely be drawn down faster than expected. This situation needs to be reviewed and USG planning revised in light of the postponement of R 11, especially as the TFM can not be used for scaling up programs.

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation

and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?
Redacted

Did you receive funds for the Country Collaboration Initiative this year?
Yes

Is there currently any joint planning with the Global Fund?
Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Round	Principal Recipient	Assistance Provided	Value of Assistance (If Known)	Programming Impact	Causes of Need
8	Ministry of Finance	procurement of HIV rapid test kits	6,000,000	Involved USG staff time	Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons

8	Ministry of Finance	procurement of anti-retroviral drugs	13,000,000	Involved USG staff time	Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons
8	Ministry of Finance	procurement of CD4 reagents	6,700,000	Involved USG staff time	Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons; Disbursements delayed to the PR, due to in-country reasons

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
	SolarAid - PPP	7287:SolarAid - PPP	SolarAid, New Partner	350,000	350,000	In collaboration with the University of Arizona, SolarAid is supporting the

						electrification of rural facilities in Mbeya region through this activity. In Year 3 of 4, this activity (a) provides solar power to rural health facilities (especially maternity wards, labs, and theatres) and to staff housing, which contributes to staff retention, and (b) creates income-earning activities for groups supporting PLWH and microenterprises for youth who sell solar portable lights to their communities. There are no COP indicators for this activity, although there are other indicators against which

						SolarAid must report progress.
	Touch-PPP		Touch Foundation, Bristol-Myers Squibb Foundation, McKinsey & Company, The Abbott Fund	2,000,000	2,000,000	The Touch Foundation partners with McKinsey & Company and the Weill Cornell Medical School to address HR issues in the health sector. They are supporting the training of more than 800 students in eight health cadres at Weill Bugando University College of Health Sciences (BUCHS) in Mwanza. Through a twinning program visiting professors provide instruction in US-based teaching methods, diagnosis, and patient care. This activity is in Year 4 of 6 and

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						(a) increases student enrollment in 12 cadres of health workers at BUCHS through partial support of student and faculty costs; (b) expands trainee practicum experiences to regional and district hospitals; (c) promotes the effective deployment of graduates through career offices; (d) coordinates development of health management training; and (e) strengthens ICT infrastructure and other infrastructure improvements to increase training capacity. The Touch Foundation reports on the Number of new HCWs who

						graduated from pre-service training.
	APHFTA - PPP		Association of Private Health Facilities of Tanzania, Bienmoyo Foundation, PharmAccess International	584,563	635,550	APHFTA represents more than 400 private, primarily for-profit, health facilities in the country. In collaboration with Wharton Business School, local consulting and training expertise, and PharmAccess International, APHFTA will establish (a) a business training program that will enable medical practitioners to establish sustainable private practices, (b) an upgraded IT network connecting its membership, and (c) a revolving loan fund primarily to upgrade lab facilities and

						train staff. This nationwide program will improve care and treatment services provided by private physicians through upgraded lab facilities and staff training. IT upgrades and modem installation will result in improved medical reporting to APHFTA and, in turn, APHFTA's ability to provide critical medical data and support. Third, APHFTA will be able to play a more influential leadership role in the health care system as its members improve their capacity to provide quality healthcare that

						is customer-oriented.
	CME - PPP		Africare, Tanzania Chamber of Minerals and Industry, African Barrick Gold	333,000	402,000	The Tanzania Chamber of Minerals and Energy (CME) represents private small, medium and large domestic and international mining companies. This activity is in Year 1 of 3 and provides prevention, care and treatment services to a MARP community that receives very little healthcare, let alone HIV and AIDS support. The objectives are (a) to enable the district health system to deliver HIV/AIDS, TB, sexual and reproductive health, and malaria services to artisanal and

						small-scale miners and (b) to complement efforts to better integrate into the formal district economy artisanal miners and small-scale miners. The Tanzania Chamber of Minerals and Energy will report on the following indicators: (1) Number of general population reached with individual and small group interventions; (2) Number of PLHIV reached with individual and small group interventions; (3) Number of PLHIV receiving treatment; and (4) Number of pregnant women who were tested for HIV and who know their

						results.
	Tourism - PPP		TBD			The objectives of this nationwide activity are to (a) establish HIV/AIDS prevention programs that target tourists, tourism employees, and communities surrounding tourist destinations and (b) mobilize funds from tourists to support work place and community-based HIV/AIDS prevention, care and mitigation activities. There are three partners envisaged for implementing this activity. First is the Tourism Confederation of Tanzania (TCT), which is the umbrella organization representing

						private businesses involved in the travel and tourism industry in Tanzania. The other two partners are expected to be the Center for Responsible Travel (CREST) and LifeAction Ltd. CREST, an international NGO that was founded in 2003 at Stanford University, conducts research on and is involved in projects that use tourism and international travel as a tool for promoting socio-economic empowerment, poverty reduction and biodiversity conservation. LifeAction is a Tanzanian registered company that

						has extensive experience in South Africa in workplace and community-based programs. LifeAction, specializes in forging public-private partnerships as an operating business principle.
	EID - PPP					The objective of this activity is to develop fast, affordable, reliable and sustainable Early Infant Diagnosis (EID) transport and reporting systems. The Tanzania Communications Regulatory Authority will be asked to consider developing a unique identifier for EID recipient laboratories. Special envelopes will

						be developed so they can be readily identified by the public in the event that they are misplaced. This will be combined with awareness raising broadcast and print media publicity. It is anticipated that this activity will be able to tap into the financial resources and expertise of international couriers such as the UK-based, TNT, which already is providing support to OVC in Tanzania through the World Food Program.The real challenge is transporting the EID specimen from the rural facility to the district level where most

						courier services end. A partnership will be explored with a number of local bus owner associations in the country and with the Tanzania Bus Owners Association (TABOA), which represents these associations at the national level. Very localized, informal daladala associations will also be invited to participate.
	Gen Mills/JHFC - PPP		General Mills, New Partner	150,000	200,000	In September 2009, General Mills entered into agreement with OGAC and USAID to transfer technical and business expertise to 15 sub-Saharan countries; Tanzania is the first country to

						participate in the initiative. This partnership may lead to long-term partnerships between General Mills and local millers. The objectives of this activity are to (a) meet the nutritional needs of PLWA, (b) develop prescription food processing capacity in Tanzania, and (c) improve the economic well-being of individuals in the production and distribution value chain. This activity is in Year 2 of 2 to (a) identify and develop the capacity of a local miller to produce fortified food for people on ARVs; (b) Procure an extrusion cooker and essential

						spare parts; (c) Install and field test the extrusion cooker; and (d) disseminate the methodology and programs to build capacity and improve and propagate fortified food production in Tanzania and sub-Saharan Africa. There are no COP indicators for this activity.
	BizWomen - PPP		TBD			The goal of this activity is to mobilize businesswomen and women managers in the private sector in the fight against HIV/AIDS. It is anticipated that the Federation of Associations of Women Entrepreneurs in Tanzania (FAWETA), which is the largest and

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						oldest women entrepreneurs' association in Tanzania with 3,500 members, is expected to be the partner in this activity. The BizAIDS program, developed and widely tested in sub-Saharan Africa by the U.S.-based International Senior Executive Corps (ISEC), integrates prevention and counseling/testing promotion with small business development. The objectives are (a) to enable FAWETA to deliver the BizAIDS program as one of its services to women-owned small and medium-sized enterprises (SMEs) and to women

						managers in the private sector who have interest in beginning their own businesses, (b) to train master trainers and to test and modify the program so that it will be a FAWETA revenue earning service for the organization by the end of one year, and (c) to increase awareness about how HIV impacts on the efficiency of SMEs and on the economic viability of the surrounding communities upon which SMEs rely to sustain their business.
	Kilicafe - PPP		TBD			The Kilicafe OVC Scholarship Fund will pay the educational

						expenses of an anticipated 100 OVC to attend public secondary schools. The objectives of this activity are (a) to provide an opportunity for OVCs, who are performing well in primary school, to attend secondary school and (b) to involve coffee cooperative members in HIV/AIDS mitigation. OVCs living in the coffee growing areas of Arusha, Kilimanjaro, Manyara, Mbeya and Mbinga will be beneficiaries of this activity. This is because the Kilicafe OVC Scholarship Fund is being established by the Association of Kilimanjaro Specialty Coffee Growers

						(AKSCG), which is a registered association comprised of 35 farmer groups in the Kilimanjaro, Arusha and Manyara area, 109 groups in the Mbinga area and 2 groups in the Mbeya area. Kilicafe is both the brand name of their premium coffee and the name of the company that exports AKSCG's coffee to roaster companies abroad.
	BIPAI-PPP		Baylor University, Bristol-Myers Squibb Foundation, The Abbott Fund	3,000,000	3,000,000	Baylor International Pediatrics AIDS initiative provides increased access to quality integrated pediatrics HIV services. Specifically it focuses on improved quality of care of

						children infected with HIV. The program also address the gaps in management of HIV-infected children and their families through provision of state-of-the-art prevention, care, treatment and support services for HIV-exposed/infected children at the Pediatric Centers of Excellence (CoE) in the Lake and Southern highlands zones. The program also contributes in the improvement of health systems through strengthening health care service delivery, with a focus on increased

						human resources for health efficiency. The programs strengthen health care workers capacity in management of child health through provision of concentrated mentoring and clinical attachments at the Pediatric CoEs. Health workers are provided with skills and competencies to provide high quality services to HIV-infected children and children at large.
	GAME - PPP					The objectives of this planned activity are to (a) provide training and onsite coaching of bio-medical technicians in the use of lab equipment, (b) develop job aids

						that will help reinforce what trainees have learned, (c) establish maintenance protocols that will be institutionalized, and (d) identify needed repair parts and consumables that might be sourced from the U.S. The anticipated primary implementing partner of this PPP will be Global Assistance in Medical Equipment (GAME). With offices in Atlanta GA near the CDC international headquarters, GAME is a voluntary coalition of global medical device experts who began their

						work in Kosovo in October 2005. . In Tanzania GAME enjoys a working relationship with the Department of Continuing Education and Professional Development at Muhumbili University of Health and Allied Sciences and with Orbis International and its partner, the Dar-es-Salaam Institute of Technology (DIT). While the provision seed financial assistance is an important contribution of PEPFAR, the more important aspect of PEPFAR is facilitating the renewal and strengthening of these linkages, including those already formed

						in the February 2009 with the Ministry of Health and Social Work. In this way PEPFAR lays the foundation for its exit.
	CIDR - PPP		Biolands Ltd., Elton John AIDS Foundation, International de Developpement et de Recherche (Centre for International Development and Research)	497,467	1,006,162	The Centre for International Development and Research (CIDR) is a French NGO that successfully established an insurance program in Mbozi District, where the attendance rate at medical facilities by members of the Community Health Insurance Fund (CHIF) is five times higher than the uninsured. PEPFAR/T funding is being used to leverage funds from Biolands Ltd, one of the major

						cocoa traders that supplies Kyela production to markets in Europe. The Elton John AIDS Foundation is funding the HIV re-insurance component. This activity is in Year 2 of 4 to (a) establish a community-managed health insurance program for cocoa producing families in Kyela District; (b) enroll at least half of the district's 200,000 population; (c) ensure quality health care for CHIF members; and (d) educate government counterparts on how to implement genuine community-based health financing programs. There

						are no COP indicators for this activity, although there are other indicators against which CIDR must report.
2011 APR	Madaktari-PPP		Cornell University, Madaktari Africa	750,000	750,000	This activity is in Year 1 of 2 at Mbeya Referral Hospital. It (a) provides on-the-job training of healthcare personnel in HIV/AIDS prevention, care and treatment; (b) strengthens healthcare systems, e.g. financial management, patient record keeping, and customer service; and (c) provides specialized expertise, e.g. renal diagnoses, cardiologic care. There are no COP indicators for this activity,

						although there are other indicators against which Madaktari Africa must report progress.
2011 APR	mHealth		Johnson and Johnson, PharmAccess International, mHealth Alliance, Deloitte Consulting Tanzania Limited, DEUTSCHE GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT (GIZ) GMBH, KfW Bankengruppe, Khanga Rue Media	1,149,394	2,000,000	Through the mHealth Tanzania Partnership, the CDC and the MOHSW are working together to create partnerships that help establish m-health systems and improve the sustainability of these system strengthening investments over the long term. In Year 3, this activity covers these main initiatives: (a) Integrated Disease Surveillance and Response to improve reporting, tracking and response to

						notifiable diseases; (b) Mama Messaging to educate pregnant women in ANC, PMTCT, malaria, birth planning, nutrition, and prevention for HIV positive women; (c) Blood Donor Communication and Outreach that entails SMS messages sent from the NBTS to improve donor retention; and (d) Messaging to educate and support patients receiving care and treatment, and to support basic monitoring for PMTCT, care and treatment. The partnership has developed a long list of potential PPPs and is continuing to follow up on these, working

						with the MOHSW to have them formally endorsed by MOHSW leadership.
2012 COP	TBD		TBD	Redacted	Redacted	Given the MOHSW's budget constraints, it is critical to integrate HIV and AIDS activities into other business or economic development activities that eventually are able to continue the activities without external funding. Potential partnerships for these TBD funds include: (1) The New Forests Company, to provide healthcare for its workers and the communities surrounding their forests; (2) Olam Tanzania, which

						operates a cashew processing factory in Mtwara with nearly 4,500 workers, 98% of whom are rural women, to start a HIV and general health workplace program; (3) the Association of Tanzania Employers, ILO, and National Microenterprise Bank, to support the BizAIDS program for youth and people working in the informal sector; and (4) Roche Diagnostics, to strengthen diagnostic laboratories and develop a comprehensive diagnostic referral network in Tanzania. Each of these potential PPPs,

						and others yet to be identified, will require a different set of indicators to track progress.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	2010 Female Sex Worker Study Mainland Tanzania	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing	N/A
N/A	2010 Tanzania Mainland ANC Sentinel Surveillance	AIDS/HIV Case Surveillance	Pregnant Women	Implementation	N/A
N/A	2010 Zanzibar ANC Sentinel Surveillance	AIDS/HIV Case Surveillance	Pregnant Women	Data Review	N/A
N/A	2011 ANC Surveillance Mainland	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation	N/A
N/A	2011 FSW Study in Zanzibar	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing	N/A
N/A	2011 FSW, IDU, MSM Study in Zanzibar	Population-based Behavioral Surveys	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men	Publishing	N/A

N/A	2011 HIV Drug Resistance Threshhold Study	HIV Drug Resistance	Pregnant Women	Implementation	N/A
N/A	2011 MSM Study	Population-based Behavioral Surveys	Men who have Sex with Men	Publishing	N/A
N/A	2011 Tanzania HIV Malaria Indicator Survey	Population-based Behavioral Surveys	General Population	Publishing	N/A
N/A	2012 ANC Surveillance Zanzibar	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Development	N/A
N/A	2012 Female Sex Workers Mapping Mainland Tanzania	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Implementation	N/A
N/A	2012 HIV Drug Monitoring	HIV Drug Resistance	General Population	Development	N/A
N/A	2012 Injection Drug User Study Mainland Tanzania	Population-based Behavioral Surveys	Injecting Drug Users	Planning	N/A
N/A	2012 Injection Drug Users Mapping Mainland Tanzania	Population-based Behavioral Surveys	Injecting Drug Users	Development	N/A
N/A	2012 Men who have Sex with Men Mapping Mainland Tanzania	Population-based Behavioral Surveys	Men who have Sex with Men	Planning	N/A
N/A	2012 MSM Study Mainland	Population-based Behavioral Surveys	Men who have Sex with Men	Data Review	N/A

N/A	ANC/PMTCT Comparison Study Mainland Tanzania	Evaluation of ANC and PMTCT transition	General Population	Development	N/A
N/A	Biological and Behavioral Surveillance (Dar Es Salaam)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Data Review	N/A
N/A	Biological and Behavioral Surveillance (Unguja and Pemba - Zanzibar)	Behavioral Surveillance among MARPS	Injecting Drug Users	Publishing	N/A
N/A	Biological and Behavioral Surveillance (Unguja and Pemba - Zanzibar) 2	Population-based Behavioral Surveys	Men who have Sex with Men	Development	N/A
N/A	Biological and Behavioral Surveillance (Unguja and Pemba)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development	N/A
N/A	Comparison of ANC/PMTCT (Zanzibar)	Evaluation	General Population	Publishing	N/A
N/A	HIV Drug Resistance Monitoring	HIV Drug Resistance	General Population	Development	N/A
N/A	HIV Resistance Early Warning	HIV Drug Resistance	General Population	Implementation	N/A
N/A	Mortality Data Surveillance	HIV-mortality surveillance	General Population	Implementation	N/A
N/A	Sample Vital Verbal Autopsy Mainland Tanzania	HIV-mortality surveillance	General Population	Implementation	N/A
N/A	Tanzania Demographic and Health Survey Population-based Behavioral Surveys	Population-based Behavioral Surveys	General Population	Publishing	N/A
N/A	Tanzania HIV/AIDS Malaria	Population-ba	General	Publishing	N/A

	Indicator Survey (2011-12) THMIS	sed Behavioral Surveys	Population		

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			14,469,460		**14,469,460**
HHS/CDC	17,256,079	3,683,000	93,175,701		**114,114,780**
HHS/HRSA			7,920,885		**7,920,885**
HHS/NIH			350,000		**350,000**
HHS/OGHA			485,760		**485,760**
PC			1,991,800		**1,991,800**
State			65,000		**65,000**
State/AF			3,831,928		**3,831,928**
USAID			146,325,608		**146,325,608**
Total	**17,256,079**	**3,683,000**	**268,616,142**	**0**	**289,555,221**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	DOD	HHS/CDC	HHS/HRSA	HHS/OGHA	PC	State/AF	USAID	AllOther	
CIRC	1,109,003	2,729,173					10,171,280		**14,009,456**
HBHC	1,536,024	8,261,132	242,875				8,695,463		**18,735,494**
HKID	150,000	1,953,032	880,050			0	21,543,419		**24,526,501**
HLAB	406,255	3,825,591	630,000			1,400,000	192,454		**6,454,300**
HMBL		4,799,806					100,000		**4,899,806**
HMIN		1,273,298					320,117		**1,593,415**
HTXD		24,433					15,368,397		**15,392,830**
HTXS	4,705,509	45,872,675	171,030				12,895,268		**63,644,482**
HVAB	525,727	984,902					2,865,585		**4,376,214**
HVCT	721,860	3,618,553	540,000				9,139,965		**14,020,378**

HVMS	1,253,188	5,322,421		485,760	1,871,800		3,906,029	65,000	**12,904,198**
HVOP	784,403	3,750,049			120,000		11,733,228		**16,387,680**
HVSI	20,988	4,774,551					1,546,489		**6,342,028**
HVTB	316,672	3,169,904	186,930			500,000	2,112,529		**6,286,035**
IDUP		2,626,788	150,000						**2,776,788**
MTCT	2,056,888	11,475,655	540,000			700,000	15,003,386		**29,775,929**
OHSS		3,450,769	4,580,000			1,231,928	27,576,842	350,000	**37,189,539**
PDCS	67,503	1,052,180					556,000		**1,675,683**
PDTX	815,440	5,149,868					2,599,157		**8,564,465**
	14,469,460	**114,114,780**	**7,920,885**	**485,760**	**1,991,800**	**3,831,928**	**146,325,608**	**415,000**	**289,555,221**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: National Medicines Policy (draft 2011?)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Ongoing		
Narrative	In the early 2000s the need for a Medicines Policy was identified to support laws in this area. Challenges: Streamlining issues related to manufacturing, importation, supply, quality, professional practice and premises for pharmacies. Stakeholders: MOHSW,	MOHSW formed a TWG in 2001. Several stakeholder meetings took place (stakeholders as in Stage 1). Challenges: Separation of regulation of pharmacy professionals from regulations of premises and businesses in order to maintain the quality of professionals and ensure	Stakeholders completed the policy; submission delayed due to doctors' strike. Key areas addressed: Supply of medicines; registration and regulation of medicines; quality assurance; rational use of medicines; regulation of pharmacies; financing; HR regulations for pharmacy industry	Not yet submitted for endorsement due to delay as a result of doctors' strike at the beginning of 2012. Ensuing crisis kept senior MOHSW officials engaged and lead to suspension of high-level officials in February, 2012		

	TDFDA, TPC, MSD, WHO, MOJCA, MAT, private sector, School of Pharmacy at MUHAS	safety of medicines and supplies				
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: Public Procurement Act (2001); amended in 2004 and 2011						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Ongoing	Ongoing	Completed	2012	
Narrative	Purpose of act: Transparent public procurement. PPRA reviews/studies on procurement indicated problems (eg, transparency in tendering, violations of regulations,	Frequent amending of the act indicates its importance. New act is strong if properly implemented and supported by new regulations. Challenges: 1) Lack of disburseme	The 2011 regulations for the act are under development. Reaching concensus on what should go into these regulations is a challenge, which slows down completion	The act was endorsed in 2001; amendments endorsed in 2004 and 2011; regulations for 2011 amendment not yet at endorsement stage	Still waiting for regulations of the act to become operational; (2004 act still in use)	Amendments took place as result of reviews. Many studies have highlighted problems in the area of procurement, resulting in serious problems and complaints in the field

	lack of knowledge on tendering procedures -- amended to strengthen procedural regulations (2004) and transparency and sanctions (2011). Stakeholders: PPRA, MSD, TFDA, MOHSW, UN, JSI, Deliver, GAD, WB	nt of funds to facilities; 2) late release to MSD; 3) formula for allocation of funds to health facilities; 4) stockout of required health commodities 5) in-ability to dispose of damaged or expired commodities that take up storage space and create security challenges	of the regulations. Stakeholders: PPRA and MOFEE are spearheading the process. Others include MSD, TFDA, CRB, CAG			
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: Tanzania Food, Drugs and Cosmetics Act, 2003 (amended with passing of the Pharmacy Act 2011)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion	Completed	Completed	Ongoing	2003	Ongoing	

Date						
Narrative	Act passed and came into force in 4/03. It provides for regulation and control of food, drugs, medical devices, herbal drugs, poisons, etc. Act amended by the Pharmacy Act of 2011 to split the functions of the Pharmacy Council and TFDA to improve efficiency. Challenges: 1) Approval and registration process is too slow; 2) lack of harmonizati	About 80% of medicines used in the country are imported. Sources are diverse and have diverse regulations. Duplication of approval efforts in the region results in poor access and non-availability of needed drugs. National drug manufacturing is minimal. Harmoni-zation of act with other countries is a rational option. Stakeholders include MOHSW, TFDA,	Major changes were introduced by the Pharmacy Act of 2011. Consequently, TFDA is left with manufacturing, importation and regulation of phar-macy business. Tanzania is involved in the regional NEPAD study on policies governing approval and regi-stration of medicines and the level of harmonization Stakeholders: NEPAD,	Endorsed 2003 (amended 2011 w/passing of Pharmacy Act)	Currently enforced as passed in 2003. Shortcomings / problems as outlined in Stages 1 and 2	

	on in the region	PHLB, MSD, CDC	MOHSW, TFDA, MSD			
Completion Date						
Narrative						

Policy Area: Access to high-quality, low-cost medications						
Policy: The Pharmacy Act, 2011						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Completed	
Narrative	The first act was passed in 2002 to establish the Pharmacy Council and to regulate the pharmacy profession. It was repealed by the Pharmacy Act in 2011 to demarcate mandates between the pharmacy profession and	The 2011 Pharmacy Act reestablishes and strengthens the Pharmacy Council which took over some of the TFDA's functions, eg, registration and regulation of practising pharmacists. Challenges: Conflicting	Considerable controversy arose during the development of the 2011 Act to address the challenges in outlined in Stage 2. The act left the Pharmacy Council to deal with professional accreditation while TFDA continued with approval,	Endorsed in 2011	Act is in force; regulations are under preparation	

	pharmaceutical business regulatory bodies and functions. Stakeholders: MOHSW,TDFDA, MOJCA, PC, MSD, WHO, TMA, private sector	interests and mandates related to professional practice and premises, accreditation and inspection	registration of medicines and supplies. As a result, TFDA is less powerful than before. Stakeholders the same as in Stage 1			
Completion Date						
Narrative						

Policy Area: Counseling and Testing						
Policy: National Guidelines for Voluntary Counselling and Testing in Tanzania (2011) NACP						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	2011	Not yet		
Narrative	MOHSW/NACP identified need for review, update & consolidation of several VCT guidelines and SOPs	Stakeholders: MOHSW/NACP; CDC; WHO; AMREF; local partners. TWG established.	Stakeholders as under Stage 2; extensive consultations. Challenges: 1) Legal/ regulatory contradictio	Draft delayed by cumbersome procedures (eg. approval of test kit); critical policy areas not		

	and adherence to HIV and AIDS Prevention and Control Act (2008) and regulations (2010). Problems: Lack of home-based HTC guidelines, low levels of HTC (55% women/40% men (adults) tested compared to coverage target of 85-90%); unknown status leading to unmet need for ART	Challenges: 1) Harmonizing policies into one; 2) unresolved policy issues (eg. HRH - lay counselors; # of professionals and skills level); approval and registration process; procurement; equity); 4) weak health system (eg. HCT services/ # of sites)	ns; 2) unresolved policy issues (eg. task shifting; licensing; approval and registration - procurement)	resolved; GF funding issues		
Completion Date						
Narrative						

Policy Area: Gender

Policy: Ineritance Laws (Indian Succession Act 1865, Customary Declaration Order 1963, Islamic Law of inheritance, Probate and Admin of Estates Act 1963)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Ongoing			
Narrative	Judges, academics, politicians, women's rights activists, and Law Reform Commission (LRC) identified discrimination in inheritance on the basis of sex and procedural inequalities as contrary to develop-ment and human rights.The many types of laws (statutory; custo-mary; religious) applied are not	Procedural laws favor selection of male administrators - even if they are distant relatives of the deceased, thus excluding women from the management of estates. In 1968 MOJCA appointed a special committee to investigate inheritance matters. In 1996 MCDGC began to push for	After studying inheritance issues countrywide, in 1987 LRC recommended reforms. In 2002 WLAC drafted a bill and obtained public support before submitting it to MOJCA. In 2004, the GOT decided to wait until after the 2005 elections to review the controversial bill. White paper to be developed;	Reforms have not taken place - therefore nothing yet to endorse	[Old laws continue to be implemented and result in continued discrimination against women. These laws pertain to the administration of the estate using either customary or religious laws, which in most cases do not give women the right to inherit]	

	harmonized w/ modern law - they deny women the right to inherit	codification of inheritance laws. Considerable CSO advocacy for decades	nothing has happened ever since. CSO advocacy has continued			
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Land Act 1999						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	1999	Ongoing	
Narrative	Due to gender inequality and conflicting interests re: use of land, Ministry of Land and Human Settlement appointed a Commission of Inquiry in 1991 to explore relevant issues. MLHS	Contentious social, political and economic issues led to national debate, involving the government, academics, and NGO coalition. Government and NGO disagreement ensued. Recommen	Process: Public hearings; studies (including exploration of gender issues and pastoral rights) by experts provided inputs to the bill(s). Expert drafted the bill, which was subsequentl	The law was passed in 1999 and came into force in 2001 after development of regulations	MLHS is engaged in activities to publicize and defend the Land Act. Implementation presents many challenges: Most people, including administrators, are not familiar with the	Law has not been reviewed, but discussions have taken place about review of some provisions in the law

	appointed a Committee to review existing laws. Stakeholders: Gender Land Task Force established, NGOs involved (eg. Hakiardhi)	dations led to review of the many laws governing land tenure. Process led to two different laws: The Land Act 1999 and the Village Land Act 1999.	y debated in Parliament. Challenges: Numerous interest groups with different agendas; politics within Parliament itself re: the customary law clauses in the bill.		provisions of the law; improper implementation; timeconsuming and expensive processes to exercise one's rights	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Management Guidelines for Health Sector Prevention and Response to Gender-based Violence (GBV) 2011 Ministry of Health and Social Welfare						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	COMPLETED	9/2011	Ongoing	
Narrative	GBV: Ongoing health and dev. problem & human rights violation in TZ identified, among	MOHSW established TWG; TA from HPI. Key stakeholders: USAID / partners; UN family; ministries and	HPI initiated drafting (7/10), working closely w/GBV TWG led by MOHSW. Larger group of stakeholder	Management guidelines adopted/ signed by MOHSW; printed in English launched 12/11; translated	Drop-in center established in Iringa to demonstrate community GBV response. 21 implementin	

	others, in 2005 WHO study and 2008 HPI GBV policy scan. Major finding: GBV survivors do not receive appropriate treatment in health facilities due to lack of GBV management guidelines. MOHSW requested TA from HPI to develop GBV guidelines (2/10).	agencies (MoJCA, MoEd, MoCDGC, MoF, police, judiciary); CSO; local gov.; medical personnel; policy directors. Challenges: MOHSW requested health sector guidelines with multisectoral involvement for TZ context, requiring extensive process of consultation - not easily managed.	s reviewed policy and provided feedback. Challenges: Conflicting views, interests, and definition of GBV due to diversity (cultural, ethnic, religious, gender). Inadequate internalization of GBV as a problem.	into Kiswahili 1/12	g partners received grants to implement. HPI oriented Iringa district councilors & ward development committees on GBV policy/guidelines. Challenges: Sustainability of partners' activities; lack of thorough knowledge of GBV policy & guidelines; weak health system; poor multisectoral coordination; funding	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Plan of Action for the Prevention and Eradication of Violence against Women and Children (2001-2015) MCDGC						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	COMPLETED	COMPLETED	Ongoing	Ongoing
Narrative	Lack of national plan of action to address VAWC before 2001 despite violence being a big problem in TZ. Stakeholders: CSO (eg. TAWLA, KIWOHEDE), MCDGC. Challenges: Early advocacy and action against VAWC were mostly taken by CSO's donor-funded projects in	MCDGC coordinated stakeholder process with CSO (US funding); UN family; MDAs. Challenges: Time and resources	MCDGC, Kivulini, WLAC, and WILDAF, KIWOHEDE engaged in action plan development. Challenge: Time and resources	Endorsed by MCDGC in 2001	Challenge: Inadequate funding for implementation by stakeholders (eg. WILDAF, KIWOHEDE), MCDGC. Funding from UNFPA,UNW. TA and funding from CAs. Multisectoral committee of 25 members including the police, CSOs and MDAs launched in 2011 to oversee implementation of action	Now developing M&E plan.

	the absence of a national framework for implementation and coordination; limited government ownership.				plan. Insufficient coordination; need for strengthening coordination on VAW (GBV)	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Policy Guideline for Health Sector Prevention and Response to Gender-based Violence (GBV) 2011 Ministry of Health and Social Welfare (MOHSW)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	COMPLETED	9/2011	Ongoing	
Narrative	GBV: Health and dev. problem/human rights violation in TZ identified, among others, in 2005 WHO study and 2008 HPI GBV policy scan. Major	MOHSW established TWG; TA from HPI. Key stakeholders: USAID and its partners; UN family; ministries and agencies (MoJCA, MoEd,	Drafting began 7/10 - HPI working closely w/GBV TWG led by MOHSW. Larger group of stakeholders reviewed policy and provided feedback.	Policy adopted/ signed by MOHSW; printed in English launched 12/11; translated into Kiswahili 1/12	Policy: used to direct development of guidelines; established roles and responsibilities & service package at different levels; currently used to	

	finding: GBV survivors do not receive appropriate treatment in health facilities due to lack of GBV manageme nt guidelines. MOHSW requested TA from HPI to develop GBV guidelines (2/10). Policy mandate required	MoCDGC, MoF, police, judiciary); CSO ; local gov.; medical personnel; policy directors. Challenges: TZ requested health sector policy with multisectora l stakeholder s for TZ context, requiring extensive process of consultation not easily managed	Challenges: Conflicting views, interests, and definition of GBV due to diversity (cultural, ethnic, religious, gender). Internalizati on of GBV as a problem		develop training package; was distributed to health managers in 3 regions. Challenges: Multi-sector al mandate/ policy required for successful coordination & implementat ion; advocacy with other branches of government required	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Sexual Offences Special Provisions Act (1998) (SOSPA)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	!980 and later	Completed	Completed	1998	Ongoing	

Narrative	The CSO (e.g TAMWA, TAWLA, MEWATA) campaign against sexual and gender based violence paved the way for demand for greater protection against SGBV. The NGO coalition worked closely with MCDGC, MOJCA, the Police, the Judiciary and Parliament, and the Law Reform Commission (LRC), which lead to commitment to draft a	Advocacy and sensitization by CSOs including TAMWA in the 1980s and 1990s led to increased awareness of the magnitude of the SGBV problem and put pressure on GoT to address the problem. With UNDP support, in 1991 the LRC studied cases and causes of rape, defilement, indecent assault, kidnapping for sexual purposes, incidence and degree	LRC presented the report with recommendations to MOJCA for drafting a bill. SOSPA was drafted and a national debate followed. MCDGC and the NGO coalition under TAMWA lobbied membes of Parliament for support	SOSPA was enacted in 1998	Challenges: Neither the law nor its implementation has been effective in combatting the serious problem of SGBV. Customs continue to perpetuate SGBV (see Stage 6 for issues). Need for more sensitization, advocacy for improved law enforcement and support for survivors; legal reform required to close gaps	Several studies conducted (eg, by UNHCR, Equity TZ). Recommendations: Strengthen knowledge about the law; amendment recommended for gaps (eg., law does not provide protection from domestic violence, marital rape, or FGM for women over age 18)

	law to protect women and children against SGBV	of violence employed in such offences					
Completion Date							
Narrative							

Policy Area: Gender							
Policy: The LAW OF MARRIAGE ACT 1971							
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	Ongoing			
Narrative	Based on a study by the Law Reform Commission (early 1990s) and advocacy by CSOs in 1980s and onwards (eg. WLAC, TAWLA), gaps in the LMA were identified and reforms recommended (about 1993). Issues included	MCDGC identfied the LMA as a priority law for reform. MCDGC and CSOs with support from UNFPA proposed areas that should be reformed. MOJCA drafted a White paper in the 1990s to address problem areas in the	White Paper re: reform was prepared in 1990s but is still pending. Through recent USAID-funded advocacy by HPI and other stakeholders, it has been decided that the White Paper will finally be	Bill not yet drafted. Will require concerted advocacy effort to resolve contentious issues and prevent the reform process from stalling again.		

	early marriage (15 years and below for girls, which interferes with girls' education and health); lack of sanctions for spousal abuse.	law. Challenges: Issues touched on culture and religious practices and met resistance.	presented to the public for debate. According to high officials (President and minister/ MOJCA), drafting of a bill to be taken to Parliament can take place after the views of the public have been collected.			
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Village Land Act 1999						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	1999	Ongoing	
Narrative	Due to gender inequality and conflicting interests re: use of land,	Contentious social, political and economic issues led to national debate,	Process: Public hearings,studies (including exploration of gender	The law was passed in 1999 and came into force in 2001 after developmen	Implementation is facing considerable challenges, having to	No review of the law has taken place. A study by the African Devleopme

	Ministry of Land and Human Settlements appointed a Commission of Inquiry in 1991 to explore relevant issues. MLHS appointed a Committee to review existing laws. Stakeholders: Gender Land Task Force established, involving NGOs (eg. Hakiardhi and WAT)	involving the government, academics, and NGO coalition. Government and NGO disagreement ensued. Recommendations led to review of the many laws governing land tenure. Process led to two different laws: The Land Act 1999 and the Village Land Act 1999.	issues and pastoral rights) by experts provided inputs to the bill. Expert drafted the bill which was subsequently debated in Parliament. Challenges: Numerous interest groups with different agendas; politics within Parliament itself re: the customary law clauses in the bill	t of regulations	struggle with / overcome customary practices and mindsets re: right to ownership of village land. The structure provided by this law to administer village land is not well known and often not properly executed. Women's role on the Village Land Committee is minimal and therefore does not make a meaningful impact	nt Bank in 2005 presented the various problems with this law. Very little has changed / improved in terms of women's ownership of land
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Women and Gender Development Policy (2000)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2000	Ongoing	
Narrative	Since the 1970s, GoT took measures to address gender issues resulting from considerable NGO (eg. UWT) advocacy. A Women in Development (WID) policy was established in 1992 and provided a framework for addressing women's issues, including affirmative action for expanded opportunitie	Government/CSO collaboration led to decision by the MCDGC (main machinery for women/gender) to develop a WID Policy after its 1992 establishment. Institutionalisation of Gender Focal Points in MDAs took place. A process of change began to change the WID policy to the Women and	During policy development process, considerable controversy ensued over different approaches (from WID to gender in development); considerable male resistence. The change required considerable convincing and advocacy by expert to politicians	Policy endorsed in 2000	Implementation faces considerable challenges: Weak coordination; lack of capacity to implement; low levels of funding for implementation, leaving most of the implementation to be done by NGOs with funding from different development partners (considerable US contribution): Challenge: GOT not investing	No structured evaluation, but many small studies to assess gender mainstreaming have taken place. Weaknesses generally found (eg. Institutional Sector and Organizational Analysis, 2005)

PEPFAR U.S. President's Emergency Plan for AIDS Relief

	s for women	Gender Development Policy 2000 to guide gender mainstreaming (men included in definition of gender)			enough in in implementation	
Completion Date						
Narrative	This policy has not been reviewed in 10 years of its existence therefore it is due for review					

Policy Area: Human Resources for Health (HRH)						
Policy: Human Resources for Health (HRH) Strategic Plan 2008-13 (2008) MOHSW						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	2008	2008	Ongoing	
Narrative	Process and challenges: With health sector reform in 1990s, this	MOHSW developed strategy w/ many partners (eg. WHO, Capacity	Completed in 2008	Endorsed in 2008.	HRH continue to be major challenge w/ unresolved issues (eg.	

	strategy was developed on basis of NHP (1996) and National HR Policy (still not completed although the draft has been updated several times). Critical shortage HR; low capacity; proper mgtm., planning, leadership. Areas needing reform: HRH retention/ deployment; training, continous education; incentive schemes; infrastructure, etc.	Project). HRH TWG was established to explore solutions for the many challenges related to HRH. Challenge: Reaching concensus in controversial or difficult areas; these present challenges for implementation, as do funding and sustainability			task shifting - as in Stages 1 and 2). HRH TWG continues its work to explore solutions; Task Shifting Task Force established (task shifting is happening in many areas, but is not an endorsed policy; awaiting study results). Deloitte implements retention and deployment strategy in 4 regions (reemp-loying retired workers).	

Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Human Resources for Health 5-Year Development Plan (2012-?) HR/MOH, Zanzibar						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing					
Narrative	HR/MOH has identified the need to update the Human Resources for Health 5 Year Development Plan 2004/05 -2008/09 to realign it with the Zanzibar Health Policy (2011) and Zanzibar Health Sector Strategic Plan 111 [2012] now in intial stages.					

Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Medical Practitioners and Dentists Act 1968						
Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	Ongoing	Ongoing	Ongoing	Completed	Completed	
Narrative	The act provides for registration and entitlement to medical practice; it has not been amended since 1968. It empowers the CMO and DMO to exempt health workers from practising restrictions Challenges: Shortages of medical doctors have led	The act is often not properly implemen-ted, potentially penalizing providers unless exempted (see Stage 1) which usually does not happen. Advocacy is taking place; needs to continue re: amendment of the act; development of generic job descriptions,	To overcome problems re: the act, MOHSW and many partners developed or revised training guidelines and other tools to strenghen capacity and expand the number of HRH, eg, training of DCHMT in HRH management; training of community health workers, lay	Act endorsed in 1968; MOHSW has endorsed training materials and other to mitigate HRH problems, including Distr. Strengthening Training Facilitator's Guide for training DCHMT (including discussions re: job descriptions and setting of expectation	If properly implemented the CMO and DMOs would designate cadres performing medical tasks to do so legally, with needed supervision and training. Training guide for DCHMT is implemened in 54 of 130 districts nationwide. Other training materials are being piloted or	

	many cadres of health workers without adequte training and supervision to perform tasks usually reserved for doctors	etc.Ongoing HPI study. Challenges: 1) Resistence; 2) ensure good training and supervision when shifting tasks. Stakeholders: MAT, MEWATA, MOHSW, others	HIV counselors, etc. Stakeholders: MOHSW, BMF, MEWATA, IntraHealth, IHRI, Pathfinder, Jhpiego, EngenderHealth; USAID; Global Fund	s). Other materials are at the pilot stage or in the process of being endorsed	introduced by many different partners although endorsement may not yet have taken place	
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: National Human Resource (HR) Policy (MOHSW) - several drafts since 1994						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	Ongoing	?		
Narrative	The need for a HR policy was identified by MOHSW at the onset of health sector	This policy is important for systematic development of HRH strategic plans. HRH	Continued work on draft. Status of draft is uncertain. According to MOHSW, revised	Expected in 2012		

	reforms in 1994. Challenges include(d) rentention and deployment of health professionals, continous education, incentive schemes, task shifting, and other. Health Network secretariat was established to coordinate initiatives like PHCP and the HRHSP 2008-2013	TWG has been working on the problems for a long time. Stakeholders include but are not limited to: MOHSW, WHO, World Bank, DANIDA, JICA, and others, including Intraheath and other CAs	draft policy is completed,awaiting review by stakeholders before endorsement. Challenge: 1) Extremely long and expensive process dealing with difficult issues; 2) lack of agreement on issues (eg. task shifting)			
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Nurses and Midwives Registration Act, 1997						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion	Ongoing	Ongoing				

Date						
Narrative	The Act provides for training, registration, enrollment and practice of nursing and midwifery. Challenges: Act has not been amended despite the fact that shortages of medical doctors and laboratory practitioners have caused many nurses to perform tasks outside their scope of work (illegally according to the Act) Stakeholders:	Acts as barrier to overcome shortage of nurses; prohibits conferring of doctors' rights to nurses and imposes penalties for illegal practice. There are ongoing discussions re: need for amending the act and developing generic job descriptions based amendments. Strong advocacy required to promote orderly and safe process of task shifting based on enabling laws and	No ongoing efforts to amend 1997 Act or to empower cadres below the nursing levels have been initated. This awaits the conclusion of the NIMR study on task shifting. Stakeholders: NIMR, MOHSW, professional organizations, Intrahealth, Benjamin Mkapa Foundation, USAID, Government of Norway, and Clinton Foundation, and many others	[Act endorsed in 1997]	[Act of 1997 is implemented and creating a barrier to solving the HRH crisis in TZ]	

	MEWATA, MAT, TARENA, MOHSW, ALTS, APNM	policies and to overcome resistence				
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Task shifting protocol (2012) National Institute for Medical Research (NIMR)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing	Completed	2012			
Narrative	No task shifting policy exists - controversial issue meeting resistanace in face of serious HW shortage; cadres performing non-designated tasks. Policy barriers to task shifting (eg. lay couselors can only	Study proposal developed by NIMR to prepare basis for task shifting policy (according to MOHSW). Funding secured; timeframe Feb-May 2012. Collaboration w/ US universities. Comprehensive	Study protocol approved by MOHSW 2/12.			

	counsel not test). Decisionmakers need more info. 2010 NIMR showed task shifing needs more exploration. Other stakeholders: AGOTA, CAs, PLHIV networks	evidence based advocacy required to promote policy development. Task Shifting Task Force established as first step towards policy development.				
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: Health Laboratory Practioners Act 2007						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Ongoing	Ongoing	Ongoing	
Narrative	In force since 2008; Act provides for registration of health laboratory technologists, but lacks objective	The Health Laborary Advisory Council met 1/12 and directed Registrar of the Council to seek partners to develop	Regulations for ethics and professional conduct for health laboratory practitioners were completed in 2010.	Act endorsed; ethics and professional conduct regulations endorsed in July 2010	Main act and regulations in force; inadequate training "standards" are currently implemented. There is	

	criteria for accreditation of training institutions of health laboratory practitioners at different levels. Challenges: 1) Lack of standard for guiding training institutions on requirements for setting up teaching health laboratories (eg. equipment and space; 2) length of study; 3) ethics, (professional conduct)	institutional training standards and review various aspects related to training. Stakeholders: Universities, colleges, and independent investors who are interested in establishing laboratories in TZ	Preliminary draft of policy document developed to guide drafting of regulations (or guidelines) for training institutions responsible for training laboratory practitioners (status: looking for partners for funding)		still need to develop appropriate training standards	
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation
Policy: Private Health Laboratories Regulations Act 1997 (revision required for harmonization)

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	Completed	Ongoing				
Narrative	Act came into force in 4/97. Plan for implmentation 2006-2011 developed. Challenges: 1) Act not revised since enactment; 2) not harmonized with new legislative changes such as the Tanzania Food, Drugs and Cosmetics Act 2003 and the HIV/AIDS Control Act 2008 (to ensure quality HIV/AIDS prevention and care	Private Health Laboratories Board met twice in 2010 and agreed to proceed with amendment of the Act once evaluation of the 2006-2011 implementation plan is completed (using the 2007 evaluation guideline developed for health laboratory products and supplies by the Curative Services Dept). Challenge: Unclear,				

	standards/ services)	overlapping roles and responsibilities outlined in different acts/regulations				
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: Private Hospitals (Regulation) Act,1977, amended in 1991 (new amendment required for harmonization)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Ongoing				
Narrative	Enacted in 1977 and in force in 1978; amended in 1991and in force in 1992. Challenges: 1) Overtaken by events related to policy and legislative changes. 2) Act now requires	The Private Hospitals Advisory Board has continued to promote revision of this act and in 5/11 decided to initiate revision of Act. Challenges: 1) Financial constraints to initiate process (no	Seeking funding for consultations leading to Cabinet Paper in order to amend the Act			

	revision to accommodate emerging needs resulting from HIV epidemic (eg HCT, PMTCTand ART). 3) Prescribed fines for violation are too low and ineffective as deterrents.	revision yet). Stakeholders: Assoc. of Private Health Facilities in TZ; TZ Medical Assoc. However, the 1996 Standards of Health Facilities to implement the Act are under revision (PharmAccess involved)				
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: Guideline for Medically Assisted Treatment of Opioid Dependences in Tanzania (Prime Minister's Office/Drug Control Commission) (2010)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	2010	2010		
Narrative	The number of people injecting	TWG established; stakeholder	In addition to, above guideline,	Guideline and supporting	Implementation began at Muhimbili	

	drugs is growing in TZ with serious economic and social consequenc es, in-cluding high HIV prevalence. (According to studies: 25K Tanzanians inject drugs with 40% HIV prevalence in this group). Challenges: 1) Lack of treatment options for opioid dependenc e 2) Stakeholder s: DCC, MOHSW, PEPFAR; 3) legal framework	s held several workshops from 2006 and onwards to discuss and plan for developmen t of guidelines and standards for medically assisted treatment for dependenc e after identificatio n of best treatment mode. Commissio n of studies continued. Challenges: 1) Lack of political support; 2) funding; 3) legal framework	supporting materials were developed, including Minimum Standards for Health Facilities Providing Medically Assisted Treatment of Drug Dependenc e (PMO /DCC); Medically Assisted Treatment for Opioid Dependenc e: A Clinical Guide for Zonal and Regional Referral Hospitals (MOHSW); Outreach Service Guide for HIV Prevention among Drug Using Population	documents endorsed in 2010 (by PMO, DCC, and/ or MOHSW)	Hospital (to date 350 patients treated w/more than 2,000 waiting for treatment according to stakeholder consulted). Challenges: 1) How to expand MAT services; 2) monitoring and follow-up of patients on methadone; 3) lack of political support; 4) insufficient funding to provide services; 5) legal framework	

			(PMO/DCC)			
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: Ongoing MARP studies and other [Draft 2011 Guidelines for Management of HIV and AIDS (Ch 8); Draft VCT Guidelines (Ch 5]						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	
Narrative	In TZ, MARP issues were/are sensitive and controversial; there was/is lack of knowledge about their magnitude and location; high HIV rates; and S&D. Stakeholders: TACAIDS with the assistance of development partners/	TACAIDS regularly calls key MARP stakeholders to meetings. Studies commissioned to increase knowledge about MARPs and inform services; inclusion in recent draft guidelines. 2011 HIV and AIDS policy identifies omission of MARPs in	Several studies conducted on IDU, MSM, etc.; others ongoing, but continued need for more information exist. Stakeholders: NIH, PEPFAR partners, University of San Fransisco; local research institutions and universities	Endorsement pending for several policy documents / guidelines that include adressing needs of MARPs for prevention and treatment services (see Stage 3)	Implementation of MARP prevention and treatment services face challenges, including S&D; inadequate training of providers; HRH shortage - lack of adoption of task shifting strategy to expand services; weak health system, procuremen	

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	PEPFAR, UNAIDS, CSOs, CAs. Challenges: 1) Place the issue of MARPs on the research agenda; 2) ensure that their needs are met for prevention and care services; 3) legal reform	programming as human rights issue. Challenges: 1) Continued controversy over MARP issue; 2) criminalization, 3) lack of protection for MARPs	(eg. IFAKARA Health Institute). Policy documents (eg. new guidelines on VCT; HIV and AIDS policy and mgmt guidelines; S&D strategy) under development include MARPs		t. Various NGOs and CAs are working to strengthen services for MARPs	
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: Zanzibar Sutstance Abuse, HIV and AIDS Strategic Plan 2007-2011						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2007	Ongoing	
Narrative	Due to the large HIV increase among people abusing drugs,	Stakeholders: MOH/ZACP with others including WHO, UNDP,	Same stakeholders as in Stage 2. Challenges: Funds for	The document was endorsed in 2007	Implementation began in 2007 after dissemination and training;	

	MOH/ZACP and Department of Substance Abuse Prevention identified need to develop an integrated strategic plan to mitigate risk and halt HIV transmission to the general population. Challenges: 1) Inadequate control of drug use and trafficking; 2) insufficient allocation of resources, vertical (not holistic) programs; 3) S&D; 4) HRH	CSO, substance abusers and parents, religious institutions, law enforcement agencies (sponsered by CDC/UNDP and WB). Challenges: 1) Addressing substance abuse, an illegal activity; 2) differing views of stakeholders (see also problems under Stage 1)	integrating HIV IDU prevention		training of health workers continues. The Zanzibar HIV Kick start Plan of Action was developed to guide implementation. High demand for treatment but nearest treatment center in Dar es Salaam; lack of treatment options hampers progress. Continued advocacy needed	

	inadequately trained in this area					
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: National guidelines for quality improvement of care, support and protection of MVC (MOHSW) 2009						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2009	Ongoing	Completed
Narrative	Among others, a 1992 study by MCDGC indicated that MVC did not receive adequate protection and care. Challenges: 1) Increasing numbers of MVC due to the HIV epidemic but insufficient resources	Around 2005 efforts to coordinate support to MVC led MOHSW to commission an assessment of MVC programs country-wide. Stakeholders: TACAIDS, MCDGC, CSOs, FBOs, MVC representatives; key service	MOHSW engaged consultants to draft the guidelines with inputs from key stakeholdders including TACAIDS, MCDGC, development partners, CAs, and CSO (including MVC organizations) Challenges: 1) Overlapping	Endorsed in 2009	The Guidelines support implementation of the Law of the Child Act 2009 and NCPA (2007-10) coordinated by MOHSW. Challenges: 1) Inproper identification of MVC who receive services; 2) insufficient coordination	AFRICARE and other stakeholders including MOHSW provided support to Muhimbili Medical Centre to conduct an evaluation of the guidelines in 2011. Information from this evaluation is being used to develop NCPA II and these

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	at the community level for providing protection and services for MVC	providers; UNICEF, USAID, FHI, and CAs (eg. AFRICARE)	mandates among ministries responsible for children required extensive consultation , which slowed the process		, community support, and local government funding; 3) lack of knowledge among providers about guidelines (now in need of updating); 4) low priority. Strong advocacy required	guidelines
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: The National Costed Plan of Action for Most Vulnerable Children 2011-2015 (MOHSW)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Ongoing	Ongoing			
Narrative	The 2007-2010 NPCA I needed update based on gaps identifed in	MOHSW initiated a process to update NPCA I, focusing on strategies to strengthen	DSW with PEPFAR support leads the development of NCPA II, which aims to put	Expected at the end of 2012?		

	the evaluation of the plan. The number of MVC has increased rapidly since the late 1990s due to the HIV epidemic, which necessitated interventions to promote and protect the rights and provide services to MVC. Challenges: 1) Many actors; poor coordination; 2) lack of resources (especially at family and community levels); 3) poor	multisectoral coordination and policy interventions. An extensive consultative process involved national and international stakeholders (eg, PACT, FHI and AFRICARE). Evaluation of guidelines developed to support implementation and the 2011 HPI study shed additional light on challenges	into action the Law of the Child Act 2009 Consultations with community stakeholders (district councils, CSO etc.) and development partners. Challenges: 1) Competing priorities for the time of key stakeholders (they are also involved in ongoing development of regulations for Law of the Child Act and other)			

	implementation					
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: ART: Standard Treatment Guideline, Zanzibar MOH, 2008						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing					
Narrative	Zanzibar is currently using its 2008 ART Treatment Guideline, now outdated. MOH intends to adapt the newly developed comprehensive guidelines (from TZ mainland) once it is finalized. Updating needed to 1) Increase access to ARV;					

	2) Comply w/ 2009 WHO guidelines; 3) Ensure ART integration with other services (PMTCT, RCH, TB/HIV); 4) Include Positive Health, Dignity and Prevention strategy					
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Guidelines for Integrating FP/HIV services (MOSW/RCH) 2012?						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Ongoing	Ongoing		Ongoing	
Narrative	Problem: No national guideline for integration of FP and HIV services leading to	Problem: RCHS and NACP formed two TWG (one for FP - one for integration); lack of	Draft under development Problem: Funding to complete the guidelines		In the meanwhile, there is national argeement that FP/HIV service integration should	

	unmet FP need, unplanned pregnacies, and infants born w/HIV. Challenges: 1) Few providers trained in FP; 2) Women become pregnant before they know their serostatus or CD4 count; 3) Myths, taboos and misconceptions	coordination. Many stakeholders, including GIZ, FHI, Engenderhealth. Unresolved issues related to perceived resistance among providers; ensuring adequate training; how to get integration beyond the clinical setting; male involvement			continue while devlopment of the guidelines take place.	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: LAW OF THE CHILD ACT 2009						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	COMPLETED	COMPLETED	Ongoing	Ongoing	Ongoing	
Narrative	Child rights scattered in several	Policy and law exist, but	Drafting of regulations began in	Endorsement of regulations	Law is being implemente	

	laws until Law of the Child of 2009 was passed. MCDGC and MOHSW with UNICEF support drafted regulations reflecting different mandates and enforcement mechanism. Challenge: MCDGC and MOHSW both have mandates re: children's issues - competing demands and priorities	regulations for enforcing the law have not yet been developed. This leads to ad hoc implementation of activities related to different components of the law, eg. MCDGC and MOHSW have different mandates that are not well prioritized and coordinated.	2010 under leadership of MCDGC in collaboration with MOHSW with TA from UNICEF -involvement of CSOs working on children's rights. Challenges: Draft regulations completed; submitted to Cabinet Secretariat; draft returned to MOHSW to familiarize new Minister with regulations in effort to ensure effective defense	by Cabinet pending presentation by MOHSW. Challenges: Competing demands with other policies in the pipeline.	d despite lack of regulations. Implementaion plan: Activities implemented by MCDGC, MOHSW, PMORALG, MOEVT, CSOs (eg. Save the Children, Plan International - support from USAID & other donors) under existing policies, including Child Development Policy of 2008.	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Adolescen Reproductive Health Strategy 2011-2015 (Ministry of Health and Social Welfare, 2011)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	2011	2011	Ongoing	
Narrative	RH problems among adolescents in TZ have persisted. MOHSW reviewed the Adolescent Health and Development Multisectoral strategy and, based on lessons learned, decided to develop a health sector strategy instead. According to MOHSW, it had little control over multisectora	Lead by MOHSW/ RCHS, TWG stakeholders, including WHO, USAID-supported CAs (such as FHI), and others identifed appropriate topics for the RH health sector strategy. Challenges: 1) Aligning partners that could provide adolescent-friendly services; 2)	Stakeholders as in Stage 2. Focused on health sector, provision of adolescent-friendly services and effective engagement of providers. Explored contributions by other sectors. Challenges: 1) External stakeholders did not readily agree to change from multi-sector	Endorsed in 2011 by MOHSW and launched 6/11 to coincide with launching of CARMA in order to link the strategy to MDG 4 and 5, thus integrating the two	Implementation is ongoing; numerous CAs participating. Challenges: 1) Integration is complicated; 2) Adolescent-friendly services are not integrated into council plans; 3) Strategy is not costed; 4) Lack of recognition of those who provide	

	l interventions; evaluations showed that other sectors contributed little	advocacy; 3) leveraging sufficient resources	al to health sector strategy		adolescent-friendly services; 5) Continued strong advocacy is required	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National guideline for the Management of HIV and AIDS Data Quality (MOHSW/NACP) 2012						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Ongoing	
Narrative	In 2005, M&E TWG led by MOHSW identifed need for updating the 2004-2008 health sector HIV and AIDS M&E plan to incorporate VTC services and	M&E TWG and subcommittee met regularly to review the 2004-2008 M&E plan to incorporate areas (described in Stage 1) to ensure high quality, standardized, realistic,appropriate,	From 2005, process of stakeholder workshops led by MOHSW, Jhpiego, and GIZ to develop M&E guideline for use at all levels. Challenges: 1) Extremely time-consu	Endorsed by MOHSW at the end of 2011. Published in 2012	Limited implementation since 2010 (by those w/access to soft copies). NACP now planning dissemination. National Guideline for the Management of HIV and AIDS Data Quality	

	manageme nt of HIV and AIDS data quality. Challenges: 1) Quality assurance 2) Data harmonizati on 3) Phase out existing complicated parallel M&E tools (time consuming, thus affecting data quality)	and timely data and foster an enviroment of data sharing and utilization for proper decision making.The University of San Fransisco provided technical support through CDC	ming: final draft in 2010; 2) Phasing out existed parallel reporting systems; 3) Brain drain (experts leaving MOHSW); 4) Multiple tasks for M&E staff; 5) Procuremen t process (eg. of consultant; printing)		2012 also introduced to help implementat ion. Challenges: 1) Finacial constraint to disseminate ; 2) Comprehen sion (not translated for lower cadres); 3) Training to use document; 4) Late publishing for M&E cycle	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Guidelines for Management of HIV and AIDS (2011) MOHSW/NACP - section on Management of TB/HIV in Adults, Infants and C+G5hildren						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2011	Ongoing	
Narrative	Review of 2009	MOHSW established	MOHSW led process	Endorsed by the	Challenges: 1)	

	guidelines initiated by MOHSW due to need to: 1. Increase access to ARV and HBC 2.Comply w/ 2009 WHO guidelines for eligibility, treatment regime, and initiation of ART. 3.Ensure integration of ART services with other services (PMTCT, RCH, TB/HIV). 4.Include Positive Health,Dignity and prevention strategy (NEW).	and led several thematic TWG that collaborated closely with TACAIDS, WHO, development partners, CAs, Muhimbili University, and other stakeholders throughout the process. Challenges: 1) Cost (costing was done to check affordability of new regime); 2) Effective linkages and data sharing with other HIV providers (eg HBC and RCH).	starting late 2009 with different TWG and organized workshops for larger groups of key stakeholders (different thematic areas) for review and feedback. Challenges 1) Costly and time-consuming process; 2) Finanical constraints and competing priorities: 3) Minimal involvment of PHC providers	MOHSW in 2011; waiting to be printed, possibly after clarification of HIV algorithm issue but funds are inadequate to print adequate number of copies.	Awareness and wide adoption/use of 2011 guidelines; 2) Dissemination and training in new guidelines; weak health system (eg. HRH; 3) Data management; laboratory capacity; 4) Availability of needed medications (ART and OIs) 5) Contraception -FP/HIV integration).	
Completion Date						

Narrative						

Policy Area: Other Policy						
Policy: National Guidelines on Home Based Care (HBC) Services (NACP, May 2010)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2010	Ongoing	
Narrative	In 2010, only 50,000 of 320,000 patients in need were receiving HBC services. Increased access to ART led to release from hospital and increased need for HBC services. Challenges: No clearly defined roles and responsibilities of different HBC providers,	Through a participatory process led by MOHSW, HBC stakeholders updated previous guidelines to strenghten and scale up implementation of the standard package of HBC services, including linkages and referrals between community based and clinical	In 2009 a participatory process took place to develop the guidelines. Lead: MOHSW / NACP. Other stakeholders: CSOs, FHI, Pathfinder, and others. Sections added on Positive Health, Gender Equity and Ethical Conduct. Challenges: The process	Endorsed in 2010 by MOHSW	Implementation is ongoing.Insufficient training and dissemination have taken place. Challenges: 1) Reaching HSSP II target of providing HBC services to 495,300 clients by the end of 2012; 2) effectively linking HBC patients to CTC and support services; 3)	

	including responsibilities for reporting, recording and referral. No section on Positive Health existed in previous guidelines	services in order to ensure provision of comprehensive care for PLHIVs are seen as the biggest challenges	took very long because of other competing priorities.		equipping HBC providers with standard HBC packages; 4) training, providing guidelines, and solving legal issues related to home use of oral morphine	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Strategy for Scaling up Male Circumcision (MC) for HIV Prevention (MOHSW/NACP, 2010) [also: 2011 draft Mgthm Guidelines HIV/AIDS, Ch 3.2)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Not yet	Ongoing	
Narrative	The results of recent controlled trials on medical MC in South Africa, Kenya and Uganda have	Need for MC strategy established by MOHSW, development partners - PEPFAR, WHO/UN family, CAs	Developed by MOHSW / TWG (see Stage 2)	Pending approval; may require advocacy	Male circumcision is provided relying on not yet endorsed strategy (eg, in Jhpiego	

	confirmed that MC reduces the incidence of HIV infection from women to men up to 60%. MC rates are about 70% in TZ but vary greatly from region to region. MOHSW and its partners identify MC as an important HIV transmission reduction strategy (in addition to condom use) that involves men	(eg. Jhpiego, EngenderHealth, FHI). MC TWG was established. Challenges: 1) Competing priorities; 2) access to services; 3) HRH issues; 4) task shifting strategy; 5) MC has not been integrated in HIV prevention services			pilot project, which also presents an example of task shifting in the field - nurses are doing a large proportion of the circumcision cases). However, MC supported in new draft TZ Mgtm Guidelines. Challenges: 1) sustainability; 2) HRH - task shifting; 3) weak health system	
Completion Date						
Narrative						

Policy Area: Other Policy
Policy: Prevention of Mother-to-Child Transmission of HIV (PMTCT) National Guidelines 2011

(MOHSW/RCHS)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2012		
Narrative	Revision and update of PMTCT National 2007 Guidelines due to new WHO guidelines. Key players: MOHSW/ RCHS. Challenges: 1) High HIV infection rate (6.9%) of pregnant women receiving antenatal care (2010); 2) low coverage of ARV prophylaxis for HIV positive pregnant women (70%) and	Stakeholders: MOHSW/RCH/ NACP, CDC, WHO, TBX and local partners. Challenges: 1) Low male participation (18% tested - ANC clinic); 2) inadequate community involvement and planning for PMTCT by councils; 3) stigma and discrimination; 4) low ART compliance; early infant diagnosis; 5) weak	Stakeholders: Same as in Stage 2 Challenges: 1) Adaptation of WHO recommendations to TZ context; 2) focus on technical and clinical accuracy in HTC, ARV for mother and child, infant feeding; 3) accommodation of partners in PMTCT services, and linkage to FP, STI and CTC services; 4) planning of local	Guideline already circulated amongst stakeholder; submitted and pending endorsement		

	for infants (76%) (below MNSF target of > 96% by 2012)	linkage to related services; 6) HRH (numbers and skills)	councils for PMTCT at facility and community levels			
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Prevention of Mother–to-Child Transmission of HIV [PMTCT], National Guideline [2011], MOH/ZACP, Second Edition						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Ongoing	
Narrative	ZACP/MOH identified need to update 2006 guideline to be consistent with recent national policies; scientific knowledge; international standards and WHO guidelines Challenges:	Stakeholders: MOH/ZACP, PMTCT TWG, CDC, UN, FBX Challenges: 1) Ensure that guideline contribute to further reduction of HIV infection among infants and that	Stakeholders as in Stage 2. Key revisions in comprehensive guideline: Eligibility and when to initiate ART (women / infants / children); what drugs to use; infant ARV regime; infant	Endorsement for Second edition was not necessary and the guideline is already in circulation among stakeholders	Training in use of guideline of health providers has started	

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	Lack of comprehensive PMTCT guidelines that address ART needs of pregnant women, infants and children. Coverage of PMTCT is below universal recommendations and not gender sensitive	mothers receive ART; 2) ensure improved quality and quantity of comprehesive PMTCT services, including mother & infant feeding; 3) safety of PMTCT; 4) S&D reduction; 5) HRH for PMTCT	feeding; infant and responsibilities of health care workers for delivering ARV. Challenges: Adaptation of WHO recommendations re: infant testing, feeding, support, capacity & HR issues			
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: Zanzibar guidelines on HBC services, MOH/ZACP, Nov 2006						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing	Ongoing				
Narrative	Zanzibar is currently using its 2006 HBC Guideline but does not	The MOH has decided that it will adopt the new guidelines currently				

	consider it user-friendly. Moreover, the guideline needs to be updated. Finally, the guideline was never translated to Swahili nor were training materials developed due to funding constraints. Notably, in Zanzibar most HBC is provided at the PHC level where it is essential to have guidelines in Swahili	under development for Tanzania mainland. According to the ZNHSP II, 80 percent of those in need of HBC should be reached by 2016. The number of those in need of HBC has increased rapidly in Zanzibar as it has in TZ mainland				
Completion Date						
Narrative						

Policy Area: Pain Management for PLWHA
Policy: National Policy Guideline for Palliative Care Services (2012?) MOHSW

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	Completed	Ongoing	Ongoing			
Narrative	Serious pain management problem in TZ. Early advocacy by Tz Palliative Care Association members. 3/11: TPCA,ORCI, ELCT met with MOHSW/ TFDA to identify gaps in existing policies and guidelines for palliative care/pain management and to standardize care. Other challenges: 1) Regulations: only	TWG established 1/12 (US funding). The MOHSW, TPCA,ORCI, ELCT and other stakeholders currently preparing for policy development. Challenges: 1) Insufficient funding; 2) insufficient involvement by lower level providers; 3) need for pain mgtm. curriculum for health providers to faciltate standardization of care;	Process just began; Initial workshops 2/12.			

	doctors can prescribe opioids. 2) Lack of training in pain mgt.; 3) lack of availability of opioids	4) policy/ legal issues need to be resolved.				
Completion Date						
Narrative						

Policy Area: Post Exposure Prophylaxis: occupational and non-occupational						
Policy: National Guidelines for Post Exposure Prophylaxis Services (MOHSW) (ongoing)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Ongoing			
Narrative	In 2011, MOHSW, CDC, JHPIEGO and other stakeholders identified need to develop separate PEP guidelines as PEP was not easily available and accessible.	MOHSW, CDC, ICAP, JHPIEGO and others established TWG and initiated consultative process. Challenges: 1) Agree on ownership and coordination of PEP, an issue that cuts across	First draft completed 12/11. Second (probably final) draft expected in 2012 after consultation with all stakeholders. Challenges: 1) Ensuring involvement of all			

	Challenges: increase PEP awareness and make it available 24/7 also outside health facilities	all services and in the community; 2) low awareness of importance of PEP even among those participating in process (stigma); 3) issues related to task shifting to ensure availability of PEP	stakeholders (eg rape survivors, police force); 2) Time consuming process; 3) Consideration of need for appropriate job aids in Kiswahili			
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Comprehensive National Multisecoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2012-2016 (Prime Minister's Office)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	2009	2010-2011	2011	2012	TBD	
Narrative	At a 2009 HPI-organized meeting in Morogoro with PLHIV	Large stakeholder meeting 6/11 to discuss/make	Lead: TACAIDS - TA from HPI. TA also to Enabling	Strategy ready for ministerial endorsement (2/12), but pending	Not yet. Anticipated challenges: Needs dissemination and	

	and religious networks, and TACAIDS to develop S&D strategy for PLHIV, TACAIDS advised initiation of a national umbrella S&D strategy instead. TACAIDS requested HPI's TA and support for national strategy development. No funding was available in HPI's budget; activity had to wait until FY11/12 (not in TACAIDS or HPI's workplan)	decisions re: strategy to be developed; TACAIDS and 27 organizations represented, including different ministries, CA, CSO. Small technical working group drawn from this group: TACAIDS, NACP, MOHSW, NACOPHA (PLHIV representation), President's Office/ Publ.Serv.Mgtm. Committee, Assoc.of TZ Employers	Environment, Advocacy and Communication Steering Committee, & S&D TWG, including support of two consultants. Technical review delayed draft to ensure inclusion of MARP strategy. Final editing completed. Barriers encountered at all stages: long, slow process; extensive consultation needed for different types of approval		consistent advocacy for multisectoral adoption, implementation, and enforcement. MARP section may encounter resistance.	
Completion Date						

Narrative						

Policy Area: Stigma and Discrimination						
Policy: HIV/AIDS Prevention and Control Act 2008						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Ongoing	
Narrative	In the 1980s, HIV began to present health and human rights challenges. Before enactment of the law, PLHIV had no specific protections. CSOs, including PLHIV networks challenged issues such as discrimination and human rights abuse pertaining to	Controversy re: protection of rights of PLHIV versus seronegative population. MOJCA commissioned study in 2001 supported by the Policy Project on existing laws in Tanzania - whether they were adquate for effective HIV response. Extensive country-wid	Process: In 2001, TACAIDS was established to coordinate HIV response, worked with MOJCA and others to draft proposals for an HIV and AIDS law, addressing issues that emerged from the study (mentioned in Stage 2). Considerable controversy	Law passed quickly in 2008 due to Presidential commitments (statements in media; launch of country-wide VCT campaign in 2007).	Law is under review. Ongoing awareness creation and advocacy to disseminate law by many stakeholders (MPs, CSOs, others). Challenges: Development of regulations is stalled - contentious issues need to be solved (eg. criminalization and punishment	

	confidentiality and disclosure of sero-status, as well as willful transmission, which kept people from seeking services.	e advocacy by CSOs (eg, LHRC, TAWLA,WAMATA, TGNP, PASADA) took place.	lead to extensive consultation and study tours to USA and Asian countries with such laws.		for willful transmission, which contradicts criminalization of discrimination). To date no test case has gone to court using the HIV and AIDS Law.	
Completion Date						
Narrative	The policy criminalizes HIV and AIDS transmission and increases stigma and discrimination.			Regulations aer being developed and plans aer underway to maintain S&D into regulations.		

Policy Area: Stigma and Discrimination						
Policy: Penal Code Cap 16 (2002)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing	Ongoing		Ongoing	Ongoing	
Narrative	According to the Penal Code Cap 16 (2002) punishable	TACAIDS/ MOHSW has decided to consider provision of	None	[The Penal Code was amended in 2002 (to incorporate	[Implemented; see issues related to SOSPA	

	offenses include prostitution and unnatural carnal knowledge (interpreted to include homosexual relations). Consider-able S&D exist in Tanzania towards PLHIV and key populations. Criminalization of sex work, injecting drug use, and MSM creates challenges in terms of people not seeking services, lack of willingness to reveal positive sero-status, etc.	medical services a right for all Tanzanians, including key populations. Advocates appear to consider advocacy for decriminalization too risky in current climate, fearing possible backlash		changes implied w/passing of SOSPA 1998)]	under SOSPA table]	

Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National Guidelines for Nutrition Care and Support for People Living With HIV (2009) MOHSW/TFNC (TZ Food and Nutrition Center)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	2009	Ongoing	February 2012
Narrative	Problem identified by MOHSW/NACP/ TFNC. Challenges: 1) Lack of appropriate nutrition information and education among service providers re: PLHIV; 2) inadequate knowledge and skills among providers re: integration	Stakeholders: MOHSW/TFNC, NACP, MoCDGC WHO, UNICEF, SUA and CSOs. Challenges: 1) Lack of a national nutrition guideline for all HIV/AIDS service providers; 2) Different needs of PLHIV regarding nutrition requirement	Key stakeholders MOHSW, TFNC, NACP, UNICEF, SHIDEPHA+, Tanga TWG, COUNSENUTH, SUA, AMREF, Stakeholders met many times and produced the guidelines for nutrition and support of PLHIV in early 2009.	Endorsed by MoHSW in 2009	According to TFNC, the policy document has been distributed to all health facilities in the country and the policy is being utilized by service providers as reference material for different groups and individuals providing nutrition care and support to PLHIV.	Ongoing discussion with stakeholders on evaluation and update

	of nutrition care with the services they provide (eg. BCC, VCT, PMTCT, CTC, HBC and MCH); 3) weak harmonization of nutrition programs	s before and during treatment; 3) Weak coordination among providers; 4) Program linkages; 5) Household food security	Challenges: Many stakeholders from different professions and backgrounds made it difficult to agree on many issues		Challenges: Weak implementation and follow-up	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National HIV and AIDS Communications and Advocacy Strategy (2012?), PMO/TACAIDS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	2012					
Narrative	Need to update National HIV and AIDS Communications and Advocacy Strategy 2006					

	identified by TACAIDS in order to align it with the new draft National HIV and AIDS Policy 2011. Only initial steps taken					
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National HIV and AIDS Policy (2011) PMO/TACAIDS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	31-July 2012		Done
Narrative	TACAIDS idetified need to update 2001 National AIDS Policy Challenges: 2001 policy outdated and not aligned with	Stakeholders: TACAIDS (lead), MDAs, private sector, CSO, FBO, academics, develop-ment partners. Challenges: 1) High risk populations	Stakeholders: TACAIDS lead, development partners, WHO, USAID, UNDP, multi-sectoral TWG, religious leaders and representaives from	Interministerial endorsement pending. Policy has been edited and translated into Swahili	Initial steps taken to bring other policy documents in line with new 2011 policy (eg. National Multisectoral Strategic Framework on HIV and AIDS	

	relevant internationa l guidelines, advances in medicine and technology, changing socio-econo mic context, determinant s of HIV infection, institutional set up, scale up of HIV prevention, emerging best practices, new M&E coordinatio n, requirement for accountabili ty	and their rights not included in oudated 2001 policy, HIV/ AIDS Law and other policies; 2) service provision inequity (rural-urban areas - limited ARTand condom outlets in rural areas); 3) weak support to PLHIV and affected persons; 4) weak HRH	regions/distr icts. Challenges: Harmonizin g interests and differences among stakeholder s who bring their cultural and traditional values to the policy developmen t process		(2007-2012) , National Multisectora l HIV Prevention Strategy (2009-2013) and Tanzania National Multisectora l HIV and AIDS M&E annual plans (2011 to 2012). Ifakara and TACAIDS are currently conducting studies on MARPs	
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Zanzibar National HIV Strategic Plan II [ZNSP-II] 2011-2016, VP/ZAC						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**

Estimated Completion Date	Completed	Completed	Completed	2011	On going	
Narrative	ZAC identified need to update ZNSP-I (2005-2009) to address gaps in national HIV response and alignment with Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP). Challenges: 1) Low HIV prevalence - very high among MARPs; 2) high HIV awareness - little change in behavior. ZNSP-1 was health focused,	Stakeholders: ZAC lead multi-disciplinary steering committee; TWG, UN Joint team; dev. partners; PLHIV; MARPs, reg. reps; Challenges: 1) MARPs are major driver of the epidemic; 2) need to incorporate new national policies/ guidelines and best practices, and use them to scale up; 3) translate high HIV awareness into behavior	Stakeholders were same as in Stage 2. Through consultative process, developed ZNSP-2 focusing on five priorities: Prevention of new infections; treatment care and support; mitigation of socio-economic impact; creation of enabling environment; and research, monitoring and evaluation. Challenges: Reaching consensus on how to deal with	Endorsed by Minister of State, First Vice President's Office in September 2011	ZNSP-II will inform update of Zanzibar National HIV/AIDS Policy [2004], Guidelines for Zanzibar's HIV and AIDS Programme Monitoring System (ZHAPMoS), 2006; Zanzibar National HIV&AIDS Advocacy and Communication Strategy [2007 – 2009], Media Guideline for Reporting HIV and AIDS in Zanzibar	

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	based on three ones but not well aligned with ZSGRP, MDGs, and socio-cultural and other issues	change; 4) compliance with standards; 5) rights based and gender sensitive approaches	MARPs in the prevailing socio-cultural context		[2009] and related training and procedure manuals	
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	18,735,494	0
HKID	24,526,501	0
HVTB	6,286,035	0
PDCS	1,675,683	0
Total Technical Area Planned Funding:	**51,223,713**	**0**

Summary:
USG/T supports the URT to deliver health and social services to improve the quality of life for an estimated 1.4 million Tanzanians infected by HIV (UNAIDS report on the global AIDS epidemic 2010) and nearly 18 percent of children under age 18 who are considered Orphans and Vulnerable Children (Tanzania HIV/AIDS and Malaria Indicator Survey, 2007-08). The program implements activities using three main strategies: (1) enhancing national-level coordination and technical leadership of care and support for PLHIV and OVC; (2) strengthening service delivery systems and mobilizing resources by building capacity of local governments and civil society; and (3) providing critical health and social services directly to PLHIV and OVC. These efforts resulted in care and support services provided to 220,000 vulnerable children most affected by the virus and 450,000 PLHIV (APR 2011).

USG/T works closely with the URT to implement its activities. In 2009, USG/T successfully negotiated a Partnership Framework with the URT which is in year three of its implementation plan (PFIP). USG/T and its partners also collaborate with and provide technical assistance to the National AIDS Control Program (NACP) and the Department of Social Welfare (DSW) under the Ministry of Health and Social Welfare (MOHSW), to develop relevant national guidelines and strategies which are used by service providers and USG partners to ensure quality and standardized services.

However, USG/T and its partners still face critical challenges to ensuring quality care for Tanzanians infected and most affected by HIV. Firstly, the sustainability of the response is uncertain, as USG/T currently directly funds roughly 80% of care and support activities within the country, including 100% of home-based care services. Furthermore, linkages and referrals between health facilities and communities remain weak; similarly, linkages between programs to ensure comprehensive health services are also limited. At the national-level, the MOHSW continues to struggle with prioritizing and mobilizing resources for critical initiatives that will support national and USG/T goals for care and support for PLHIV and vulnerable children. For instance, FY 2011, the DSW, which is tasked with coordinating the OVC response, received less than 1% of the MOHSW budget to carry out its mandate. Furthermore, the URT has been reluctant to approve the use of lay workers to counsel and test for HIV, which hinders service providers from widely scaling-up HIV counseling and testing (HCT) at the household level, a critical intervention for Positive Health, Dignity, Prevention (PHDP) programs at the community level.

MAJOR ACCOMPLISHMENTS
In COP 2011, USG/T strengthened linkages between facilities and communities, improved the management and governance of local government authorities (LGAs), and supported national structures in coordinating the response to care for HIV-affected households. Through aggressive interventions, USG/T introduced active TB case finding among PLHIV, resulting in TB screening of 73.4% of PLHIV, as reported in APR 2011, compared to 71% in APR 2010. In addition, strengthening of facility-community linkages has resulted in a 26% increase in the number of HIV-affected children receiving treatment since FY 2010, contributing to nearly half of the URT goal.

Improvements in community-based care for PLHIV and OVC have been strengthened by the development of national PHDP guidelines. The guidance responds to strategic shifts in provision of HBC services, which are now more focused on prevention of re-infection and general well-being rather than palliative care. In addition, USG/T supported the government to launch a national para-social worker model that has resulted in the training and placement of approximately 3,000 para-social workers. This initiative supported the development of curricula and qualification for the social work profession. Establishment of a new social work scheme of services, which supports decentralization of the social work system, will ensure integration of qualified social work professionals into local government structures and budgets.

KEY PRIORITIES AND MAJOR GOALS IN THE NEXT TWO YEARS
Resources from COP 2012 will target increasing program sustainability and addressing critical challenges to linkages and referrals to health and social services for PLHIV, their families and vulnerable children. USG/T will roll out critical strategic program shifts that respond to the changing needs of PLHIV and OVC in a mature epidemic and address program sustainability. Significant resources have been allocated to strengthening local governments' planning and management of care and support activities; building capacity of communities and civil society to improve support to PLHIV and OVC; and building human resource capacity nationally to effectively provide health and social welfare services.

USG/T has been prioritizing strengthening the continuum of care approach, which is consistent with the Tanzania Global Health Initiative (GHI) strategy launched in September 2011 and will continue in COP 2012. In line with the strategy, planned procurements and continued support in FY 2012 are aiming to ensure a full range of sustainable, community-based interventions that meet the comprehensive health and well-being needs of PLHIV and OVC. This includes improving access to reproductive, maternal and infant/child health services (GHI Intermediate Result 1) and increasing health-seeking behavior through health promotion and behavior change communication (GHI Intermediate Result 3) amongst PLHIV and OVC households. These initiatives will receive support from COP allocations in addition to PMTCT Acceleration plan and Gender Based Violence initiative funds.

Prioritizing strengthened linkages between facilities and communities in the current year will continue to be a key strategy in COP 2012 to address high levels of loss to follow up in facility programs. Interventions will result in improved health for HIV-infected and affected children. Interventions to scale-up PMTCT and HIV early infant diagnosis (EID) at the community-level to prevent HIV infection in children will also be a major focus. Current USG/T efforts increase and improve integration of nutrition assessment, counseling and support (NACS) across Care programs. In addition, gains in child health will be achieved by promoting integration of OVC, maternal newborn and child health (MNCH), PMTCT, and pediatric AIDS programs to ensure the continuum of care for HIV-affected children.

Over the next two years, the care portfolio will continue to shift its strategy toward HBC service provision to address the changing needs of the 20% of PLHIV who currently receive ART (APR 2011) and, as a result, are living longer and healthier. These beneficiaries are increasingly requiring less palliative care and more comprehensive health and social services. An assessment of HBC workers, kits, and support to the government was conducted in FY 2012 in order to utilize the data to update HBC strategies and

guidance. USG/T will also build upon a pilot that was initiated in FY 2011 which integrated HIV community care into MNCH community health workers training. USG/T will expand the pilot to two additional districts and provide a grant to MOHSW to develop a community health strategy that will harmonize community-based health promotion and present facility-based services to form an integrated platform for comprehensive health. Strategies to promote the para-social worker model and piloting of child protection systems will be implemented to reduce the incidence of gender-based and sexual violence, both of which are key contributors to HIV infection. These activities will be supported through a partnership with UNICEF and resources from the global Gender-Based Violence (GBV) Initiative.

Finally, USG/T will focus on promoting program sustainability by increasing URT and local capacity to plan and provide services, a key activity of the PFIP. Significant investments will target strengthened skills and numbers of community and facility-based care providers through human resource for health (HRH) activities. Furthermore, USG/T will continue to invest in building management capacity and fiscal accountability of LGA structures to improve planning and implementation of HIV-related programs and service integration at local levels. For interventions at the household level, the program will leverage investments from the flagship Feed the Future program to enhance food security and nutrition for PLHIV and OVC households. USG/T also plans to intensify household economic strengthening interventions to increase household economic security and reduce vulnerability of PLHIV and OVC households.

ALIGNMENT WITH GOVERNMENT STRATEGY AND PRIORITIES
USG/T will provide significant technical, financial, and capacity building support to the URT to promote strategies and achieve goals that drive the national response to HIV/AIDS. Over the years, USG/T has supported the National AIDS Control Program (NACP) to implement Quality Improvement (QI) measures across HIV/AIDS service platforms. In COP 2012, USG/T will continue to support QI work to standardize operating procedures in delivering quality services to PLHIV and OVC. USG/T is also supporting the URT to review and update the pediatric HIV care and treatment guidelines, training package, and job aids to align with 2012 WHO guidelines. In support of efforts to improve TB management among children, USG/T is also providing technical assistance to the Ministry of Health National TB and Leprosy program (NTLP) to develop pediatric TB/HIV guidelines, corresponding training materials, and job aids.

Within the OVC program, USG/T will build on findings from an evaluation of the National Costed Plan of Action for Most Vulnerable Children, 2007-2011(NCPA); the UNICEF-supported report, Violence Against Children in Tanzania; and other available data to support the URT in developing a subsequent plan that will help guide the OVC response over the next several years.

COLLABORATION WITH OTHER DEVELOPMENT PARTNERS
The care portfolio will prioritize increasing support and engagement from URT and other key stakeholders to promote sustainability of the HIV/AIDS response. In addition, collaboration with a variety of development partners will be used to enhance national investments. For instance, to promote improvements in the evidence-base around social safety nets for PLHIV and other vulnerable populations, USG/T will conduct evaluation activities of the planned national cash transfer program implemented by the Tanzania Social Action Fund (TASAF) and supported by the World Bank as well as co-funding the follow-on national safety nets program. Collaborations with UNICEF are ongoing to strengthen child protection systems and support Department of Social Welfare to coordinate the national response to OVC. Furthermore in COP 2012, USG/T will collaborate with UNICEF to extend reach to nutrition services to severely undernourished PLHIV and OVCs, prioritizing women and children in 1000 days of life. The intention is to leverage UNICEF's core competencies in order to expand reach to nutrition services and ensure continuum of care services.

POLICY ADVANCES OR CHALLENGES
Sustaining the HIV/AIDS response through increased Tanzanian ownership and investments in HIV care and support activities continues to challenge the USG/T care portfolio. This challenge is especially

reflected within the OVC portfolio, which is shifting from a commodity-driven approach to prioritizing service delivery, systems and community safety net strengthening, household economic security, and Tanzanian leadership of interventions. USG/T team continues to work with partners and government counterparts to provide guidance and support in implementing more sustainable approaches, while focusing investments on capacity building at decentralized levels.

Lack of URT approval of a home-based counseling and testing guideline for use of lay counselors is another challenge. This has slowed the recruitment of clients in both clinical and community care and hindered an opportunity to test family members of HBC clients. In response, USG/T continues discussion with the government and other development partners to address this gap. In addition, the portfolio continues to face challenges in moving towards a more integrated health programming within the existing portfolio, as outlined in the GHI strategy. The USG/T team will work to address this challenge at the implementation-level, partly through strategic changes in community-level human resources to consolidate services given by care providers (i.e. community-health workers, HBC volunteers, para-social workers, and other cadres that deliver services in communities). Using care providers as an entry point to integration, USG/T expects to be able to strengthen program linkages and referral networks across the continuum of care.

EFFORTS TO ACHIEVE EFFICIENCIES
The care portfolio appreciates the impact of continued funding constraints and increasing limits on URT financial capacity; thus the program will continue to prioritize efficiencies in programming. Sustained investments in quality improvement across the HBC and OVC programs will achieve efficiencies in service delivery and program costs. In addition, through innovative public private partnerships with General Mills International and collaboration with Power Foods Tanzania and Nutriset France that were initiated in 2011, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and USG/T Care program will continue to benefit from reductions in procurement costs and efficiencies in the distribution of locally procured of Ready to Use Therapeutics Foods. Capacity building and technical assistance investments of partners will focus on improving budgeting and costing skills for program interventions as well as utilizing costing data to better inform program decision making. Lastly, the revamping of HBC kits is expected to produce further cost savings and efficiencies in commodity procurement.

EFFORTS TO BUILD EVIDENCE BASE
The USG/T care portfolio has prioritized several ongoing efforts and planned activities to inform the evidence base for effective planning and decision making. As international evidence and policy responds to the changing needs of PLHIV and OVC in a maturing epidemic, the care portfolio plans to initiate or continue evaluation and documentation of innovations in HBC and OVC service delivery models. These plans include piloting an integrated health programming model in the Lake Zone, which will leverage the President's Malaria Initiative and USAID MNCH resources, to provide continuum of care services for HIV-affected children. Furthermore, USG/T will pilot several interventions to protect vulnerable children from physical and sexual violence, particularly models for improving child protection systems at the community to the judicial levels. USG/T will also invest in assessing the social safety net program piloted by TASAF, which will provide critical information to guide the government decision-making about the potential for a government-sponsored cash-transfer safety net program. Finally, the care portfolio will support assessments that examine the roles of HBC volunteers, the package of household services provided to PLHIV, and the contents of HBC kits in order to inform changes in program implementation.

CROSS-CUTTING PROGRAM ELEMENTS

Public Private Partnerships
The care portfolio plans to leverage private sector engagement to promote vocational training and employment of vulnerable youth and PLHIV and facilitate market linkages with beneficiaries who are

engaged in income-generating activities. In addition, USG/T will promote private sector contributions to scholarships for secondary education and vocational training targeted at vulnerable girls and women.

Key Vulnerable Populations and Targeted Interventions
Given the GHI priority of improving quality of life for girls and women, USG/T will support several interventions that reduce vulnerability and improve the health of this targeted group. Interventions include a scholarship and vocational training project for girls that aims to improve employability, strengthen life skills, and increase adoption of healthy behaviors. Another planned intervention aims to improve access to reproductive health and family planning (RH/FP) services for vulnerable girls. USG/T will ensure that vulnerable girls and women are targeted with quality prevention and care services through the implementation of several centrally funded initiatives: the PMTCT Acceleration Plan, NACS Integration Plan, and the GBV Initiative.

Health Systems Strengthening
The USG/T care portfolio for COP 2012 will supplement current efforts to strengthen LGA capacity by increasing health and social welfare investments at the regional, district, and ward levels. A follow-on program is planned to strengthen the capacity at regional and district levels to manage HBC and OVC programs, through technical assistance and mentoring of local governments and civil society organizations that are tasked with developing, delivering, and managing HIV care services. The aim is also to ensure fiscal accountability and increase prioritization of resources for HIV/AIDS care and support interventions at LGA levels. USG/T will continue to invest in the development of the social welfare workforce that will contribute to improved services for vulnerable children. Current USG/T funds are also being allocated to improve the care and support skills of home-based care providers by training them to roll-out PHDP interventions and increase health promotion and screening services.

CARE PORTFOLIO PRIORITIES

Home-based Care and Support
The package of family-based services that USG/T provides for adult care and support as well as OVC includes ART adherence, cotrimoxazole provision, management of opportunistic infections (OIs), and NACS. Interventions to reduce the risk of HIV transmission and re-infection are incorporated into all levels of programming. USG/T has identified economic strengthening interventions to be a critical component within the portfolio. Development Alternatives Inc. received a three-year grant in FY 2011 to provide enhanced and increased economic strengthening activities for PLHIV and OVC households. Further economic strengthening interventions are planned for expansion into new regions in COP 2012. Meanwhile, coordination with multilateral support mechanisms, including the GFATM, enhances primarily commodities and nutrition activities.

In FY 2011, USG/T supported the URT at the national level to initiate the revision and development of critical guidelines to improve care for PLHIV, which remain a priority in FY 2012. Recent revisions to the national HBC guidelines will incorporate the development of standard operating procedures outlining how HBC services will be packaged and delivered. In addition, USG/T supported URT in drafting the national PHDP integration guidelines, helping to pave the way for implementation of PHDP approaches in community and facility-based care services. Efforts are currently underway to include PHDP into the national training curriculum for home-based care providers. In FY 2011, PHDP monitoring and evaluation tools were developed and PHDP indicators are in the process of inclusion into partners' project implementation plans for the current year.

At the service-delivery level, USG/T will prioritize health and social service integration to strengthen the continuum of care for PLHIV and OVC. Over the next two years, service delivery packages in OVC and HBC programs will be refined to increase sustainability and program efficiency. Investments in HRH, including strategies that support HBC service providers and the social welfare workforce, will be a key

component of this strategy. The program will conduct assessments of HBC and OVC service provision to determine the current needs, how services are delivered, and identify gaps, particularly those related to continuum of care. This information will be used, along with data from a similar assessment of maternal and child health workers, to develop efficiencies in HIV service provision. Assessments of the current national HBC kits will help to identify a revised list of contents that can adequately respond to the changing needs of HBC beneficiaries. Due to the increased numbers of eligible PLHIV, an insufficient supply of cotrimoxazole has become problematic in meeting the requirements of this group, as per the current national guidelines. Collaboration with the GFATM and URT will help to address this issue and ensure a sufficient and sustainable supply of cotrimoxazole will be available.

Pediatric Care and Support
In Children and AIDS: Fifth Stocktaking Report 2010, UNICEF reported that an estimated 160,000 children are living with HIV in Tanzania. USG/T and its partners support MOHSW to provide clinical and community services to these children. In line with the PFIP and URT's National Scale-up Plan for PMTCT and Pediatric HIV Care and Treatment (2009-2013), USG/T plans to increase the number of children on treatment from the current 21,000 to approximately 30,000 by FY 2013, contributing to URT's goal of ensuring that 20% of all clients on treatment are children. In order to achieve this, technical support will be provided to scale up HIV EID through strengthened linkages between facilities and communities. Interventions for the current year and planned for COP 2012 will contribute to all three intermediate results of Tanzania's GHI Strategy by increasing access to MNCH and RH services that offer EID and PITC; strengthening health systems to improve pediatric HIV care; and increasing adoption of health seeking behaviors through community-level behavior change and outreach interventions, which will promote linkages to health facilities for HIV-infected and exposed children.

Since FY 2011, USG/T supported improved government coordination by strengthening the national Pediatrics HIV Technical Working Group and development of a Centers of Excellence for pediatric AIDS in the Southern and Lake Zones to improve pediatric HIV management. However, there are still challenges in scaling up EID and following-up with HIV-infected and exposed children at the community-level, partially due to low levels of community awareness of pediatric HIV services. USG/T began to address these challenges in COP 2011 by scaling-up EID and ART initiation of HIV-exposed infants, and will continue to do so in COP 2012 . Activities will include strengthening linkages between OVC and MNCH programs, increasing community-level outreach and referrals, and improving tracking of lost to follow-up clients with children. These interventions are also expected to increase community-level education and support for continued breastfeeding of HIV-exposed infants in addition to supporting the national scale up plan for PMTCT.

A planned health and HIV integration pilot in the Lake Zone, which will leverage community-level interventions in pediatric AIDS, child health, and OVC services, will also provide USG/T with information on best practices in community-based identification for EID as a crucial component to the continuum of care for HIV-exposed infants.

TB/HIV
The goal of the TB/HIV program is to support national efforts to strengthen integrated TB/HIV activities. USG/T supports TB/HIV in the country by working directly with MOHSW, through the National TB and Leprosy Program, the NACP, and implementing partners.

USG/T efforts increased the number of PLHIV screened for TB from 71% in APR 2010 to 73.4% in APR 2011. In COP12, the program aims to reach full coverage TB screening by supporting quality improvement initiatives at the facility level, and training home-based care providers to screen potential TB infection and refer clients for testing. In addition, the program will continue to promote use of the standardized TB screening tool, which was harmonized with the patient monitoring system throughout the country. New laboratory techniques will be evaluated and rolled out to increase TB case detection.

Despite these accomplishments, identification of active TB cases remains a challenge due to limited community-level awareness about TB and weak linkages between the facilities and communities.

Scaling up implementation of the 3 I's - intensified TB case finding (ICF), infection control (IC), and isoniazid preventive therapy (IPT) – is a key priority for COP 2012. Community-level implementation of the 3 I's aims to maintain the health of TB patients and reduce the risk of spreading TB to household family members and the wider community. USG/T will scale-up TB case finding by using community-level health workers to locate and refer TB patients who have stopped collecting their medication to appropriate health facilities. TB management will be strengthened within the scope of HBC volunteer work, which will include TB treatment adherence support, education of household members and families, stigma reduction, and psychosocial support. Community sensitization about TB and linked outreach activities will work towards increasing the demand for TB screening and other services, such as promotion of the importance of BCG vaccine for children. Furthermore, the program will continue to strengthen M&E through supportive supervision and mentorship to health care providers in order to deliver quality data and incorporate its use in improving health services.

Multiple development partners and multilateral bodies are also supporting implementation of difference aspects of TB control activities. At the national level, COP 2012 will direct activities toward strengthening coordination of such activities throughout the country, such as engaging in the TB/HIV TWG as well as working with TB/HIV coordinating committees at the district and regional levels.

Food and Nutrition
NACS is a critical component of the HIV/AIDS portfolio and cuts across key program areas, particularly treatment, care, and OVC services. NACS services reduce malnutrition in adults and children infected with HIV, which is a major cause of HIV-related morbidity and mortality. USG/T along with its Food and Nutrition program partners and URT, use the NACS approach to improve the nutrition of PLHIV, particularly positive mothers and their children. In FY 2010 and FY 2011, USG/T supported the national technical working group on nutrition and HIV to develop guidelines for quality NACS services and procurement of nutrition therapeutics, which has increased efficiency in distribution of nutrition commodities at facilities. In FY 2011, USG/T began implementing the NACS/PMTCT Integration Plan, which aims to increase HIV-free child survival; use nutrition indicators (e.g. growth faltering as a proxy for chronic illnesses) to identify HIV-exposed children for HIV services; and increase access to maternal and child nutritional services. The integration plan also supports Intermediate Results 1 and 2 of Tanzania's GHI strategy by supporting integrated, quality RH and MNCH services and strengthening health systems. Please refer to the NACS Integration with PMTCT Acceleration Plan submitted with COP 2012, for more details on these interventions.

The nutrition program still faces several challenges. The lack of effective nutrition assessment tools and nutrition information materials result in inadequate dissemination of information about nutrition and infant and young child feeding to expectant and lactating mothers at facilities and in communities. The nutrition program is also challenged by continued use of services that emphasize food distribution as the center of nutrition rather than more sustainable NACS interventions. In addition, referrals to nutrition services in communities are weak, partially as a result of inadequate prioritization of nutrition interventions in district-level government plans and budgets.

In response to these challenges, USG/T is promoting universal application of the NACS tools in COP 2012 and evaluating its effectiveness in addressing the nutrition needs, while targeting pregnant mothers, through PMTCT program linkages, and children for services. NACS interventions will prioritize strengthening capacity of district councils and community structures to provide essential NACS services through capacity building of LGAs and working with existing OVC, HBC, and PMTCT programs. Effective referral linkages to the Feed the Future program will help to expand the available resources for eligible beneficiaries.

Orphans and Vulnerable Children (OVC)
The scale of child vulnerability to the impacts of HIV/AIDS in Tanzania has critical implications for the nation's health and development goals. Approximately 18% of children in Tanzania are considered vulnerable as defined by eight criteria of the URT. Of those, more than 1.3 million children have lost one or both of their parents to AIDS and roughly 160,000 children in Tanzania are living with HIV. In addition, the recently released report commissioned by UNICEF, Violence Against Children in Tanzania, revealed that nearly one out of three girls and one out of six boys have experienced some form of sexual violence prior to the age of 18.

In response, USG/T supports URT to provide adequate care and protection services to children and their families who are vulnerable to the impact of HIV/AIDS. In partnership with the MOHSW and guided by the PFIP, USG/T is investing in improving national and decentralized policy and programming; strengthening civil society and community-level safety nets; and enhancing quality and accessibility of health and social services for vulnerable children.

Since the signing of the Partnership Framework, USG/T has made significant headway in strengthening the URT to care for and protect OVC. Most recently, USG/T supported an evaluation of the implementation of the NCPA and will facilitate the development of a subsequent plan that emphasizes program sustainability and a multi-sector response to OVC.

Despite these achievements, there is a significant unmet need for interventions to protect and support vulnerable children in Tanzania. The loss of GFATM support to the OVC national response in 2010 resulted in a reduction of at least 42% of funding for vulnerable children. Of the more than 2 million orphan and vulnerable children caseload projected in the NCPA I, 69% have yet to be registered or provided with any kind of service. The majority of these children live in families; however, most of these households are headed by chronically ill adults and elderly grandparents, while 12% are headed by children themselves. Furthermore, a severe human resource shortage within the country exacerbates the gaps in access to services for vulnerable children. For example, there are approximately only 114 social welfare officers working nationally, roughly 1 per 200,000 children, in communities where most vulnerable children's committees have been established, their performance is varied due to inadequate capacity and lack of technical support and guidance.

In response to these gaps, USG/T will collaborate with the World Bank to prioritize strengthening the capacities of households and communities, with targeted investments in the national social safety nets pilot program. In addition, there will be an increase in funding for the scale-up of evidenced-based economic strengthening interventions. USG/T will focus on capacity development at the local government level and within civil society to design, manage, implement, and mobilize resources for OVC programs.

USG/T is currently support URT to develop and implement a follow-on national plan of action that will emphasize a multi-sector response, address gaps in the former plan, and further enable country ownership and support for the national response to OVC. In COP 2012, USG/T will strengthen linkages with other HIV and health interventions to enhance leverages and integrate services with a focus on contributing to PMTCT scale-up, increasing use of reproductive health services amongst adolescent OVC, and ensuring HIV-infected children access treatment.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	6,454,300	0

HVSI	6,342,028	0
OHSS	37,189,539	0
Total Technical Area Planned Funding:	**49,985,867**	**0**

Summary:

INTRODUCTION

Tanzania is in the process of Decentralization by Devolution in all sectors, which means that 133 Local Government Authorities (LGAs) are responsible for service delivery at district and lower level facilities. The Ministry of Health and Social Welfare (MOHSW), who is recognized as having technical expertise, remains as the policy and normative body and conducts supervision. It also oversees tertiary care facilities at the zonal level, while coordinating with regions on the management and supervision of regional hospitals. However, the LGAs are responsible for planning, coordinating, and providing quality and comprehensive health services at district hospitals, health centers, and dispensaries under the leadership of the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG). In addition to these multiple actors, the President's Office for Public Services Management, which is responsible for all public services employees, and the Ministry of Finance, which is responsible for financing of health services, are also heavily involved in the healthcare system. Additionally, approximately 40% of health facilities are private sector, including faith-based and for-profit providers. Traditionally, these facilities have been critical in the service delivery scheme, and indeed many faith-based facilities work with a service agreement to function as a district designated hospital. With the passage of the Public Private Partnerships Act of June 2010, the MOHSW is emphasizing the importance of having LGAs coordinating and entering into service agreements with private healthcare providers.

There are three primary constraints for sustainability in the health system with the most visible being a dramatic shortfall of adequately trained human resources for health (HRH), with nearly two-thirds of the positions vacant, particularly in remote areas. Aside from the challenges of attaining a doctor or nurse-to-patient ratio that meets WHO standards, there are serious issues of inequity with an inability to recruit or retain skilled health workers in rural areas due to very poor infrastructure such as lack of water, power, and schools. Other HRH challenges include low staff retention caused by low salary levels, lack of opportunity, and poor performance management. Acute shortage of qualified staff sometimes calls for other staff cadres to multi-task beyond their job descriptions. For example, non-medical health workers often play an important role as lay counselors and home-based care providers. Yet, the HRH strategic plan does not recognize non-medical health workers. Efforts are underway to explore task-shifting as one method of response to this HRH crisis. The United Republic of Tanzania (the URT) recognizes this serious issue and is working towards improving the situation of training and retaining health workers, while optimizing presently available resources.

A second critical challenge is the lack of a reliable supply chain and commodity logistics system. USG/T works closely with the MOHSW, the National AIDS Control Programme (NACP), and the Medical Stores Department (MSD) to address these challenges; however, Tanzania still experiences frequent stock-outs, cumbersome systems and processes, and stressed infrastructure and capacity resulting from significantly increased service volume related to the HIV/AIDS response.

The third critical constraint is health financing. The likelihood of the health sector receiving a greater proportion of public funding is unlikely given financial difficulties in the URT's ability to disburse and execute according to the current budget. At this time, approximately 55% of the health sector budget is already donor supported. To respond to these issues, Tanzania is developing its first-ever health financing strategy, identifying options for financing methods that are more sustainable through pre-paid community insurance schemes that also provide greater incentive for service quality.

USG/T has increased its emphasis on improved accountability to ensure that existing health funds are used efficiently and appropriately. Not only are districts being strengthened for improved programmatic and fiscal accountability, but USG/T will also expand efforts to improve quality and comprehensive health services. At the national level of the health system, USG/T is providing technical assistance (TA) to revamp the procurement unit in the MOHSW to become more efficient, transparent, and compliant with the Procurement Act of 2004. Fthe URThermore, USG/T is working in collaboration with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) eliminate stock-outs.

To promote a strengthened policy environment and create high-level awareness of pivotal issues, USG/T has supported creation of a Policy Advisory Committee of senior officials. The committee has endorsed the USG/T approach on policy issues to focus on advocacy and capacity targeting four groups: 1) parliamentarians; 2) media; 3) religious leaders; and 4) PLHA groups. In the past two years, USG/T programs have built the capacity of these groups to shape and influence public opinion and policy on HIV/AIDS, including fighting stigma, discrimination, and gender-based violence (GBV), while promoting PLHA involvement in the policy arena. Particular attention has been paid to the leadership and advocacy skills of National Council of People Living with HIV and AIDS (NACOPHA), a prominent PLHA network.

USG/T has served in a leadership role with the Development Partners Group (DPG) on HIV/AIDS and is a key participant in the DPG on Health, the Tanzania National Coordinating Mechanism, the Basket Finance Committee, and the Sector Wide Approach (SWAp) Technical Committee and its Working Groups such as human resources, health financing, public private partnerships (PPPs), and local government. USG/T closely collaborates with other donors, particularly with the GFATM in the Round 9 award for health systems strengthening (HSS). Under the direction of the MOHSW, the GFATM co-funds USG/T activities addressing health information systems; commodities and logistics; pre-service training; leadership and management capacity building (particularly human resources management); recruitment and retention interventions; and professional boards and associations strengthening. Greater collaboration with the GFATM will ensure a broader and more accelerated scale up of critical programs and will simultaneously support responsible transition of USG/T programs to the URT and local partners. The holistic interventions that form the USG/T overarching HSS approach align with the WHO Health System Building Blocks.

GLOBAL HEALTH INITIATIVE (GHI)
The Tanzania GHI Strategy promotes ‘smart’ integration of health programs to increase efficiency, effectiveness, quality, and comprehensiveness of services, with a focus on strengthening country leadership and systems to ensure sustainability. The HSS priorities in the Partnership Framework align directly with the four GHI interdependent intermediate results for HSS: improved HRH for efficient quality service delivery; improved integration and effectiveness of monitoring and evaluation (M&E) systems; strengthened governance, management, financing, and accountability in advancement of national policies and systems; and improved health support systems, including for commodities and laboratories. This alignment between PEPFAR and GHI systems strengthening work will optimize investments by ensuring that the HIV/AIDS response can be effectively integrated with programs in the areas of malaria, TB, nutrition, maternal, newborn and child health (MNCH), and family planning/reproductive health as well as other cross-cutting programs such as democracy and governance, economic growth and education.

USG/T expects that the broadening of PEPFAR systems strengthening guidelines and the introduction of GHI will also have an important significant spillover effect on MNCH, family planning, and malaria programs. For example, many of the major social and policy issues arising from stigma and discrimination, gender-based violence, male behavioral norms, and the ineffective implementation of policies, laws, and regulations that impact HIV and AIDS also are barriers to implementation of MNCH, family planning, and malaria programs. The same is true of work being done for HIV/AIDS in terms of HRH, financing, leadership and accountability, M&E, and commodities and logistics systems.

Similarly, the USG/T's work in PPPs has systems strengthening benefits for GHI. USG/T works with the SWAp PPP Technical Working Group (TWG) to promote alliances with the private sector in response to HIV/AIDS. Opportunities to explore ways in which the local and international private sector can contribute resources and expertise to broader health and health systems issues is of interest to both the private sector and USG/T.

LEADERSHIP, GOVERNANCE, AND CAPACITY BUILDING
Through the PF, the USG/T is strategically focused on building country ownership and program sustainability by increasing the URT's programmatic and financial responsibility for the national HIV /AIDS response in a variety of areas. Most notably, the transition of responsibility from USG/T to the URT is occurring in procurement, blood and injection safety, and management of centralized data to eliminate parallel reporting systems. The need for effective national leadership to address the AIDS epidemic applies equally to regional and local levels. USG/T supports a critical capacity building program that is strengthening local systems for budgeting, planning, monitoring, and reporting. LGAs use prescribed methods and execute according to their budgets and plans, accounting for funds in an auditable way. For sustainability, the USG/T works closely with PMO-RALG and encourages a community participatory approach to budgeting and planning.

To encourage increased private sector responsibility in responding to HIV/AIDS, the USG/T works with the URT to develop innovative PPPs. The program has benefitted within the past year from the inclusion of new partners from various sectors, such as finance and banking, communications, and medical manufacturing. Leadership of private sector engagement in HIV/AIDS was reinvigorated by the Association of Tanzanian Employers replacing the now defunct AIDS Business Coalition of Tanzania. Also, the TripartitePlus Forum for HIV and AIDS, which includes representatives from government, private sector, labor, and donors, is working together to resolve legal, policy, and practical HIV/AIDS workplace program implementation issues. The SWAp PPP TWG is developing the MOHSW Health Sector Public Private Partnerships Policy Guidelines. The PPP TWG is also coordinating a Private Health Sector Assessment, which is being co-funded by MOHSW, the International Financial Corporation's Health in Africa Initiative, and the Strengthening Health Outcomes through the Private Sector activity of the USG/T. The assessment will ascertain the capacity of private health providers to play a greater role in the delivery of health services.

Capacity building support to civil society began in 2002 with the PEPFAR-funded Rapid Funding Envelope, which has mobilized more than $18 million in funds from the private sector and donor community to strengthen more than 120 civil society organizations (CSOs) involved in the HIV/AIDS response. Recently, this capacity building has been expanded to include both small as well as larger CSOs. Fthe URTher expansion to include more umbrella CSOs will take place in COP 2012. USG/T also works through its implementing partners in clinical services, HRH, and district strengthening to provide substantial direct support to build the skills of local organizations in programmatic and fiscal accountability.

STRATEGIC INFORMATION
USG/T supports implementation of the URT's M&E strategies and seeks to improve integration and effectiveness of M&E systems for data use. Efforts has also been leveraged with other donors supporting the health sector's M&E strengthening initiative. A coordinated approach ensures all USG/T investments in routine data collection, surveys, surveillance, vital registration of births/deaths, and research are aligned and integrated with those of the URT's system for ensured sustainability.

In FY 2011, USG/T continued its integrated strategy firmly aligned with the sixth goal of the PFIP of supporting the URT in evidence-based and strategic decision-making. Strengthening and coordinating M&E systems to ensure quality vertical and horizontal flow of information and use of data, were supported

through provision of technical assistance in the revision of the care and treatment program tools and the successful implementation of an operational, revised national system for care and treatment which all care and treatment stakeholders will utilize. Additional guidance contributed to the simplification of the national M&E by reducing the number of indicators (from 49 to 19) and the reporting frequency (from monthly to quarterly). PEPFAR outcome indicators were also successfully added into this national system. USG/T subsequently supported the URT in the development of a MOHSW endorsed M&E plan for the health sector response to HIV/AIDS and national data quality guidelines.

USG/T support to HIV surveillance activities increased the national capacity to implement key national and sub-population surveys, studies and evaluation activities. USG/T also provided technical support during the implementation of the Tanzania Demographic Health Surveys (TDHS) and the 2012 Tanzania HIV and Malaria Indicator Survey (THMIS), as well as a national Health Management Information System (HMIS) vision that integrates HIV/AIDS into routine health care systems.

Challenges and opportunities for future support and collaboration include addressing the lack of clear data sharing and material transfer policy that lead to delay in implementation of surveillance activities; barriers in the government's procurement system leading to delay in acquisition of necessary surveillance reagents; and implementation of activities; and shortage of M&E staff at national, regional and district levels resulting in delay of reports and poor quality of data. Partly to address these gaps, USG/T provides scholarships to HCWs to study M&E in Ethiopia. For sustainability, efforts are underway to establish an in country M&E masters degree training program.

The strategy for COP 2012 will include continued support to the URT to make evidence-based strategic decisions via implementation of the revised care and treatment M&E system, with the aim of strengthening the national system and reducing the burden of reporting for health care workers. USG/T will continue to undertake data quality assessments (DQA) to improve the quality of the reported data. In support of adopting best practices in evidence-based and strategic decision making the USG/T team is working with the URT on validating use of routine PMTCT program data as a proxy for ANC Surveillance. USG/T will continue to provide TA for implementation of Sample Vital Registration with Verbal Autopsy (SAVVY), which estimates the proportion of deaths due to HIV/AIDS among persons aged 18-59 years and implementation and expansion of an Integrated Disease Surveillance Response system. USG/T will continue to oversee the implementation of PEPFAR Records and Organization Management Information System (PROMIS) to fulfill its requirement to report data to OGAC.

Findings from Public Health Evaluation (PHEs) and Basic Program Evaluation (BPEs) are important areas in guiding the programming of various interventions. Implementation of these evaluations will align with the URT's existing National HIV Research Strategy. The USG/T Implementation Science Interagency Technical Team (ITT) provides analytical expertise to other ITTs to strengthen their skills in planning and implementing PHEs with partners and the URT. USG/T will also coordinate and provide technical expertise for BPEs to support programming on evidence-based decision-making.

SERVICE DELIVERY
USG/T regionalizes partners in order to manage the scale up of services among tertiary health facilities where implementing partners continue to support improvements in patient flow and service delivery gaps, in addition to addressing weaknesses through quality improvement activities, supportive supervision, and mentoring. In COP 2012, partners will focus on improving access to full and complete care packages, which include nutrition assessments, family planning, STI services, screenings and prophylaxis for opportunistic infections, and linkages to community services. In order to reduce HIV transmission, USG/T will strengthen interventions in PMTCT, PHDP, provider-initiated testing and counseling, post exposure prophylaxis, and infection control activities and interventions. Improvements on initiatives designed to improve client, family, and community health outcomes will include encouraging male involvement in PMTCT programs and facilitating family-centered approaches in pediatric care and, treatment, OVC

programs, and wraparound economic strengthening programs.

USG/T partners will work in collaboration with MOHSW, regional and district health management teams, and health facilities management and staff to minimize the loss of patients and poor adherence. All stakeholders will utilize quality improvement methods in developing measurable activities and initiatives that lead to a demonstrated reduction in loss to follow up data. Partners will coach providers to identify specific program gaps and delivery weaknesses that contribute to poor adherence and missed appointments. Examples of quality improvement initiatives undertaken by partners that have proven to be effective at reducing loss to follow up rates include: improved coordination of service delivery and referrals along the care continuum to increase linkages to other services; enhanced peer education programs; improved pre-ART counseling and supportive methods and practices among nursing and counseling staff; introduction of block appointment systems to reduce wait times and improve patient flow; and the integration of services through "one stop shops" for comprehensive care, not only at care and treatment facilities, but also at TB clinics and reproductive and child health facilities

USG/T will be placing increased emphasis on transitioning service delivery from international NGOs to local NGOs and government facilities over the next years. Prime partners will apply capacity building methods, such as didactic trainings, supportive supervision, coaching, and mentoring to develop skills of the MOHSW, regional and district health management teams, facility staff and local NGOs. They will also work with LGAs to ensure that programs are designed to meet the disease profile of the specific geographic area and that data is used for prioritization and decision making. Strengthening linkages between LGAs and CSOs and NGOs will continue. Approaches to transitioning are closely monitored and evaluated for effectiveness in order to maintain high quality in service delivery as well as financial accountability and transparency.

HUMAN RESOURCES FOR HEALTH
Under the Partnership Framework and the GHI strategy, HRH is aligned with the URT's HRH Strategic Plan and the Health Sector Strategic Plan III. USG/T strategy to strengthen comprehensive health services through improved HRH for equitable, efficient, and quality service delivery. USG/T works closely with other donors to support the implementation of these strategic plans through a multi-donor supported Global Workforce Initiative. Key elements of the USG/the URT partnership include the scale up of pre-service training (PST), investments to increase training throughput, district strengthening to better manage and retain the workforce, policy reform to optimize the available workforce, and performance-based management to improve health workers' productivity. Given the complexity of the issues, the USG/T works closely with MOHSW, President's Office-Public Service Management (PO-PSM), PMO-RALG, and Ministry of Finance and Economic Affairs. There is close collaboration with the MOHSW to implement GFATM Round 9, particularly since the GFATM and USG/T HSS inputs are intertwined to complement each other in scaling up interventions in PST, HRH recruitment, retention, productivity, and management.

The URT is committed to scaling up pre-service training, though it requires significant infrastructure investment. Currently, the MOHSW estimates 6,760 health professionals graduate per year, with the goal of producing 10,000 new graduates annually by 2015. Unfortunately, the health training institutes (HTIs) are well beyond physical capacity. In COP 2012, USG/T will support infrastructure improvements at a limited number of schools and construct staff housing at remote facility sites with efforts that were coordinated with GFATM capital improvement projects. Scholarships and student aid programs will also support the scale-up to enroll students at all levels of the health system, including para-social workers.

While significant efforts are underway to scale up production of health workers, strategies that continue to improve the quality of pre-service training remain crucial. Supporting the URT to upgrade training curricula across multiple cadres, standardizing faculty development, and equipping schools with training materials, equipment, and furniture remain important priorities that build upon training improvements that

have already been achieved for the medical, clinical assistant/officer, laboratory, and nursing cadres. USG/T is supporting MOHSW in hiring and deploying tutors to HTIs most in need and who will eventually be absorbed into the public sector after two years, as agreed in the Partnership Framework. Fthe URThermore, coordination with the Medical Education Partnership Initiative (MEPI), will ensure that other universities in the country benefit from this support particularly through preceptorships will be offered through the program and other resources such as developed materials.

In COP 2012, more emphasis is on fthe URTher strengthening of PST in order to achieve greater efficiency and measurable effectiveness of in-service training, ensuring sustainable performance improvements in the health workforce. Moving forward, USG/T will place increased emphasis will be placed on coaching, mentoring, and supportive supervision approaches in the workplace.

With 25% of health workers lost in the first year after deployment, recruitment and retention pose critical problems for Tanzania. To address these problems, the USG/T has prioritized strengthening LGAs to better plan for and manage the health workforce. This includes improvements in the work climate, living conditions, staff development, leadership, and performance management. Collaborating with the GF, USG/T will work in half of the districts within the whole country, while the GFATM will implement the same projects in the remaining districts. To improve morale and career development issues, distance education alternatives will be offered to provide upward mobility and additional training on-site. As an incentive to work in remote areas, both the USG/T and the GFATM will construct staff housing in the areas with the most need, with district contributing infrastructure on a matching basis. USG/T also works with the PMO/RALG and LGAs to implement an effective Human Resource Information System (HRIS) to benefit national as well as local governments' need for a management tool and accurate data that will be utilized for efficient planning, informed decision-making, and improved operations research. Assessments of district level interventions and dissemination of best practices are planned in COP 2012.

To optimize the existing workforce, the USG/T will work with PO-PSM, MOHSW, and PMO-RALG to improve performance management and increase productivity through implementation of Tanzania's Open Performance Review Appraisal System (OPRAS). USG/T will also work to strengthen the effective use of task-shifting. For many years, task-shifting has occurred throughout Tanzania informally, yet no national policy exists to govern implementation. Guidance has been given to the URT in support of the goal to develop a clear task-shifting strategy and implementation plan that would address manpower planning, training, and supervision. A study of nurse-led patient screening utilizing personal digital assistants equipped with standardized treatment protocols at CTCs will be completed in March 2012. Results from this study and two other imminent evaluations on task-shifting - one at the community level funded by COP 2012 and the other at the facility level funded by COP 2011 - are expected to fthe URTher inform policy dialogue.

USG/T provides technical assistance to the MOHSW to finalize staffing norms and help rationalize the workforce. USG/T will coordinate with PO-PSM to plan for appropriate and equitable deployment of skills that will fill critical gaps with the funded position permits that are issued each year. The expected outcome will be a human resource/manpower plan which will articulate HRH needs for a range of entities, from health facilities to health institutes, and the corresponding financial gaps. This in turn help to drive the development of a training plan for HCWs to respond to those identified gaps.

In addition, the USG/T is helping to enhance the health workforce by strengthening the training of non-clinical professionals, such as health managers, data managers, and biomedical engineers, in order to allow for health workers to focus on providing quality services.

Lastly, health worker professional bodies are influential and promote the professionalism of health workers. USG/T will continue to support institutional capacity building of these organizations, which include the Tanzanian Nurses and Midwifery Council, the Tanzanian National Nurses Association, and

the Medical Association of Tanzania, in order to increase membership, strengthen advocacy and leadership, and link continued education in health and social work to professional quality standards. USG/T provides assistance to the National Social Worker Association to develop a professional social work infrastructure in Tanzania.

LABORATORY STRENGTHENING
An effective laboratory system is an essential component of a functioning national healthcare system and foundation for high-quality HIV and AIDS clinical and outreach services. In Partnership Framework signed in 2009, both the URT and USG/T are committed to ensuring that laboratory services necessary for the maintenance and scale-up of care and treatment services are accessible, sustainable, and meet international laboratory standards. The goal is to address several technical and systems issues affecting the provision of quality lab services necessary for the maintenance of existing care and treatment services, in particular: the shortage of laboratory personnel; limited implementation of lab quality management system; frequent stock-out of laboratory reagents/supplies; lack of equipment service contract; and safety issues including poor laboratory physical infrastructure and aging equipment.

The network of laboratory services in Tanzania is a tiered system that is comprised of a National Health Laboratory, a Quality Assurance and Training Centre, six referral hospital laboratories, 23 regional laboratories, and 133 district laboratories. The majority of larger health centers maintain laboratory facilities while dispensaries perform simple diagnostic procedures that do not require the presence of laboratory technicians. Prior to PEPFAR, laboratories in Tanzania were the weakest link in HIV/AIDS care and treatment service provision as they exhibited poor infrastructure, lagged in technological advances, and lacked skilled human resources. The situation has improved significantly since USG/T started providing direct financial and technical assistance to the MOHSW in both Tanzania Mainland and Zanzibar.

As a result of the national adoption of the Laboratory Quality Systems Principles as a framework for laboratory operations throughout the country, significant accomplishments have taken place, among them the development of an operational plan for a national laboratory system to support HIV/AIDS care and treatment and development of a National Laboratory Quality Assurance Framework. Other notable improvements have been the procurement of standard laboratory equipment, development of standard operating procedures, review of the pre-service training curriculum to include new technologies, and training of in-service personnel. However, with all these accomplishments, a substantial shortage in trained laboratorians in the Tanzania health care system still remains. USG/T will continue to support activities to address this shortage by establishing a continuing medical education program for laboratorians and supporting infrastructure improvement of laboratory schools, as well as teaching aides to improve intake capacity and learning conditions.

With the support of the USG/T, the MOHSW developed a five-year National Health Laboratory Strategic Plan (2009 – 2015) to ensure effective quality service delivery. A laboratory quality mentorship program will be rolled out across all levels of laboratories with USG/T support, using trained in-country laboratory experts from professional organizations and NGOs. The USG/T will continue supporting the Strengthening of Laboratory Management through Accreditation and the Stepwise Laboratory Improvement Process towards Accreditation, which will target four zonal referral hospital laboratories to attain international accreditation (ISO15189) along with 33 laboratories to attain at least two stars WHO accreditation by the end of COP 2012.

As a systems strengthening priority, the USG/T will continue to conduct capacity building for MOHSW to enable the diagnostics section to improve the planning, managing, accounting, and providing of leadership for the National Health Laboratory Services in accordance with the Partnership Framework goals. In line with this, the work with MOHSW to improve the national logistics and procurement systems for the appropriate ordering and distribution of laboratory commodities, supplies, and equipment is

currently underway. In COP 2012, the program will support the implementation of a facility-based stock management system in 244 facilities in collaboration with the Supply Chain Management System (SCMS). Other areas of support include the roll out of the Electronic Laboratory Information System (ELIS) in referral hospital laboratories.

HEALTH EFFICIENCY AND FINANCING
It is unlikely that the URT can invest additional funds in health given the current fiscal environment. Due to the decreased resources both internal and external, with support from USG/T, is developing its first Health Financing Strategy to create a sustainable financial base for healthcare. Though pre-payment options through a community health fund and a national health insurance fund exist, enrollment is low and deliberate actions must be taken to expand such programs and ensure that funds flow appropriately. USG/T, along with other donors, will assist Tanzanian planners to consider and model pre-paid financing options, achieve increased efficiencies through the integration of HIV/AIDS services with other essential health services as envisaged in the GHI strategy, and develop payment mechanisms that stimulate improved quality of care. Currently, USG/T supports the MOHSW in conducting a National Health Service Costing Study of health facilities in the country (public, faith-based, and private), which will be the basis for determining realistic prices for insurance reimbursement or service agreements between the government and non-government health facilities. TA will also be provided to formulate a regulatory framework for health insurance. Also, USG/T will strengthen MOHSW capacity to conduct national health account analyses and public expenditure reviews without donor assistance.

SUPPLY CHAIN AND LOGISTICS
As also described in the Treatment Technical Area Narrative, USG/T supported the URT’s most recent quantification of ARVs, test kits, and lab reagents for the period of April 2011 to April 2014, which is reviewed and updated quarterly. The comprehensive plan, produced for NACP, includes various scenarios that anticipate program and treatment guideline changes. All supply chain stakeholders coordinate activities through a TWG chaired by the NACP, with USG/T secretariat support. Recently, JICA and Clinton Foundation withdrew support for HIV related commodities, leaving the GF, USG/T, and DANIDA as the major international procurement and supply chain donors.

The URT recently mandated MSD to provide direct delivery to all facilities in Tanzania, increasing the drop points from 500 to 5000. This change provides greater accountability within the supply chain system for deliver to lower level facilities; however, this mandate necessitates a complete redesign of the sales and order system and requires a new Enterprise Resource Program (ERP) as well as significant expansion of infrastructure and fleet capacity to be fully implemented. With support from Coca Cola, Gates Foundation, Accenture Development Program (ADP), and USG/T, MSD studied Coca Cola’s distribution system in selected areas to develop a model of how it might achieve the “last mile” mandate throughout the country. USG/T is also supporting a three-year ERP upgrade at MSD that includes the development of an Integrated Logistics Management System (ILMS) and an Electronic Integrated Logistics Management System (e-ILMS) to support the last mile direct delivery. The project is 35% funded by MSD and 65% funded by USG/T in COP 2012. The ILMS supplies data through a paper requisition and reporting system used by all facilities receiving supplies from MSD. The e-ILMS project will transform the paper system into an electronic system that will be implemented downwards to the district facility level beginning in 2012.

USG/T is supporting the improvement of warehouses by redesigning existing facilities, utilizing prefabricated storage products, and assisting warehouse managers in improving standard operating procedures and security systems. In July 2011, a Lab Supply Chain Management Advisor (SCMA) was placed in each of the nine MSD zonal facilities to complement the Pharmacy Supply Management Advisors who were previously assigned to all zonal distribution centers to reduce the risk of commodity stock-outs. All of these SCMAs spend half of their time at the zonal medical store and the other half of their time visiting individual sites providing technical assistance and stock re-alignment. With MSD’s

current five year strategic plan ending in 2013, the next five year strategic plan will focus on transition. USG/T is providing training to MSD mid-level managers from central and zonal stores in basic logistics, quantification, and procurement. with an emphasis on operationalizing ILMS.

USG/T also provides supply chain and procurement training to the Pharmaceutical Supply Unit and Procurement Management Unit of the MOHSW. In collaboration with the Public Procurement Regulatory Authority (PPRA), USG/T developed supply chain training course designed to educate the URT staff on PPRA requirements. In COP 2012, USG/T is helping to create web-based training modules which will be accessible by procurement units in all ministries. Training of Tanzania Food and Drug Authority inspectors and key management staff will be provided in order to improve their capacity to monitor the quality of health commodities in the country. In these ways, interventions to improve the supply chain is taking place at key points throughout the health system. Finally, USG/T is collaborating with Muhimbili School of Pharmacy and the Tanzania Food and Drug Authority to develop a sustainable in-country pharmaceutical testing program, which is expected to be available for use in all East African countries.

GENDER
USG/T continues to focus on integrating gender considerations across all relevant HIV/AIDS programs. Both the GHI Strategy and the Partnership Framework identify gender as a key cross-cutting issue, and COP 2012 programs are accordingly aligned to ensure consistency with both strategies. Each agency has designated gender focal points that work across program areas to ensure gender-sensitive approaches to programming.

Programming to prevent GBV will continue to scale up in COP 2012 through both dedicated central GBV funds, as well as through COP FY 2012 funding. These activities will continue to complement a wide range of clinical and community-based services and prevention activities. This multifaceted approach targets women and girls, as well as boys and men at the national, community, and individual levels. USG/T is currently working in conjunction with MOHSW to develop National Medical Management and Policy Guidelines for addressing GBV. In COP 2012, partners will also continue to work with MOHSW to ensure that health care providers at all levels of health facilities are trained in effective implementation of the guidelines through the incorporation of gender training into pre-service and in-service curricula for health care workers.

Finally, in COP 2012, USG/T plans to continue to build capacity to conduct gender-based situational analyses and programming through additional training of implementing partners and the URT stakeholders. To improve the evidence base for gender-response interventions, USG/T has incorporated several new gender specific indicators into the program. In addition to new indicators, central funds will support an evaluation of norms, changing behavior, programming in the workplace, and "men as partners" community based interventions. A centrally funded, three year evaluation of the GBV initiative will also start in March 2012.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	12,904,198	
Total Technical Area Planned Funding:	**12,904,198**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	14,009,456	0
HMBL	4,899,806	0
HMIN	1,593,415	0
HVAB	4,376,214	0
HVCT	14,020,378	0
HVOP	16,387,680	0
IDUP	2,776,788	0
MTCT	29,775,929	0
Total Technical Area Planned Funding:	**87,839,666**	**0**

Summary:
OVERVIEW OF THE EPIDEMIC
Tanzanian President Jakaya Kikwete has observed on several occasions that preventing new HIV infections is a key national priority. To ensure coordinated implementation of HIV prevention services, USG/T contributes to a URT-led national prevention program that is guided by the Tanzania National Multi-Sectoral Prevention Strategy (NMPS) 2009-2012. There is recognition that some prevention investments can be implemented relatively quickly and have a rapid impact on the epidemic, while others that address cultural, structural, and institutional determinants of vulnerability may require more time to achieve change. After a thorough analysis of the existing country HIV data and a conscious effort to align with URT targets, the USG/T prevention portfolio has been strengthened to fund an optimal set of interventions—biomedical, behavioral and structural—that when implemented with quality and scale can significantly reduce HIV incidence.

The most recent epidemiological data detailing the state of the epidemic in Tanzania comes from the 2007/08 Tanzania HIV and Malaria Indicator Survey (THMIS) and the 2010 Tanzania Demographic and Health Survey (TDHS). The 2007/08 THMIS reported a 5.7% adult HIV prevalence (6.6% adult females, 4.6% adult males), which represented a statistically significant decline from a 7.0% adult HIV prevalence in the 2003/04 THMIS (7.7% adult females, 6.3% adult males). USG/T recognizes that this decline is associated with improved coverage of both HIV prevention and treatment programs.

The 2007/08 THMIS also indicates that HIV prevalence varies dramatically by region and location, with the most affected region being Iringa (15.7%) and the lowest prevalence belonging to the Zanzibar archipelago (0.8% on Unguja, Zanzibar's largest island). Epidemiological data have resulted in adjustments in USG/T prevention planning and support over the past two years, with intensified efforts in the eight highest prevalence regions.

According to the NMPS 2009-2012, there are socio-economic and demographic subgroups of the population with disproportionately higher risk, vulnerability, and HIV prevalence. For instance, women are more affected across reproductive age groups than men and adults aged over 30 years are more likely to be infected than youth. Individuals who are either in marital union or were formerly married have higher HIV infection rates than those never married, as do individuals living in more wealthy households.

Despite a generalized epidemic, MARPs play a critical role in HIV transmission dynamics. Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. Studies carried out in Dar es Salaam indicate that the HIV prevalence is 42% among PWID (2007) and 31.4% among SWs (2010), while data for MSM in Dar es Salaam are not yet available. Studies conducted on Unguja Island (Zanzibar) in 2007/08 revealed an HIV prevalence of 16% among PWID, 12.3% among MSM, and 10.8% among SWs. In addition, an assessment in correctional facilities conducted in Zanzibar, showed a 2.8% HIV prevalence and evidence of injection drug use and transactional sex among prisoners.

KEY DRIVERS OF THE EPIDEMIC
The socio-cultural context that shapes behaviors and attitudes is crucial to understanding the complexity of the HIV epidemic. Multiple and concurrent partnerships and low levels of condom use in high-risk sexual encounters are key drivers of HIV transmission. In the 2010 TDHS, 21% of men and 4% of women reported having sex with two or more partners in the past 12 months. Among these men, only 24% used a condom during their last sexual intercourse. Among those ever having sex, women reported a lifetime average of two sexual partners compared to over six for men. Low rates of condom use, particularly during high-risk sex, are also of major concern. Less than half of sexually active adults report the use of a condom at last sex.

Transactional and commercial sex remains a major obstacle to HIV prevention efforts as social issues, including abject poverty and gender inequities, leave women - and particularly young girls - at an increased vulnerability for acquisition of HIV. 15 percent of men paid for sex in the 12 months prior to the 2010 TDHS. Prevailing gender norms heighten female vulnerability; 2010 TDHS data show that 33% of women suffered from acts of violence during the past 12 months. A USG- and UNICEF-supported assessment on violence against children in 2009 also indicated that nearly one-third of females aged 13 to 24 reported experiencing at least one incident of sexual violence before the age of 18. Finally, according to the 2007/08 THMIS, 6.3% of married or cohabiting couples are in HIV-discordant relationships.

GLOBAL HEALTH INITIATIVE
While the aforementioned context has direct effect on HIV transmission dynamics, most, if not all, of these same factors impact other health arenas. As such, USG/T recently developed its GHI Strategy to ensure a more comprehensive response that focuses on quality integrated services, health systems strengthening, and healthy behaviors. Intensified interventions under each of these focus areas will accelerate expected health impact. This strategy, along with the PFIP prevention section, guides the prioritization of prevention activities.

HIV PREVENTION STRATEGY
Following internal prioritization discussions and the new PEPFAR Prevention Guidance, USG/T has identified certain key programmatic areas that can be strengthened this year. The team has carefully selected interventions that are prioritized in the national plan and are well-coordinated, cost-effective, and focused on higher-risk populations and regions. The desire is to develop a USG/T prevention portfolio that more adequately identifies those individuals who are most likely to become HIV infected and intervene at all levels (individual, community, and national). In addition, there is a clear desire to address HIV prevention in a more integrated fashion, including leveraging existing platforms to offer more holistic services.

In COP 2012, there will be an increased budgetary focus on the core prevention interventions, as described in the PEPFAR Prevention Guidance. Through the assistance of PMTCT Acceleration Funds, the PMTCT portfolio is addressing bottlenecks to expanding services, while strengthening linkages between PMTCT and maternal and child health services. Recognizing the potential for VMMC impact in

high HIV prevalence and low MC prevalence regions, the COP 2012 budget for VMMC increased by over 60% from the COP 2011 original submission level, which represents a five-fold increase from the COP 2010 budget for male circumcision. USG/T has furthermore identified reprogramming opportunities that will shift COP 2011 funds in the next operational update period to increase the budget for male circumcision. An increased emphasis will be placed on reaching men over 24 years of age. Given the comprehensive nature of PMTCT and VMMC services, HTC targets are set at their highest level to date. Condom availability and accessibility are critical to prevention interventions and USG/T will continue to provide over 120 million male and female condoms countrywide. Despite a generalized epidemic, data clearly indicate that certain populations are most at-risk for HIV infection. Thus, USG/T will continue to put resources towards determining population size estimates and surveillance systems for MARPs while simultaneously expanding services to these often hard-to-reach populations. Finally, integrating comprehensive quality HIV prevention for PLHIV into routine care, in both clinic and community settings, will be closely monitored.

Following the PEPFAR Prevention Guidance, USG/T is repositioning social and behavior change programs (sexual prevention) as comprehensive platforms that serve to mobilize individuals and communities to change norms and behaviors, increase uptake of services, and adhere to treatment regimens. This approach will maximize synergies with other HIV and health services and contribute to more efficient use of limited resources. Sexual prevention programming will focus on interventions that carefully target key drivers of the epidemic, including partner reduction and condom promotion and services for MARPs, while simultaneously building local NGO capacity to own and sustain the HIV response.

All of the aforementioned prevention activities are expected to use a gender lens, given the cultural context surrounding gender inequities. Recent data from the 2010 TDHS have fed into the design of PEPFAR GBV Initiative activities, which began in October 2011. In addition to these activities, the GHI Strategy mandates that a strong gender focus be built into the communication strategies for all USG/T programming (e.g., mother and child health, reproductive health, malaria, and HIV). Regardless of the target population within the general population (e.g., youth, military, men, etc.), alleviating the vulnerability faced by young girls and women continues to be a programmatic focus.

Finally, in an effort to ensure a full combination prevention portfolio, USG/T identified a structural intervention that could address some of the key drivers of the epidemic. COP 2012 will see a new cash transfer program that will address some of the social determinants that heighten young women's vulnerability to HIV infection. This will nicely complement other structural interventions that can be found within the USG/T-funded health systems strengthening activities.

The USG/T prevention refined approach is perhaps best exemplified through the USG/T's focus on combination prevention interventions. Combination prevention, which consists of using mutually reinforcing interventions to address the risks of HIV transmission and acquisition, is being actively pursued and evaluated across the country. USAID has a large-scale, centrally-funded impact evaluation in Iringa (the region with the highest HIV prevalence in Tanzania), while CDC and DOD have in-country funded outcome evaluations in the two urban settings of Kagera and Mbeya, respectively. While each agency has a slightly different package of interventions, all incorporate expanded VMMC and ART services and improved linkages between HTC and care and treatment. Improved understanding of the interactions between the various interventions will help to inform future programming and funding allocation.

OVERARCHING ACCOMPLISHMENTS
The USG/T prevention portfolio showcases a VMMC program that has received international accolades for its ability to reach exceptionally high numbers of men in a cost-effective manner. Despite a national MC prevalence of 70% among adult men, several regions have MC prevalence below 30%.

USG/T-supported VMMC activities take place in the seven regions with the lowest MC prevalence, with special attention placed on providing VMMC services to high-risk men such as fishermen and miners. COP 2012 funds will not expand to additional regions but rather increase the reach within the communities and districts that are already targeted.

To increase HTC uptake and reach specific populations, USG/T supports an array of HTC modalities, including facility- and community-based services. Modality selection is done after thorough analysis of the epidemiological data in a particular area and is informed by such factors as HIV prevalence and presence of high-risk populations. Preparations for scale-up and improved couples HTC have been initiated, taking into account the rates of sero-discordant relationships. Following the promising results of the HPTN 052 trial indicating that ART reduces transmission of HIV in sero-discordant couples, strengthening the linkages between HTC and care and treatment services will be a priority focus for COP 2012.

Blood and injection safety programs also play an integral role in reducing new HIV infections in Tanzania. USG/T has worked closely with the relevant government authorities to improve the quality of blood collected, evidenced by a transfusion transmissible infection prevalence of less than two percent in all zones. Through USG/T technical assistance, URT has identified strategies to retain consistent HIV-negative donors by establishing blood donor clubs that cover all 26 regions. Local research suggests unsafe injection practices occur in 47% of instances, with 50-90% of curative injections being avoidable and high rates of inadequate disposal procedures (89%) reported. These findings have informed medical transmission prevention efforts that include improved implementation of universal precautions, access to PEP, and enhanced health care waste management procedures. Through USG/T support, in-service trainings have covered nationwide 63.5% of public tertiary/secondary health facilities (139 out of 219) and 74.8% of health care workers (15,794 out of 21,110). In addition, the implementation of an integrated Infection Prevention and Control - Injection Safety (IPC-IS) model within the Reproductive and Child Health Services Department in MOHSW has resulted not only in a decreased risk of medical transmission of HIV and other infectious diseases but also has provided a model of integration potentially replicable for other programs.

KNOW YOUR EPIDEMIC

Over the past few years during the prioritization process and assembling of the prevention portfolio, a lack of quality data on the HIV epidemic was frequently cited. To address this critically important issue, USG/T supports the Tanzania Commission for AIDS (TACAIDS) and UNAIDS to conduct a “Know Your Epidemic” study, for which preparations started during COP 2011. COP 2011 also provided funding for 13 new basic program evaluations, including four outcome evaluations, primarily for sexual transmission prevention, behavioral interventions, and communication programs, to better track the scope and coverage of USG/T activities. An inventory of existing evaluation efforts funded through previous years was developed and indicated that an additional 13 studies or evaluations are currently underway. Given the complexities and scope of this evaluation portfolio, a USG/T established an in-country Prevention-SI Working Group in 2010 to monitor progress made in this area. COP 2012 will see additional basic program evaluations, and select partners will be asked to move beyond the minimum required PEPFAR indicators to develop custom indicators for output and outcome monitoring. The prevention portfolio also has three on-going public health evaluations focused on: (1) PHDP; (2) HTC and treatment uptake as well as enhanced linkages between the two; and (3) costs and cost-effectiveness of various HTC modalities.

Size estimates and data on MARPs are lacking, but COP 2011 funds are currently supporting: (a) a behavioral surveillance study for sex workers in Tanzania; (b) PWID studies and size estimations in four cities on Tanzania Mainland; and (c) injection drug use mapping and size estimations across six additional regions. MSM study protocols for Dar es Salaam and Tanga, funded by the US National Institutes of Health, are in development. Finally, Zanzibar recently completed data collection for all three MARPs on Pemba Island and is preparing for repeat surveillance on Unguja Island. With a more thorough understanding of the epidemic, USG/T has translated this knowledge into targeted HIV prevention

activities, including supporting MARP programmatic efforts in Zanzibar since 2009 and in Dar es Salaam since 2010. COP 2012 programming includes the expansion of the recently awarded large-scale SW project that addresses the continuum of transactional to commercial sex work as well as the expansion of PWID and MSM activities into two regions, Mwanza and Mbeya. As additional data become available, USG/T will validate its programs and make course correction where necessary.

COLLABORATION WITH OTHER DEVELOPMENT PARTNERS
Although USG/T is the largest bilateral donor in the country, there are opportunities to build upon and leverage the substantial multi-lateral partners, coordination structures, and resources already in place in Tanzania. USG/T is collaborating with UNICEF, a key policy partner, on structural interventions directed toward GBV and violence against children. URT, using Global Fund monies, is responsible for purchasing and distributing HIV test kits, although bottlenecks in the procurement process have caused serious concerns. In addition to other major donors listed throughout the other technical area narratives, USG/T has opportunities to capitalize on synergies within the other USG/T-supported programs, such as PMI, democracy and governance, and Feed the Future.

PROGRAM AREAS

PMTCT
Please refer to the Tanzania PMTCT Acceleration Plan 2012 submitted concurrently with COP 2012 for information on the USG/T prevention interventions in the area of PMTCT.

HIV Testing and Counseling
HTC, a core element of the national HIV response, is a prerequisite for access to care, treatment, and support services. HTC programming provides funding to a mix of approaches aimed at reaching targeted populations and key geographic areas with high HIV prevalence. Emphasis is placed on strengthening linkages and referrals to relevant services. HTC modalities currently supported by USG/T include: (1) client-initiated testing and counseling; (2) provider-initiated testing and counseling; (3) community-based mobile HTC; and (4) home-based HTC.

Despite reduced funding for the HVCT budget code in every year since COP 2008, USG/T-funded partners have continued to increase the number of individuals counseled and tested each successive year. Although cost-efficiencies were identified over the past several years, USG/T was not confident that another budget decrease would cover the needs for the scaling of other critical programs. For the first time in four years, the HVCT budget code will not decline, even though VMMC and PMTCT partners already have HTC services and costs built into their budgets. Funding decisions were guided by partner performance, geographic coverage, modality needs, and regional HIV prevalence. In accordance with the GHI Strategy, accelerated roll-out of couples HTC in eight high prevalence regions, in collaboration with enhanced PMTCT activities, has been highlighted.

Given the recent recall of SD Bioline HIV 1/2 3.0 and the potential public loss of confidence following the negative and confusing information disseminated by the local media, HTC-related issues have been elevated to a national level and USG/T continues to be at the forefront of advising on and improving the HTC landscape. USG/T is currently in the process of procuring HIV rapid test kits to minimize stock-outs, prioritizing limited test kit distribution, providing TA to MOHSW for the development of a temporary algorithm, and evaluating test kits for the establishment of a new HIV rapid testing algorithm. USG/T will also ensure that implementing partners address misperceptions and rebuild public trust in HTC services and HIV results.

HTC QA activities will continue to be expanded to ensure that beneficiaries are receiving correct and consistent results and messages. USG/T technically supported the finalization of the new guidelines, which will include the adaptation of new WHO guidance regarding re-testing. USG/T will also play a key

technical role in advising on the evaluation for a new national rapid testing algorithm. Finally, USG/T will continue to advocate for structural changes, including lay counselor involvement in HIV rapid testing, as outlined in the PFIP.

Given the promising results from HPTN 052, USG/T testing partners will be required to strengthen their linkages with HIV care and treatment services through improved post-test counseling and enhanced client tracking systems. Additionally, as a result of the high rates of violence against women and alcohol abuse, the HTC program will begin integrating GBV and alcohol screening, introducing brief interventions where possible, and linking clients to appropriate services.

Condoms
Continued condom promotion within all prevention, care and treatment activities is of utmost importance. Projections for both public sector and social marketing condom needs are established annually as part of the preparation of the Contraceptive Procurement Tables (CPT). Public sector condoms are donated by USG/T and the GF, while the Medical Stores Department (MSD) is responsible for distributing public sector condoms from the central level to district hospitals. These hospitals are in turn charged with distribution of the condoms to public health facilities. Additionally, a USG/T-supported partner is responsible for the procurement and distribution of all socially-marketed male and female condoms nationwide.

Male condom coverage is nationwide; at the moment, female condoms are available through social marketing channels exclusively, and primarily in urban areas. USG funds contributed approximately 128 million male condoms and 1.1 million female condoms in 2010, of which approximately 70% of the male condoms and 100% of female condoms were provided through USG/T's social marketing partner. Condom shortages and stock-outs are not typically a problem; nonetheless, USG/T provides technical assistance for supply chain management and helps build the capacity of the Pharmaceutical Supply Unit and MSD.

Voluntary Medical Male Circumcision
In 2009, the successful establishment of VMMC demonstration sites within Iringa, Mbeya, and Shinyanga lead to expanded activities in those three regions. Additionally, VMMC activities were started in three regional hubs in Kagera, Tabora, and Rukwa, as well as VMMC supportive campaigns targeting fishermen on the Lake Victoria Islands. Since October 2009, over 146,000 surgical procedures have been performed with approximately 98% HTC uptake and only 0.80% adverse effects reported. USG/T has substantially increased the number of circumcisions performed each successive year, highlighted by a COP 2012 target of 187,000 men receiving VMMC services. USG/T aids URT in its effort to achieve a national target of 1.4 million procedures performed between July 2011 and June 2012. Unfortunately, due to nominal financial support from URT and other sources to supplement the USG/T contribution, less than 20% of this goal will be achieved.

Reprogramming of at least $3.6M pipeline funds and a significant shift of COP 2012 resources from budget codes HVAB to CIRC demonstrate the prioritization placed on VMMC services by USG/T. Pipeline will continue to be monitored and VMMC activities will be strongly considered for additional funds should they be identified.

The program utilizes static (hospitals) and outreach sites (dispensaries and non-medical facilities) as well as mobile services and campaigns. The MOVE model, which consists of task-shifting to nursing cadres, task-sharing among clinicians, bundling of instrument sets, use of time-saving surgical techniques, such as forceps-guided method and electrocautery, multiple surgical bays, and client scheduling has allowed for the rapid scale up of services. In February 2011, the first external quality assurance visit to11 VMMC sites was conducted jointly by MOHSW and USG staff. Recommendations included increased VMMC promotion among older men aged 25-34 years, on-site STI treatment, and improved linkages to HIV care.

Sites are now working to implement the recommendations. To support improved VMMC monitoring, PEPFAR NGIs have been included in VMMC reporting systems.

Costing and modeling of the impact of VMMC are underway and will further inform program planning and scale up. Increased involvement of private sector and faith-based supported facilities, as well as an assessment of the feasibility and acceptability of neonatal circumcision services are planned in COP 2012 to heighten opportunities for sustainability.

Positive Health, Dignity and Prevention
MOHSW has finalized a PHDP strategy for community-level interventions and is in the process of developing a PHDP strategy for health care facilities. A USG/T partner will train MOHSW trainers, who will in turn train health care providers on engaging PLHIV around issues such as sexual risk behavior, STI screening, unintended pregnancies, and safer pregnancy options.

Currently, STI treatment and family planning commodities are not provided at ART sites, although there are efforts to develop comprehensive sites that offer such services at point-of-care for specific populations, such as MARPs. In addition to promoting and providing condoms, providers are also being equipped with the skills to assess client needs, including nutrition, disclosure, alcohol abuse, GBV, and family planning. Specific services and messages for discordant couples are outlined in the couples HTC strategy, which is in the process of being rolled out in eight high prevalence regions.

To ensure a continuum of care for PLHIV, community-based efforts reinforce many of these same prevention messages delivered at facilities. HBC activities have begun integrating PDHP messages into their existing services. Members of community-based PLHIV support groups, many of whom are linked with HBC programs, serve as role models and provide peer support on challenging issues, such as adherence and disclosure.

USG/T partners have been encouraged to monitor and document linkages between facility and community programs to provide learning opportunities on how to strengthen this continuum of care. Efforts over the past year, including a large MOHSW-led stakeholder meeting, have led to the development and harmonization of PHDP M&E tools for facility- and community-based PHDP activities.

Most At-Risk Populations
As detailed in the prevention overview section, COP 2011 funds are currently providing a stronger link between epidemiologic, behavioral, and socio-cultural data and prevention activities, which will lead to more effective prioritization and program implementation.

In line with WHO/UN and PEPFAR guidelines as well as existing evidence for successful HIV incidence reduction, USG/T supports partners to provide a strong PWID package of services that includes combining ART and opiate substitution treatment (OST) while linking with other donors and programs engaged in NSP activities. OST programs are effective in substantially reducing illicit opiate use and HIV risk behaviors while improving adherence to antiretroviral therapy and the physical and mental health of PWID. Tanzania was the first sub-Saharan country to establish OST in February 2011 and has enrolled, as of January 2012, over 300 PWID on methadone. Site expansion in both Dar es Salaam and Zanzibar is underway.

Similarly based on approved recommendations and informed by emerging evidence, COP 2012promotes an agreed upon minimum package of services for SWs and MSM. In COP 2012, USG/T's comprehensive SW program will be expanded geographically and will begin addressing MSM populations in targeted areas. Due to a heightened vulnerability that is driven by a high level of stigma toward MSM, another USG/T program has started to carefully increase collaboration with local MSM groups and will strive to adapt best practices from MSM programs in similar contexts.

To facilitate appropriate MARP-friendly clinical services, USG/T treatment partners are investing additional resources in developing more appropriate services for these often marginalized populations. To ensure a strong link between facilities and community, select MARPs will be trained to provide peer education and support to their respective populations by promoting risk reduction and facilitating access to services.

Given that lasting impact will largely be determined by the broader social environment, USG/T collaboration with relevant government counterparts has led to the establishment of national policies and guidelines for HIV prevention and care in PWID. Discussions to establish similar partnerships and improved coordination for services for SW and MSM have been initiated with TACAIDS and prevention stakeholders.

GENERAL POPULATION
USG/T has developed a prevention portfolio that predominantly focuses on vulnerable groups within the general population. Key geographic areas and venues have been targeted, which include high prevalence regions, densely populated areas, locations with high concentrations of high-risk industries, and hotspots frequented by MARPs. However, a few broad approaches have been developed to address a wider segment of the population. USG/T-sponsored programs include mass media campaigns aimed at addressing gender norms, partner and concurrency reduction, other sexual risk behaviors, and increasing demand for biomedical services. Linked community and interpersonal activities reinforce these messages, particularly among vulnerable populations, including truck drivers, fishermen, young women, and MARPs.

To ensure this approach is successful, partners will be expected to move beyond the minimum required PEPFAR indicators and address such issues as coverage and dosage. Several partners will be conducting process evaluations, which document and analyze the early development and actual implementation of the strategy or program, assessing whether strategies were implemented as planned and whether expected output was actually produced. These real-time feedback evaluations are complemented by end of project outcome evaluations. Protocols are currently in development for over five outcome evaluations that are planned to take place using COP 2011 and COP 2012 funds.

Following the completion of USG/T's flagship youth program, a thorough review of the epidemiology, and an effort to align with the prevention guidance, targeted youth activities were significantly reduced in COP 2012. However, HIV prevention interventions, including sexual and reproductive health services, will continue to be strengthened within the OVC portfolio. A needs assessment conducted in 2010, in collaboration with other USG/T-funded OVC partners, identified specific TA needs. In fact, the prevention and OVC portfolios currently co-fund a project that recently provided TA to other OVC partners to improve the integration of HIV prevention messages in OVC activities.

In alignment with the GHI Strategy's prioritization of girls and young women, the new cash transfer program will address the underlying social norms and the overall risk environment that increase their vulnerability to HIV infection. In addition to the cash transfer program, USG/T directly supports the Ministry of Education and Vocational Training for a small-scale, school-based peer education and school counselor program.

CROSS CUTTING AREAS

Health Systems Strengthening and Human Resources for Health
Given scarce human resources, the utilization of different cadres, including volunteer and non-professional personnel, is critical to the success of many HIV prevention interventions. The URT is currently in the process of developing a defined scope of work for community-owned resource persons (CORPs), which would incorporate all non-professional cadres, including, but not limited to,

community-based distributors, community-based health care workers, lay counsellors, and traditional birth attendants. To date, the training for this volunteer workforce has not been standardized, which has led this group to obtain skills through a variety of mechanisms, often depending on partner trainings. Some unique partner training models include long-distance radio training. PFIP highlighted the need for task-shifting, which remains a critical and complex issue that has yet to be fully addressed.

As part of the effort to hasten the transition to greater country ownership, the number of national and indigenous entities as PEPFAR prime and sub-partners continues to grow. Meanwhile, USG/T has called for international partners to expand the scope of their skill transfer activities to include everything from administrative/organizational and technical matters to financial and advocacy issues.

MEDICAL TRANSMISSION
Targeted advocacy efforts by USG/T and IPC-IS partners have led to improved integration and efficiency through support for universal precautions and waste management from selected USG/T-funded care and treatment partners. However, further efforts for increased integration into all clinical settings across regions and sites needs to be continued. Specific activities started in COP 2011 to increase safety of phlebotomy practices, support adequate health care waste management, and access to PEP will be continued.

Under the PFIP, IPC-IS and blood safety (BS) program transition to government ownership was stipulated as a priority. A transition concept note was developed in 2011 as well as the establishment of the IPC-IS and BS transition committees, which are chaired by MOHSW. Last year's IPC-IS efforts included strengthening the capacity of URT-affiliated academic medical institutions to provide pre-service training and education in the application of standard safety precautions and procedures, including waste management. In COP 2012, planned activities include strengthening supervisors' capacity to provide on-the-job mentoring and supportive feedback and incorporation of IPC-IS indicators into the national integrated supervision checklist. USG/T will continue to advocate for inclusion of IPC-IS activities in Comprehensive Council Health Plans and the URT's Medium Term Expenditure Framework for sustainability.

USG/T supports the National Blood Transfusion Service (NBTS) through direct funding as well as technical assistance. Seven zonal centers have been established and blood collection has increased from 5,000 units in 2005 to an average of 110,000 units a year since 2008, of which 80% are collected from voluntary, non-remunerated donors with about 30% being repeat donors. Over 50% of donors receive HTC results and referrals to care for those with a transfusion transmissible infection.

In COP 2012, the NBTS will work closely with the PMTCT program to increase the availability of safe blood to address obstetric hemorrhage, as stipulated in the GHI Strategy. A planned Funding Opportunity Announcement is designed for a local non-governmental partner to assist the NBTS in blood collection. Since current blood collection meets only 30% of the need on the mainland, other HIV programs, including VMMC, HTC and behavioral interventions, will be strengthened to ensure that blood donation messages are better integrated.

GENDER
Tanzania has been selected as one of three focus countries under the new PEPFAR GBV Initiative with implementation starting in October 2011. Gender and GBV interventions and services are highlighted in the USG/T GHI Strategy. In COP 2012, USG/T is dedicated to addressing harmful gender norms, reducing high-risk behaviors through the promotion of positive and equitable partnerships, and improving gender equity in accessing services. In addition to funding programs that are primarily focused on gender issues, many USG/T partners have incorporated a gender lens within programming onto already existing platforms as a way to ensure women's access to services and promote men's involvement in family health as well as HIV care and treatment. This combination of both dedicated and integrated gender

programming will ensure that gender issues are addressed in both clinical and community-based settings.

Support for evidence-based programming continues to be a guiding principle of the Partnership Framework and the GHI Strategy. Building on findings from the GBV module of the 2010 TDHS and 2009 violence against children study, USG/T will support the incorporation of new gender specific indicators. In addition to these new indicators, USG/T will be conducting two evaluations: (1) a large-scale evaluation of GBV Initiative activities to monitor GBV service uptake and detail specific models used to link survivors of GBV to relevant services; and (2) community male involvement activities (Men As Partners curriculum).

STRATEGIC INFORMATION
The USG/T prevention portfolio currently includes over 30 prevention PHEs and BPEs, which are managed through a joint Prevention/SI Technical Working Group. The activities include determining the HIV/STI prevalence, behavior, population size estimates, and potential prevention methods for MARPs. These studies will enhance the team’s understanding of the successes and challenges in prevention programming and results will be systematically shared with all relevant partners.

The SI team is working with MOHSW on validating PMTCT program data, which will eventually provide guidance on whether it can replace HIV ANC surveillance in the future. The team will collaborate with MOHSW and other stakeholders to implement M&E activities and provide technical assistance to HIV surveillance activities, including surveillance, MARPs, HIV drug resistance threshold survey, and HIV drug resistance monitoring activities.

COP 2012 will continue to undertake DQAs with the aim of improving the quality of the reported data and building capacity of implementing partners and URT counterparts. Examples of these include HTC QA activities and external VMMC QA newly introduced in close collaboration with MOHSW and NACP over the past year.

Among most partners, and nearly all local partners, the utilization of data for program improvement is limited. The lack of capacity to conduct statistical analyses and interpret the data for course correction has inhibited partners from altering program direction in a timely fashion. USG/T SI staff is becoming more engaged with partner M&E staff to build the skills and culture of data use.

CAPACITY BUILDING
To ensure a comprehensive national response to the HIV epidemic, USG/T’s capacity building priorities are to strengthen URT’s ability to coordinate and oversee the NMPS and other national strategies, such as the National Prevention Strategy, at the national, regional, district, and local levels. Simultaneously, USG/T has been improving the capacity of civil society to influence their communities to increase uptake of healthy behaviors and utilize health services and products. Finally, USG/T is a leader in developing PPPs that promote sustainability by mobilizing private sector expertise and other resources. USG/T participates on the MOHSW PPPTWG, the National PPP Coordinating Committee in Health, and the Tripartite Forum Plus in HIV/AIDS and Workplace Programs.

Technical assistance to government, civil society, and the private sector represent a significant portion of USG/T’s budget and staff time and is highlighted as a critical component of the GHI Strategy. Activities span technical, policy, financial, and organizational development assistance. Some examples include strengthening the capacity of URT-affiliated academic institutions to provide pre-service training and education and working with community-based organizations to improve governance and accountability.

For a successful transfer to country ownership, USG/T works to develop national strategies and DQA tools with the intention of standardizing and harmonizing efforts countrywide. As Tanzanian institutions take on greater roles in leadership and conceptualization of program design and planning, USG/T continues to reduce its role in service delivery and increase its focus in supporting quality integrated

services, health systems strengthening, and promotion of healthy behaviors.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	15,392,830	0
HTXS	63,644,482	0
PDTX	8,564,465	0
Total Technical Area Planned Funding:	**87,601,777**	**0**

Summary:
ADULT TREATMENT

Context and Background
The United Republic of Tanzania (URT) has an estimated 1.4 million adults living with HIV/AIDS according to the UNAIDS report 2009. USG/T remains a key donor for HIV services in Tanzania and continues to support the efforts and expand the capacity of the URT to meet national targets. In conjunction with other international donors and partners, USG/T provides services to the majority of patients in care and treatment programs while the majority of ARV drugs are procured by URT with funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). As of September 2011, USG/T was supporting 289,433 individuals actively on antiretroviral treatment (ART), out of which 86,957 patients had been newly initiated on ART in FY 2011. Progress was made in transitioning some components of the program to local partners and regional health management teams (RHMTs) to promote ownership and sustainability. USG/T will also continue to support URT to adopt new WHO Treatment guidelines. To verify the number of current patients on ART, USG/T under the leadership and with the collaboration of URT, carried out a physical count of all patients on treatment in September 2010.

In partnership with URT, a number of strategies have been developed to expand the program while improving quality of services. These include strategic scale-up of ART services considering the new guidelines and areas of need, improved regular supportive supervision with newly revised tools, strengthened facility-based continuum of care with linkage to communities, strengthened patient monitoring systems, improved drug and reagents security, clinical and nutrition mentoring and promotion of health seeking behaviors. Multiple studies for impact evaluation are underway. There are also ongoing efforts to build capacity of local partners in areas of program oversight including planning and implementation, financial accountability, technical support and monitoring and evaluation. The treatment program along with the M&E team, will improve reporting systems in line with USG/T emphasis on data accuracy and quality of reporting, with the goal to have this reporting system owned and managed by the country.

The transition plan for treatment places a strong emphasis on decentralized coordination mechanisms. USG/T has designed multiple activities in COP 2012 that will help build capacity at the regional level, including direct funding of some champion RHMTs. Partners are also working through a district approach for planning, implementing, and monitoring programs jointly with district health management teams (DHMTs) as well as RHMTs to build leadership capacity at local levels. During COP 2012, USG/T will continue to coordinate partners' efforts for procurement through SCMS while building capacity of the Medical Stores Department (MSD) for subsequent transition as agreed upon in the Partnership Framework. USG/T is working closely with URT to strengthen this system and ensure that gaps and

weaknesses are being addressed adequately.

USG/T recognizes the results of randomized, controlled clinical trials which demonstrated efficacy of ART to prevent sexual transmission of HIV in sero-discordant couples. During COP 2012, public health evaluations will be conducted to determine the feasibility and acceptability of potential interventions.
In COP 2012, USG/T will continue to apply the Global Health Initiative (GHI) strategy. Adult treatment is contributing to the Intermediate Results (IR) 1.1 which focuses on increased access to quality comprehensive services for women and newborns. USG/T will work toward this by increasing the number of pregnant women who are initiated on HIV treatment for their own health as well as for prevention of transmission, through point of care CD4 testing (PIMA); improving linkages and referrals between HIV program areas and between HIV and non-HIV programs; strengthening support groups in facilities and communities; improving health seeking behaviors as well as integrating family planning methods in HIV/AIDS care and treatment services. ART is also an essential component of the combination prevention strategy together with voluntary medical male circumcision, prevention of mother to child HIV transmission and condom availability.

The URT continues to use AZT as the first line regimen, with TDF as an alternative, mainly due to funding limitations. USG/T has recommended to the Ministry of Health and Social Welfare (MOHSW) through the National AIDS Control Program (NACP) to move to a TDF-based first line regimen, and continues to work with the URT toward this transition. It is anticipated that TDF will be used more widely in future, as it is a more robust first line regimen. Stavudine is being phased out completely.

Access and Integration
The URT has adopted a phased approach to implementing the new WHO guidelines for ART initiation, in order to avoid overburdening health care services with an influx of patients who would immediately become eligible for ART upon institution of the new guidelines. During the first phase, ART will be initiated for all HIV positive pregnant women with CD4 counts below 350; all TB patients co-infected with HIV, irrespective of CD4 counts; and all HIV positive children below the age of 24 months, irrespective of their CD4 counts. As under the old WHO recommendations, patients with clinical stage 3 and 4 will continue to be eligible for ART regardless of their CD4 counts. In the second phase, initiation of ART will encompass all patients with CD4 counts below 350.

The MOHSW recently approved the revised guidelines for Tanzania, which were drafted along these lines. USG/T continues to lobby for rapid adoption of phase 2.

Based on CD4 distribution in pre-ART patients, it is suggested that the number of patients in need of ART will increase by 40% when implementing the new guidelines. This poses a challenge to the treatment program not only in terms of need for additional funding, but also in terms of limited absorption capacity at the facility level, logistics for ARVs and lab commodities, and an inadequate health care work force. Simplification of the treatment approach in accordance with the WHO / UNAIDS-led Treatment 2.0 strategy will be explored further by USG/T to address these challenges. USG/T will also continue to support pre-service training of health workers including expansion of training institutions to address the health care worker crisis as key bottleneck for expansion and sustainability.

USG/T will support the URT in scaling-up ART services to all qualified health facilities in order to achieve its vision of universal access. However, continuous quality improvement at existing facilities needs to be implemented and maintained at existing facilities at the same time. Various quality improvements are underway, including a new national standard for supportive supervision and revised tools for facility assessment. The first conference for quality improvement in Tanzania took place in 2011 with substantial support from USG/T.

The goal for USG/T remains to ensure uninterrupted services for existing patients on treatment and to

accommodate those patients who have been identified in need for treatment from feeder systems, such as PMTCT, TB/HIV clinics, provider-initiated testing and counseling (PITC), and early infant diagnosis (EID). In addition, USG/T will prioritize treatment support for HIV-infected pregnant women to reduce maternal mortality and prevent HIV-transmission to the baby. Point of care CD4 tests at ANC and integration of ARV services into TB and ANC clinics where feasible, are key strategies for this approach. Close monitoring of program growth as well as close coordination with URT and other key donors (mainly GFATM) are also viewed as critical priorities for success.

Quality and Oversight
One of the greatest challenge to building sustainable continuous care systems in Tanzanian settings continues to be the use of information for program planning and management. This is true at national, regional, and district levels and poses an enormous challenge for partners in the areas of continuous quality improvement and positive progression of HIV/AIDS patients' health outcomes. To address this challenge, MOHSW has developed mentorship manuals, guidelines and supportive supervision tools for data use, and a Quality Improvement Training program for people working in health programs both directly as clinical staff as well as employees of implementing partners. Concurrently, partners are training local staff and supportive supervision visits to facilities are conducted jointly between partners, USG/T staff and local health management teams.

In Tanzania, immunological and clinical parameters are used to identify treatment failure. However, viral load measurements are only available for monitoring of treatment program quality and not for individual patient management. Efforts are underway to develop guidelines for patient selection for virological screening. In the Partnership Framework, USG/T committed to implementing a plan to support the establishment of HIV drug resistance monitoring capacity at the National Reference Laboratory and at the Mbeya Referral Hospital.

The National Centre for Adverse Drug Reactions, which reports under the Tanzania Food and Drugs Authority (TFDA), monitors, collects, and evaluates Adverse Drug Reaction (ADR) reports and offers feedback on its findings to the healthcare professionals and the general public. Reported information is also communicated to WHO. The system captures all pharmaceutical ADRs including ARV-related events. However, the motivation of health care workers to fill out the monitoring tools is not adequate. Measures meant to improve this are regular supportive site visits as well as raising awareness at the national level.

The URT procures ARVs with support from GFATM. Delays in funding for these procurements, as well as discontinuation of GFATM support, would severely impact PEPFAR supported programs. USG/T recognizes this potential vulnerability and will continue to focus on improved coordination with GFATM and URT during COP 2012, including providing support for TACAIDS for GFATM expenditure monitoring and tracking as well as developing the Global Fund liaison position within the PEPFAR Coordination Office.

Lab reagents and supplies are also being supplied through the national system with support from the GFATM Round 8. However, due to frequent shortages caused by disbursement delays, USG/T partners have been repeatedly asked to procure these products to avoid stock out situations. In 2010, in order to create greater efficiencies, USG/T pooled 50% of partner lab commodity funding within SCMS while leaving the other 50% with partners. By using the pooled procurement through SCMS, approximately 100% savings in product cost was achieved. The long term vision is to build the capacity of the MSD so that partners and districts can fully rely on a strong national commodity and supply system similar to that for ARVs. Partial funding for commodities is expected from the AIDS Trust Fund, recently established by the URT as a step toward decreasing donor-dependency and increasing sustainability in the long-term.

Sustainability and Efficiency

Based on information from the 2010 ART costing study, USG/T assisted the government in modeling cost implications of the adoption of new WHO guidelines. This model has played an important role in guiding URT towards a prioritized and phased approach for implementation and will be updated regularly as newer information becomes available. The model plays a critical role in estimating funding needs which can be applied to such projects as the application for the apply for the Transitional Funding Mechanism of the GFATM

OGAC recently approved the USG/T expression of interest for closer collaboration and coordination between GFATM and PEPFAR, as both programs have invested substantially in Tanzania. The key support proposed will be to improve the function of the Tanzania National Coordinating Mechanism secretariat, which is responsible for GFATM grant management in Tanzania. Close coordination between the two programs mainly on procurement of drugs and lab commodities, will lead to a substantial increase in efficiency as both programs are targeting the same individuals; while USG/T is supporting ARV services, drugs and commodities are almost exclusively procured through GFATM support. Joint planning and reporting will lead to better grant performance and minimize the need for expensive emergency procurements.

With the adoption of new WHO recommendations, a different group of patients is being targeted. Whereas the old guidelines were targeted towards the treatment of sick patients with CD4 <200, the targeted group now is expected to be healthier and will most likely not be in need of as much close clinical monitoring as the previous group. New models of drug distribution (such as community based versus facility based) and monitoring for treatment failure and complications will be explored in order to ensure the best impact with existing funding.

Lastly, USG/T recently awarded Cooperative Agreements to five regions for HIV program management. This includes service oversight as well as financial accountability and monitoring of programs. While this approach may need some investments in the short term, more country ownership and sustainability will lead to more efficiency and cost savings in the long term.

PEDIATRIC HIV TREATMENT

Context and Background
UNICEF estimates approximately 160,000 children are living with HIV in Tanzania (Children and AIDS: Fifth Stocktaking Report 2010). APR 2011 reported that 18,729 children below 15 years are receiving ART, among which 1,560 (8%) are infants below 12 months. With the 7,217 children below 15 years who were enrolled in care, 1,244 or 17% were infants below 12 months. Children represent 8% of all patients currently on ARV treatment, with approximately the same proportion of those in care. Because there is only limited surveillance data specific to children available in Tanzania, estimates of the pediatric burden have been based on modeling while targets have been developed in relation to the number of adults receiving services.

USG/T supports 683 care and treatment sites which provide treatment to both adults and children. However, the enrollment of children into ART has been very slow. Early HIV diagnoses through EID, PITC, and linkages to treatment have been the main challenges for the program. There are four zonal laboratories that provide DNA PCR HIV testing; currently approximately 1,500 out of 4,000 PMTCT/RCH health facilities provide HEID services through Dried Blood Spot specimen collection to zonal labs for testing. MOHSW reports 25,558 infants were tested using DNA Polymerase Chain Reaction, of which 2,903 were tested positive (EID December 2010 report).

URT is committed to pediatric HIV care and treatment and has set the national target that 20% of all patients on ARV should be children; USG/T committed to supporting this approach and will increase the proportion of children receiving ARV treatment from 8%   to 10% in COP 2012 as a first step, with 30% of

those children on treatment being infants who are less than two years of age.

Key Priorities and Major Goals for the Next Two Years
Pediatric HIV is most directly related to the Partnership Framework goals of service maintenance, scale-up, and human resources. However, all other goals are also addressed in program planning and implementation. Implementing partners for pediatrics HIV activities, as with other services, are working through a district approach to plan, implement, and monitor programs jointly with district and regional health management teams to help build leadership capacity at the regional and local levels. USG/T partners are strengthening the capacity of DHMTs to monitor, supervise, and provide mentoring on pediatric HIV interventions to health providers at the lower health facilities, which include program and service roll out. Capacity building is also conducted at the MOHSW level, with particular attention paid to finalizing policies and guidelines related to pediatric HIV management.

Pediatrics HIV activities in the next two years will focus on improving the quality of services being provided to children infected with HIV, with a specific focus on scaling up early diagnosis through HEID and linking infected children to early care and treatment. URT has developed a five year (2009-2013) national scale up plan for PMTCT and pediatrics HIV care and treatment, with the goal of improving the health of parents and their children by scaling up comprehensive PMTCT and pediatrics HIV care, treatment, and support services. One of the main targets is to increase the percentage of health facilities with RCH services providing integrated PMTCT and pediatrics care and treatment from 65% to 100%. USG/T is supporting this national scale up plan.

Another focus will be on strengthening PITC for older children at all pediatrics entry points, including MCH, pediatrics wards, malnutrition rehabilitation wards, care and treatment clinics, and out-patient departments. USG/T is supporting MOHSW in the review process of both the PITC and PMTCT guidelines, in which there will be strong emphasis on early identification of HIV exposure and infection status. Health care providers will be trained on PITC with a strong focus on identification and testing of infants and children. The PMTCT and EID training packages have recently been merged to allow health care providers to gain knowledge and skills on both EID and PMTCT. USG/T has also supported the review of the Pediatrics HIV Treatment Guidelines to adopt WHO 2010 recommendations. However, its implementation will be in phases where phase one will include treatment for all HIV infected children below two years followed by a revision of the immunological thresholds for initiating ART for older children at a higher CD4 count.

National pediatrics HIV program evaluation is another activity that will be conducted in the next two years to determine and document the treatment outcomes of children on ART and the quality of pediatrics ART services. This has not been done since the inception of the program in 2004. Plans are also underway to develop systems and monitor perinatal HIV transmissions from mother to child to help determine the transmission rate in the country.

The pediatrics HIV program has been facing several challenges including transportation of specimens to and from the zonal labs particularly within the "last mile" between districts and facilities. Clinton Health Access Initiative (CHAI) has supported the government to address part of this challenge by installing SMS printers at district hospitals which are connected to the zonal lab using mobile phone technology to facilitate sending results back to districts. Currently, approximately 97 districts of the 133 districts are using this technology, with the availability of test results at these sites having shown dramatic improvements. USG/T has planned to support the government in this initiative for the remaining districts to get printers. MOHSW has also provided a guideline on HIV EID sample transportation from health facilities to district hospitals and zonal labs to address the transportation challenge. Other initiatives to identify for-profit organizations for regular transport of specimens, particularly from districts to facilities, are underway, though initiatives may vary by district as a one size fits all approach may not be possible in the country. In addition, USG/T is currently working to establish a new public private partnership (PPP)

that will improve the transportation of EID blood samples to zonal laboratories to ensure the results are available on a timely basis.

Tracking infected infants and children once HIV test results are available at the site level and initiating them on treatment are another challenge faced by the pediatric program. This is specifically critical as children infected with HIV deteriorate to death much faster than adults and therefore early treatment is critical to saving their lives. Reasons for this loss to follow-up are multifaceted, and implementing partners are working to identify best practices that can then be shared with other providers to improve retention. “Mom to Mom” support programs were established and scaled up mainly by PMTCT partners and community groups, which helped with the follow-up of HIV-exposed infants and assisted with linking them to care and treatment.

Another challenge has been the lack of HCW skills and confidence in managing pediatrics HIV. Pediatrics focused USG/T partners are providing technical support to other implementing partners in order to improve health workers’ skills and confidence in counseling and managing children with HIV. Baylor International Pediatric AIDS Initiative (BIPAI) is addressing this through in-service training for health care providers as well as onsite mentorship and clinical attachments in two. BIPAI, in collaboration with the regional implementing partner, builds the capacity of the district mentors who will then trickled-down the mentorship program to facilities.

USG/T is supporting the pediatric HIV program in all aspects of service delivery, while CHAI-support procured drugs and EID commodities. At the beginning of 2012, CHAI no longer supported pediatric ARV procurements. At the request of URT, USG/T agreed to pick up the full cost of pediatric ARVs. These drugs will be procured through SCMS based on the national quantification and procurement plans prepared by National AIDS Control Program (NACP). USG/T will continue to support pediatric ARV procurement through the end of the Partnership Framework. At that time, as agreed, ARV funding and procurement will become the responsibility of URT.

CROSS-CUTTING AREAS

Supply Chain
When PEPFAR began in Tanzania in 2004, the major international procurement and supply chain stakeholders in the country consisted of the GFATM, USG, Danish International Development Agency, Clinton Foundation, and Japan International Cooperation Agency (JICA), though JICA and Clinton Foundation have withdrawn their support over the past year. All partners have been working together to coordinate technical assistance and procurement through a working group chaired by NACP, with secretariat support from SCMS. Procurement and technical assistance is focused on supporting NACP and MSD in the direct procurement of commodities and the strengthening of the supply chain system.

As also described in the Governance and Systems Technical Area Narrative, USG/T supports the URT in annual forecasting, quantification of products, and pipeline monitoring. The most recent quantification of ARVs, test kits, and lab reagents took place in April 2011 for the period April 2011 to April 2014. The quantification utilizes several different tools and blends a combination of commodities issue data, eligibility data, projected scale up rates, and anticipated program and treatment guideline changes; it serves as the basis for a procurement plan for NACP program use, including the schedule of when products need to be procured. Each quantification is reviewed quarterly and adjusted based on the most current information available, with SCMS in the lead coordinating role for the annual quantification.

To help reduce the risk of commodity stock outs in 2009, USG/T supported deployment of pharmacy supply chain advisors (SCMA) in all nine MSD zonal distribution centers, which COP 2012 funds will continue to support. The SCMAs spend half their time at the zonal medical store and half their time at individual sites. They take monthly stock counts of ARV supplies at MSD and work with individual health

facilities on supply chain management issues. Beginning in July 2011, a lab supply chain advisor was placed in each MSD zonal facility with the same breakdown of hours . They monitor stock levels of lab supplies at MSD and work with individual health facilities on supply chain management issues. MSD, NACP, and SCMS hold bi-weekly meetings to discuss procurement and distribution issues, in addition to this support to the field.

To help improve health commodities storage and distribution capacity USG/T is working with MSD to improve warehouse functions through redesigned floor layouts, install new racking and packing lines and assist warehouse managers with improving standard operating procedures and providing a modern security system design and implementation. USG/T is also providing support to develop five new prefabricated warehouses which will increase national storage capacity by 14,000 square meters, allowing for better storage conditions and increased stock levels which will increase stock availability and reduce stock outs.

There are three critical information systems strategies which the USG/T is currently supporting through SCMS: (1) Enterprise Resource Program (ERP); (2) Integrated Logistics Management System (ILMS) and Electronic Integrated Logistics Management System (e-ILMS); and (3) Last Mile direct delivery project.

The ERP is a three year project to address known weaknesses in MSD's internal business processes through assessment, design, and implementation of a new ERP system to meet the changing business practices set by international standards. The project is 35% funded by MSD and 65% by USG/T.

The ILMS supplies data for program management use in planning through a paper requisition and reporting system used by all facilities receiving supplies from MSD. USG/T provides support for the training and mentoring of staff at each facility in the proper use of the forms. The e-ILMS project will focus on transforming the paper system into an electronic system down to the district facility level beginning in 2012.

Recently, URT mandated that MSD provide direct delivery to all facilities in Tanzania. This increased MSD's drop points from 500 to 5,000. This change provides greater accountability within the supply chain system for deliver to lower level facilities; however this mandate necessitates a complete redesign of the sales and order system and requires a new ERP as well as significant expansion of infrastructure and fleet capacity to be fully implemented. Through a public-private partnership (PPP), Coca Cola, Gates Foundation, Accenture Development Partnerships (ADP), and USG/T have been working with MSD to map out a process to meet the mandate to cover "the last mile". The implementation phase is expected to last up to three years until all health facilities are fully transitioned to the new system. This project requires a complete redesign of the sales and order system, in which the new ERP should be fully operational along with any changes made to the ILMS system.

USG/T is committed to investing in important human resource development activities over the next two years with a strategic focus on supply chain management, to increase the capacity of the URT public supply system to procure, manage, and distribute health commodities to support the national response to HIV/AIDS. The USG/T is providing capacity building training to MSD mid-level managers from central and zonal stores in training that is designed to include coursework on basic logistics, quantification, and procurement with an emphasis on operationalizing ILS. The training will equip managers to review orders and identify and flag problematic facilities. In partnership with ADP, coordinated training budgets and training needs will be assessed while 50 MSD staffers will be given access to ADP's Supply Chain Academy web-based training programs. USG/T also supports human resource training within MOHSW and their various departments that are involved in supply chain and procurement, including the Pharmaceutical Supply Unit and the Procurement Management Unit. USG/T supports the Public Procurement Regulatory Authority in development of supply chain training for use across all ministries

within the URT. In addition, USG/T is working with the TFDA to train inspectors and key management staff to improve their monitoring capacity of quality health commodities in the country.

Currently, all supply chain system program support is designed to transfer skill sets to host country nationals. As a requirement, MSD is to take the lead role in all PEPFAR-supported projects. USG/T is actively working with URT, MOHSW, and MSD to develop a transition plan for supply chain issues. With MSD's current five year strategic plan ending in 2013,it has been agreed upon that transition of the supply chain management will be incorporated into the next five year strategic plan and become institutionalized within MSD.

While some non-ARV pharmaceuticals are procured in country, USG, in collaboration with Muhimbili School of Pharmacy, TFDA, John Snow, Inc., and SCMS, has a project to develop a sustainable, in-country pharmaceutical testing program which will be available to the public and private sectors in all East African countries. Work with specific pharmaceutical manufacturers and distributors are taking place to help them meet USG/T quality standards. An initial set of 37 non-ARV products have been identified for inclusion in the project with the intention of significant scale up in 2012.

LABORATORY
Tanzania National Health Laboratory Services (NHLS) is guided by two documents: a five year strategic plan, the 2009- 2015 National Health Laboratory Strategic Plan (NHLSP); and a two year operational plan for 2009-2011. The NHLSP defines the scope, structure, and strategic direction of the national lab services, and addresses six objectives focusing on services and quality management systems across the tiered national laboratory network. The midterm review of the NHLSP is to be conducted in 2012. The operational plan for the National Laboratory System to support HIV/AIDS care and treatment describes harmonizing laboratory equipment choices and provides the appropriate testing capacity at each level of the laboratory network. In a stepwise manner, it also details the modifications to the physical infrastructure, the procurement and installation of equipment, the training of personnel, the procurement of reagents, the implementation of quality management systems, including data capture and its management, equipment maintenance, and oversight for the implementation of the plan. Through USG/T support, harmonization of laboratory referral networks throughout the healthcare system is ongoing.

The NHLS recognizes laboratory biosafety and biosecurity as critical elements of laboratory capacity. To address space and safety issues, a national reference laboratory, 23 regional laboratories, and 10 district laboratories have undergone major infrastructure upgrades. Biosafety and biosecurity training have also been provided to all laboratories through implementing partners. Starting in COP 2011 and continuing in COP 2012, two year pilot on the implementation of 13 biosafety elements is taking place in three laboratories with the goal of scaling up to other labs. The laboratory strengthening agenda is linked with laboratory accreditation to national or international standards.

The Partnership Framework cites a target of accrediting 44 laboratories to national and international standards by 2013. Currently, there are 18 laboratories on the roadmap to accreditation using a WHO-AFRO Stepwise Accreditation program and ISO 15189. COP 2012 funds will support an additional 12 laboratories. The Tanzania health laboratory standard policy guidelines were published in 1993 and reviewed in 2003. Although the document describes the scope, structure, and roles of national laboratory services, it does not address specific laboratory service policy issues or describe linkages to programs across ministries or different mandates. The review of the policy guidelines is expected in the near future. USG/T will provide funding and technical assistance to ensure that critical policy issues are properly addressed.

Overall, the workforce development policies and strategy for laboratory technicians are underdeveloped. This has led to an ineffective development plan for laboratory technicians, which ultimately has led to decreased interest and motivation for the laboratory services field. With support from USG/T , a significant

improvement has been realized in strengthening laboratory services, including human resource development. The pre-service schools have increased from four to more than fifteen over the seven years of USG/T support in Tanzania through PEPFAR. However, enrollment capacity for the lab schools is limited by lack of sufficient infrastructure, shortage of faculty and other teaching materials. USG/T support for infrastructure development in COP 2012 including the building of dormitories and increasing the number of classrooms, will strengthen human resource development.

STRATEGIC INFORMATION (SI)
In COP 2012, USG/T will put more efforts on strengthening the treatment information base and the use of the information base through integrated SI approaches. The URT recently adjusted the care and treatment reporting system with USG/T support, resulting in a revised national system that alleviates the burden on health care workers by reducing the reporting frequency, and also harmonizing and reducing the number of required indicators. Through harmonization, PEPFAR indicators such as outcome indicators, were added into the reporting system. Consequently, data collected for the APR/SAPR will also feed into in-country planning and monitoring priorities in addition to OGAC reporting requirements. This will achieve both a short-term and long-term balance between meeting USG/T data requirements and supporting national systems for regular M&E, survey and surveillance, and routine information systems. This harmonization works toward addressing SI challenges associated with multiple donors, vertical programs and priorities.

Coordination of M&E efforts among key stakeholders has been limited and as a result, partners collect data on an extensive number of overlapping indicators with varying definitions. USG/T will continue to explore ways to help the URT achieve a balance between supporting national systems and meeting reporting and planning requirements for data collection by USG/T and other stakeholders.

USG/T has invested heavily in PROMIS, a reporting system that focuses on country level planning and monitoring requirements, and will use COP 2012 funds to maintain the system. All USG/T partners currently report SAPR and APR data via Tanzania's PROMIS system that provides data on all treatment indicators which are eventually disaggregated by region, district, and facility. The Treatment SRU is demonstrating the value of this investment as the information is facilitating improved evidence-based decision making and helping to identify areas for data quality improvement.

Regular ANC surveillance activities will continue in COP 2012 while simultaneous investments will take place in ANC/PMTCT comparison studies to pursue more cost effective ways to get HIV prevalence information over the long term.

To address the data quality concerns over the long term, USG/T is working closely with the URT to establish a data quality assurance process that makes use of a common set of tools and methods across the country. In particular, the M-health PPP is supporting this national initiative by improving systems to collect data of priority care and treatment indicators. In addition, a new initiative that leverages M-health will ensure the mothers receive educational messages on maternal health issues, including the availability of PMTCT services and reminders to attend ANC.

Use of information by USG/T and the URT at national and sub-national levels is a core priority across the USG/T portfolio. There are investments at all levels to ensure data is disseminated and made available to stakeholders in a format and time frame that emphasizes effective use and evidence-based decision-making.

The USG/T program is working with the private sector to advance key priorities in provision of treatment. The USG/T team prioritized a long term vision of sourcing USG/T data from URT systems to minimize the burden on facilities and government departments during the development of PROMIS, intending to show support for the new URT tools and systems. In addition to routine systems, all major surveillance and

survey activities are either implemented or led by URT organizations (ex ANC, THMIS, DHS etc) and USG/T provides either technical or financial support.

HUMAN RESOURCES FOR HEALTH
In Tanzania, the acute shortage of physicians and nurses has been a limiting factor for the rollout of HIV care and treatment. This factor has contributed to a growing interest in task-shifting, the delegation of routine tasks performed by physicians to other categories of health workers, of many stakeholders engaged in providing health services in Tanzania, including care and treatment HIV services. However, the URT has not yet formalized task-shifting practices. The lack of policies around this issue has made it difficult to facilitate a conducive environment that recognizes the contributions of non-clinical staff, particularly in rural settings where there is a severe shortage of clinical personnel.

URT's goal is to develop a clear task-shifting plan that identifies training needs and demonstrates innovative methods to expanding the workforce in a safe and systematic process. To support this development, USG/T is providing information, resources, and guidance on effective task-shifting approaches, which will ultimately help to inform and structure the national policies around task-shifting. A study of nurse-led patient screening utilizing personal digital assistants equipped with standardized treatment protocols at CTCs, is being implemented and will be completed in March 2012. Several evaluations of facility and community-based task-shifting are also being developed. The MOHSW and the National Institute for Medical Research, supported by previous year COP funds, will soon begin a situational analysis of task-shifting at the facility level to determine the different types of task-shifting happening in health facilities. COP 2012 will be funding a subsequent situational analysis of task-shifting at the community level. Once these studies are completed, relevant information will be used to inform task-shifting policies in Tanzania.

Professional quality standards and continued education are essential for patient care. USG/T promotes excellence in clinical practice through supervised post-training practical experiences which are strengthened through clinical twinning programs. USG/T is also supporting a new clinical education expansion program that will bring multidisciplinary groups of students to rural regional and district hospitals. Pre-service training programs that bring HCWs to underserved areas help to improve deployment and retention of workers in areas where they are needed most. USG/T supports institutional capacity building of HCW professional bodies, such as the Tanzanian Nurses and Midwifery Council and the Tanzanian National Nurses Association, in order to increase membership, strengthen advocacy and leadership, and link continued education in health and social work to professional quality standards. In addition, USG/T provides assistance to the National Social Worker Association to support development of a professional infrastructure for social work in Tanzania.

USG/T focuses its support on training cadres that contribute most directly to frontline health services, particularly for women and children, such as social workers and other community health workers. USG/T palliative care training and services strengthen the capacity of communities to provide quality palliative care training to healthcare and non-healthcare personnel working within the guidelines set out by NACP. The training of community volunteers with their respective nurse supervisors helps to broaden their skill set towards becoming community health workers (CHWs) who serve as adjuncts to health care professionals. Nurse supervisors are linked to the program to achieve sustainability and to provide supportive supervision so that CHWs can continue to maintain quality of care for patients.

In COP 2012, USG/T partners are continuing to incorporate a gender lens within programming onto already existing platforms as a way to ensure gender equitable access to services and promote men's involvement in family health as well as HIV care and treatment. In addition, Tanzania has been selected as one of three focus countries under the new GBV Initiative, which started in October 2011. Clinical partners from three high HIV prevalence regions, i.e. Iringa, Mbeya, and Dar es Salaam, are involved in the design of models to link survivors of GBV to facility-based services based on the new national GBV

guidelines, including post-rape care and HIV care and treatment services for HIV-infected survivors. It is expected that improved clinical services for GBV survivors will be put in place in these regions during the course of COP 2012, and that these efforts will inform future expansion of services to other regions.

In COP 2012, USG/T will work with partners to explore areas of collaboration with Most At Risk Populations countrywide. Currently, collaborations are taking place in Dar es Salaam and Zanzibar. The Prevention Technical Area Narrative provides more details on these proj

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Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2012	Justification
P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women who were tested for HIV and know their results	1,459,024	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	73 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	81,616	
	Number of HIV-positive pregnant women identified in	112,106	

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	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	28,806	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	52,810	
	Single-dose nevirapine (with or without tail)	0	
P4.1.D	P4.1.D Number of injecting drug users (IDUs) on opioid substitution therapy	n/a	Redacted
	Number of injecting	900	

	drug users (IDUs) on opioid substitution therapy		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	161,200	Redacted
	By Age: <1	0	
	By Age: 1-9		
	By Age: 10-14		
	By Age: 15-19		
	By Age: 20-24		
	By Age: 25-49		
	By Age: 50+		
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	17,760	Redacted
	By Exposure Type: Occupational	17,280	
	By Exposure Type: Other	0	

	non-occupational		
	By Exposure Type: Rape/sexual assault victims	480	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	318,987	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are	653,180	

	based on evidence and/or meet the minimum standards required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	260,615	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive	n/a	Redacted

	interventions that are based on evidence and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	217,826	
	By MARP Type: CSW	17,741	
	By MARP Type: IDU	7,130	
	By MARP Type: MSM	12,340	
	Other Vulnerable Populations	180,015	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	3,516,372	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	276,415	
	By Age/Sex: 15+ Female		
	By Age: 15+	3,239,957	
	By Age/Sex: 15+ Male		
	By Sex: Female	2,334,406	
	By Sex: Male	1,181,966	

	By Test Result: Negative		
	By Test Result: Positive		
P12.5.D	By age: 0-4	466	Redacted
	By age: 10-14	6,593	
	By age: 15-17	40,448	
	By age: 18-24	63,857	
	By age: 25+	74,475	
	By age: 5-9	833	
	By geography: Districts*	186,672	
	By sex: Female	103,813	
	By sex: Male	83,159	
	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion	186,672	
P12.6.D	By age: 0-4	435	Redacted
	By age: 10-14	2,095	
	By age: 15-17	4,412	
	By age: 18-24	6,196	
	By age: 25+	7,579	
	By age: 5-9	1,005	
	By sex: Female	17,231	
	By sex: Male	4,491	
	By type of service: GBV screening	15,506	

	Number of GBV-related service-encounters	21,722	
	By type of service: Post GBV-care	6,215	
P12.7.D	P12.7.D Percentage of health facilities with Gender-Based Violence and Coercion (GBV) services available (GBV pilot indicator)	45 %	Redacted
	Number of health facilities reporting that they offer (1) GBV screening and/or (2) assessment and provision or referral to the relevant service components for the management of GBV-related health needs	327	
	Total number of health facilities in the region or country being measured.	729	
	By type of facility: clinical	155	
	By type of facility: community	15	
	By type of service: GBV screening	170	
	By type of service: Post GBV-care	157	
C1.1.D	Number of adults and	797,281	Redacted

	children provided with a minimum of one care service		
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	511,025	
	By Age/Sex: 18+ Female		
	By Age: 18+	286,256	
	By Age/Sex: 18+ Male		
	By Sex: Female	477,848	
	By Sex: Male	319,433	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	591,457	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	82,376	
	By Age/Sex: 15+ Female		
	By Age: 15+	509,081	
	By Age/Sex: 15+ Male		
	By Sex: Female	395,944	
	By Sex: Male	195,513	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	82 %	Redacted
	Number of	483,257	

	HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis		
	Number of HIV-positive individuals receiving a minimum of one clinical service	591,457	
C2.3.D	C2.3.D Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	4,232	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.		
	By Age: <18		
	By Age: 18+		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	89 %	Redacted

	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	527,606	
	Number of HIV-positive individuals receiving a minimum of one clinical service	591,457	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	4 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	24,576	
	Number of HIV-positive individuals receiving a minimum of one clinical service	591,457	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	34 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the	38,408	

	reporting period		
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	112,106	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
	By timing and type of test: virological testing in the first 2 months	38,408	
C5.1.D	By Age: <18	93,666	Redacted
	By Age: 18+	68,094	
	Number of adults and children who received food and/or nutrition services during the reporting period	161,760	
	By: Pregnant Women or Lactating Women	146	
T1.1.D	By Age/Sex: <15 Female	12,439	Redacted
	By Age/Sex: <15 Male	6,125	
	By Age/Sex: 15+ Female	69,826	
	By Age/Sex: 15+ Male	34,391	
	By Age: <1	2,211	
	By: Pregnant Women	30,534	
	Number of adults and children with	122,781	

	advanced HIV infection newly enrolled on ART		
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	370,250	Redacted
	By Age/Sex: <15 Female	35,887	
	By Age/Sex: <15 Male	17,669	
	By Age/Sex: 15+ Female	212,186	
	By Age/Sex: 15+ Male	104,508	
	By Age: <1	16,067	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	77 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	66,269	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who	86,595	

	have stopped ART, and those lost to follow-up.		
	By Age: <15	9,710	
	By Age: 15+	56,559	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	707	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	56	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	420	Redacted
	By Cadre: Doctors	65	
	By Cadre: Midwives	0	
	By Cadre: Nurses	66	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	8,016	Redacted
H2.3.D	The number of health care workers who successfully completed an	51,532	Redacted

	in-service training program		
	By Type of Training: Male Circumcision	688	
	By Type of Training: Pediatric Treatment	565	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7231	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	2,350,000
7232	Management Sciences for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	975,281
7234	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	41,383,617
7235	ICF Macro	Private Contractor	U.S. Agency for International Development	GHP-State	61,332
7238	University of North Carolina	University	U.S. Agency for International Development	GHP-State	1,956,231
7239	Mbeya Referral Hospital	Host Country Government Agency	U.S. Department of Defense	GHP-State	2,550,908
7241	PharmAccess	NGO	U.S. Department of Defense	GHP-State	150,000
7242	Central Contraceptive Procurement	Private Contractor	U.S. Agency for International Development	GHP-State	0
7244	Mbeya HIV Network Tanzania	NGO	U.S. Department of Defense	GHP-State	1,000,979

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7245	Resource Oriented Development Initiatives	NGO	U.S. Department of Defense	GHP-State	849,294
7246	SONGONET-HIV Ruvuma	NGO	U.S. Department of Defense	GHP-State	0
7254	Mbeya Regional Medical Office	Host Country Government Agency	U.S. Department of Defense	GHP-State	2,099,019
7256	Rukwa Regional Medical Office	Host Country Government Agency	U.S. Department of Defense	GHP-State	2,000,688
7257	Ruvuma Regional Medical Office	Host Country Government Agency	U.S. Department of Defense	GHP-State	2,354,491
7287	SolarAid	NGO	U.S. Agency for International Development	GHP-State	0
7629	AME-TAN Construction	Private Contractor	U.S. Agency for International Development	GHP-State	1,550,000
9453	JHPIEGO	University	U.S. Agency for International Development	GHP-State	3,404,438
9455	Ministry of Health and Social Welfare, Tanzania	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	751,943
9595	National Institute for Medical Research	University	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	33,000

			Control and Prevention		
9597	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	3,820,000
9614	American International Health Alliance Twinning Center	NGO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	2,772,925
9616	IntraHealth International, Inc	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,000,000
9618	Touch Foundation	NGO	U.S. Agency for International Development	GHP-State	2,390,150
9627	World Health Organization	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	295,000
9630	Ifakara Health Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	490,000

9631	University of Dar es Salaam, University Computing Center	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	310,000
9634	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	180,120
9639	Bugando Medical Centre	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,059,000
9641	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	257,371
9642	American Society of Clinical Pathology	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	300,000
9643	Clinical and	NGO	U.S. Department	GHP-State	500,000

	Laboratory Standards Institute		of Health and Human Services/Centers for Disease Control and Prevention		
9644	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
9645	Kikundi Huduma Majumbani	NGO	U.S. Department of Defense	GHP-State	523,847
9655	University of Rhode Island	University	U.S. Agency for International Development	GHP-State	400,000
9658	African Wildlife Foundation	NGO	U.S. Agency for International Development	GHP-State	200,000
9665	Pathfinder International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	4,933,100
9678	Development Alternatives, Inc	NGO	U.S. Agency for International Development	GHP-State	1,900,000
9681	National Tuberculosis and Leprosy Control Program	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	1,762,430

			Control and Prevention		
9685	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-State	1,727,372
9694	African Medical and Research Foundation	NGO	U.S. Agency for International Development	GHP-State	2,800,000
9695	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	1,750,000
9702	Engender Health	Private Contractor	U.S. Agency for International Development	GHP-State	1,997,254
9795	African Palliative Care Association	NGO	U.S. Agency for International Development	GHP-State	200,000
9798	Axios Partnerships in Tanzania	NGO	U.S. Agency for International Development	GHP-State	450,000
10006	FHI 360	NGO	U.S. Agency for International Development	GHP-State	1,610,431
10044	Muhimbili University College of Health Sciences	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	850,000
10067	Ministry of Education and Training	Host Country Government Agency	U.S. Agency for International Development	GHP-State	200,000
10070	Baylor College of	University	U.S. Agency for	GHP-State	3,000,000

	Medicine International Pediatric AIDS Initiative/Tanzania		International Development		
10087	Tanzania Marketing and Communications Project	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	930,850
10088	Drug Control Commission	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	800,000
10092	Tanzania Youth Alliance	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	966,045
10095	Engender Health	Private Contractor	U.S. Agency for International Development	GHP-State	1,745,000
10351	JHPIEGO	University	U.S. Agency for International Development	GHP-State	2,700,000
10807	Futures Group	Private Contractor	U.S. Agency for International Development	GHP-State	900,000
10809	African Field Epidemiology	NGO	U.S. Department of Health and	GHP-State	185,018

	Network		Human Services/Centers for Disease Control and Prevention		
10811	Francois Xavier Bagnoud Center	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	831,500
10970	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	0
10973	Jane Goodall Institute	NGO	U.S. Agency for International Development	GHP-State	200,000
11528	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	120,000
12192	JHPIEGO	University	U.S. Agency for International Development	GHP-State	5,961,696
12193	Africare	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,649,607
12196	United Nations Children's Fund	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	700,000

			Prevention		
12197	Fintrac Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	730,000
12200	UNAIDS - Joint United Nations Programme on HIV/AIDS	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	95,000
12204	CDC Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	400,000
12208	Regents of the University of Minnesota	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
12217	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	400,331
12227	Population Services International	NGO	U.S. Agency for International Development	GHP-State	4,260,000
12234	Tanzania Commission for AIDS	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	100,000

			Control and Prevention		
12238	Tanzania Interfaith Partnerships	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,942,355
12245	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,000
12246	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, Central GHP-State	18,951,792
12247	Harvard University School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, Central GHP-State	1,150,000
12249	Ministry of Health and Social Welfare, Tanzania	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	500,000

			Prevention		
12728	Research Triangle International	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	233,281
12738	FHI 360	NGO	U.S. Agency for International Development	GHP-State	2,000,000
12757	Research Triangle International	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	490,000
12758	Muhimbili University College of Health Sciences	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,320,000
12810	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	6,490,000
12818	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Central GHP-State, GHP-State	13,882,967
12823	Elizabeth Glaser	NGO	U.S. Department	GHP-State,	9,868,402

	Pediatric AIDS Foundation		of Health and Human Services/Centers for Disease Control and Prevention	Central GHP-State	
12827	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHP-State	7,151,265
12829	JHPIEGO	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	800,000
12861	Africare	NGO	U.S. Agency for International Development	GHP-State	2,900,000
12906	Christian Social Services Commission	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Central GHP-State, GHP-State	2,160,025
12926	Population Services International	NGO	U.S. Agency for International Development	GHP-State	2,045,177
13013	American Association of Blood Banks	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	650,000

			Prevention		
13262	Ministry of Health and Social Welfare, Tanzania	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,200,000
13301	World Education	NGO	U.S. Agency for International Development	GHP-State	2,589,294
13327	TBD	TBD	Redacted	Redacted	Redacted
13343	TBD	TBD	Redacted	Redacted	Redacted
13348	TBD	TBD	Redacted	Redacted	Redacted
13350	ICF Macro	Private Contractor	U.S. Agency for International Development	GHP-State	250,000
13351	Northrup Grumman	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	450,000
13355	Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	179,682
13359	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and	GHP-State	5,147,960

			Services Administration		
13518	TBD	TBD	Redacted	Redacted	Redacted
13553	Balm in Gilead	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	629,300
13554	Foundation for Innovative New Diagnostics	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	11,852
13555	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	763,973
13662	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	400,000
13774	International Youth Foundation	NGO	U.S. Agency for International Development	GHP-State	600,000
14536	Ariel Glaser Pediatric AIDS Healthcare Initiative	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	Central GHP-State, GHP-State	1,412,647

			Prevention		
14537	TBD	TBD	Redacted	Redacted	Redacted
14538	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
14540	TBD	TBD	Redacted	Redacted	Redacted
14541	TBD	TBD	Redacted	Redacted	Redacted
14542	U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)	Implementing Agency	U.S. Department of Health and Human Services/National Institutes of Health	GHP-State	150,000
14543	TBD	TBD	Redacted	Redacted	Redacted
14544	TBD	TBD	Redacted	Redacted	Redacted
14545	U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)	Implementing Agency	U.S. Department of Health and Human Services/National Institutes of Health	GHP-State	200,000
14547	TBD	TBD	Redacted	Redacted	Redacted
14548	TBD	TBD	Redacted	Redacted	Redacted
14549	TBD	TBD	Redacted	Redacted	Redacted
14550	TBD	TBD	Redacted	Redacted	Redacted
14551	Kagera RHMT	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	168,308

			Prevention		
14552	Mtwara RHMT	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	168,310
14553	Mwanza RHMT	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	168,310
14554	Pwani RHMT	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	168,310
14555	Tanga RHMT	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	160,000
14556	TBD	TBD	Redacted	Redacted	Redacted
14559	TBD	TBD	Redacted	Redacted	Redacted
14560	TBD	TBD	Redacted	Redacted	Redacted
14570	Management development for Health	NGO	U.S. Department of Health and Human Services/Centers	Central GHP-State, GHP-State	15,552,695

			for Disease Control and Prevention		
14573	National AIDS Control Program Tanzania	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,236,060
14653	TBD	TBD	Redacted	Redacted	Redacted
14680	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHP-State	9,107,821
14682	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	0
14685	TBD	TBD	Redacted	Redacted	Redacted
14687	TBD	TBD	Redacted	Redacted	Redacted
14689	Pastoral Activities & Services for People with AIDS	FBO	U.S. Agency for International Development	GHP-State	3,592,009
14690	Selian Lutheran Hospital, Tanzania	FBO	U.S. Agency for International Development	GHP-State	1,874,657
14691	TBD	TBD	Redacted	Redacted	Redacted
14692	TBD	TBD	Redacted	Redacted	Redacted
14693	TBD	TBD	Redacted	Redacted	Redacted
14694	TBD	TBD	Redacted	Redacted	Redacted
14695	TBD	TBD	Redacted	Redacted	Redacted
14696	TASAF/WB	NGO	U.S. Agency for International Development	GHP-State	450,000
14697	TBD	TBD	Redacted	Redacted	Redacted

14698	United Nations Children's Fund	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	400,000
14699	TBD	TBD	Redacted	Redacted	Redacted
14701	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	2,450,000
14702	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7231	**Mechanism Name: Wajibika**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,350,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,350,000

Sub Partner Name(s)

FHI 360		

Overview Narrative

Wajibika directly contributes to PEPFAR II's emphasis on developing country ownership and capacity for implementing HIV/AIDS programs in Tanzania. It strengthens local government leadership as envisaged in the PF Goal 3 (Leadership) and enhanced local systems and organizations as articulated in GHI IR2 (Systems Strengthening). Although the activity currently operates only in 27 districts in four regions, it has demonstrated a successful model that can scale-up to other areas of the country. The activity is strengthening core functions of local government authorities (LGAs), namely planning, procurement, accounting and auditing and LGA health sector planning and implementation. Preliminary mid-term results show that the activity has led to effective optimization of resources and improved programmatic and fiscal accountability at the LGA level.

At the core of the model is the use of mentors in each district who guide capacity building at the LGAs. Discussions are underway with the MOHSW and PMO-RALG as to how this model can use mentor coordinators at zonal levels—versus at the more numerous regional levels—to make the model more cost

effective and affordable for the government's full adoption of the model without continued PEPFAR support.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	337,500

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7231**		
Mechanism Name:	**Wajibika**		
Prime Partner Name:	**Abt Associates**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0
Narrative:			
This activity currently operates only in 27 districts in four regions, but since its implementation two years ago, it already has demonstrated a successful model that can scale-up to other areas of the country. Wajibika is strengthening core functions of local government authorities (LGAs), namely planning, procurement, accounting and auditing and provides specific LGA health sector planning and implementation technical assistance. Preliminary mid-term results show that the activity has led to effective optimization of resources and improved programmatic and fiscal accountability at the LGA level.			

This activity provides technical assistance to local government authorities (LGAs) for developing their Comprehensive Council Health Plans (CCHPs), which entails gathering needs and planning data at the village and facility levels through participatory planning methods. This includes evaluating data pertaining to needs related to the care of PLWHA and incorporating this into LGA-wide plans and budgets. The plans take into account all types of HIV care and support services, location/s of service delivery sites (facility, community, home based) and target audience/s (adolescents, adults, women, MARPs, others). These plans also consider linkages between program sites with other HIV care, treatment and prevention sites within the LGA, and linkages to regional level support for PLWHA. The regional level monitors and evaluates implementation of the LGA CCHPs, and this provides valuable information for the subsequent annual planning cycle.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,050,000	0

Narrative:

The URT's decentralization by devolution policy places the burden of raising and utilizing resources squarely on local government authorities (LGAs). Unfortunately, most LGAs do not have the financial and general management systems in place nor the human resource capacity to fulfill this mandate. This activity directly addresses these weaknesses. Wajibika is strengthening core functions of local government authorities (LGAs), namely planning, procurement, accounting and auditing and provides specific LGA health sector planning and implementation technical assistance. Preliminary mid-term results show that the activity has led to effective optimization of resources and improved programmatic and fiscal accountability at the LGA level. This activity currently operates only in 27 districts in four regions, but since its implementation two years ago, it already has demonstrated a successful model that can scale-up to other areas of the country.

COP 2012 funds will :

- support continuation of improved planning and governance through strengthened programmatic and ficsal accountability
- ensure that PMO-RALG and MOHSW support decentralized management, effective optimization of resources from various sources, financing linked to performance, and the critical needs for stronger management controls, and
- develp a plan for PMO-RALG to expand interventions to other districts to ensure that priority programs (i.e. HIV/AIDS, PMTCT, MCH, OVC) are implemented in an integrated and accountable ways.

While the focus has been addressing core LGA fiscal functions and addressing health sector planning and implementation, the spillover effects to other sectors is occurring. For example, other LGA departments are adopting the participatory approach used by the MOHSW in developing the LGA CCHPs. This has increased interest on the part of the PMO-RALG in the Wajibika project, and thus has secured important political support and anticipated increased financial support in the future.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	500,000	0

Narrative:

This activity currently operates only in 27 districts in four regions, but since its implementation two years ago, it already has demonstrated a successful model that can scale-up to other areas of the country. Wajibika is strengthening core functions of local government authorities (LGAs), namely planning, procurement, accounting and auditing and provides specific LGA health sector planning and implementation technical assistance. Preliminary mid-term results show that the activity has led to effective optimization of resources and improved programmatic and fiscal accountability at the LGA level.

This activity provides technical assistance to local government authorities (LGAs) for developing their Comprehensive Council Health Plans (CCHPs), which entails gathering needs and planning data at the village and facility levels through participatory planning methods. This detailed plan sets forth MTCT targets as well as strategies for achieving these targets, including a timetable for periodically measuring progress. Consideration is given to planning for activities that promote demand creation such as community mobilization, male involvement, and couples CT services in order to increase PMTCT uptake. Increasing attention is being given to the integration of MTCT with routine maternal child health/reproductive health services, adult and pediatric treatment services, and broader prevention programs. The regional level monitors and evaluates implementation of the LGA CCHPs, and this provides valuable information for the subsequent annual planning cycle.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	600,000	0

Narrative:

This activity currently operates only in 27 districts in four regions, but since its implementation two years ago, it already has demonstrated a successful model that can scale-up to other areas of the country. Wajibika is strengthening core functions of local government authorities (LGAs), namely planning, procurement, accounting and auditing and provides specific LGA health sector planning and implementation technical assistance. Preliminary mid-term results show that the activity has led to effective optimization of resources and improved programmatic and fiscal accountability at the LGA level.

This activity provides technical assistance to local government authorities (LGAs) for developing their Comprehensive Council Health Plans (CCHPs), which entails gathering needs and planning data at the village and facility levels through participatory planning methods. This is a detailed plan that will provide data pertaining to the enrolment and retention of patients initiated on ART, management of opportunistic infections, laboratory services, community-adherence activities and other performance data. The regional level monitors and evaluates implementation of the LGA CCHPs, and this provides valuable information for the subsequent annual planning cycle.

Implementing Mechanism Details

Mechanism ID: 7232	**Mechanism Name: ICB**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 975,281	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	975,281

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The project goal is to strengthen the performance of HHS/CDC-supported local partners and solidify their ability to deliver high impact and sustainable services to respond to the HIV/AIDS epidemic in Tanzania. In line with the five-year Partnership Framework, TZ-ICB will achieve the set goals by strengthening various aspects of leadership and management, organizational systems and structures, accountability and governance, human resources, project management and execution, grants management and reporting (technical and financial), and supporting evidence-based and strategic decision-making.

The project covers Tanzania Island and Mainland while mainly working with MOHSW, the Diagnostic Service Section of MOHSW, National AIDS Control Program (NACP), Zanzibar AIDS Control Program (ZACP), National Institute for Medical Research (NIMR), National Blood Transfusion Services (NBTS), and National Tuberculosis and Leprosy Program (NTLP).

The project's strategy for becoming more cost efficient over time include the use of coaching and mentoring in capacity building interventions while utilizing the network of local consultants where needed. The transition to a partner government requires work with the partner institutions through established Change Agent Teams (CATs) to plan and execute activities. The CAT is made up of members from the partner institutions where their role is to spearhead the changes within those institutions.

Monitoring will continue to be conducted through routine data collection using available data collection tools and forms. Supportive supervision visits will be conducted quarterly while monthly meetings will be held with the respective institutions. Mid-line and end-line evaluations will be conducted on this five year project.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	975,281

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

TB

Budget Code Information

Mechanism ID:	7232		
Mechanism Name:	ICB		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	100,000	0

Narrative:

Diagnostic Service Section (DSS) is a unit of the MOHSW with oversight responsibility of all laboratory, radiology, imaging and medical equipment services in the country.   In FY 2011, an institutional review was conducted that identified the following priority areas for institutional capacity building : Leadership and Management, Human Resource Management, Financial Management and Planning.   In FY 2011, the project trained selected staff in new resource development, publicized the DSS mandate and started to review the Financial Expenditure Management System.

For COP 2012, the project will continue to build DSS institutional capacity in the same areas, but in addition shall also focus on strengthening quality assurance, monitoring and evaluation.   MSH has several tools for implementation of capacity building activities.   The approach may be same across programs but could be tailor-made to suit the needs of a particular organization.   The approach for achieving capacity building will be similar to that used for institutions supported through OHSS funds, with a strong emphasis on coaching and mentoring.   The following areas will be addressed:

Organizational Review: The project will design specific project monitoring tools that will highlight challenges in implementation throughout the year and conduct an annual participatory review at the end of project year.   These two exercises will inform adjustments in implementation and be a forum for providing feedback to a broad representation of staff.

Planning: The project will continue supporting interventions for strengthening both strategic and operational planning and build capacity to monitor implementation of plans through coaching and mentoring.   Through various forums, the DSS mandate will be disseminated.

Coaching and Mentoring: The project will continue to assign short-term experts to DSS to provide ongoing backstopping and technical support as DSS implement capacity building activities.

Management (Human Resource, Financial, Inventory & Asset Maintenance): Mentors will be assigned to support DSS in strengthening their financial and internal control procedures based on the financial

management review findings. Special training workshops on finance and HRM will be conducted to supplement coaching and mentoring in these areas.

Resource Development: The project will assist DSS to identify opportunities for the diversification of resources and benefit from these opportunities. Through coaching and mentoring, DSS staff will be supported to develop strategies for attracting additional resources.

Quality Assurance, Monitoring and Evaluation: Appropriate interventions will be implemented for DSS. TZ-ICB will conduct a project midterm review and share results with stakeholders.

Leadership and Management Training: The project will continue to support leadership and management training employing training, coaching and mentoring, and MSH's web based courses. Workshop for leaders and senior managers from DSS will be held twice a year.

Strategic Activity Fund for Innovation (SAFI): Based on performance in the implementation of capacity building interventions, DSS will receive rewards in form of equipment or budget outlays. Networking of TA providers and inter-organizational exchanges and study tours will be facilitated. TZ-ICB success stories will be disseminated via website, newsletter and breakfast meetings, national and international conferences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	800,000	0

Narrative:

MSH provides "Institutional Capacity Building Assistance to support Local Partners in developing their Leadership, Organizational, and Financial Management Capacity to Provide a Sustainable Response to the HIV Epidemic in the United Republic of Tanzania under PEPFAR. The TZ-ICB project specifically supports the first two goals of PEPFAR's strategy for the next five years: 1) to transition from an emergency response to promotion of sustainable country programs and 2) to strengthen partner government capacity to lead the response to this epidemic and other health demands. As a capacity building mechanism, MSH conducts similar strengthening activities across different budget codes.

Under COP 2011, the focus of institutional capacity building was on establishing solid ground for the project, organizational reviews to identify the performance gaps, resource development, planning, financial management, coaching and mentoring. COP 2012 funding will continue to build institutional capacity of local partners to support high-impact, sustainable programs for transitioning of ownership to

the GOT. This will be accomplished by providing targeted assistance to at least five local partners (NACP, ZACP, NIMR, NTLP and MOHSW) to strengthen their governance, financial management, budget forecasting and reporting systems by addressing these areas:

Organizational Reviews: The project will design specific project monitoring tools that will highlight challenges in implementation throughout the year and conduct an annual participatory review at the end of project year. These two exercises will inform adjustments in implementation and be a forum for providing feedback to a broad representation of staff.

Planning: The project will continue supporting interventions for strengthening both strategic and operational planning and build capacity to monitor implementation of plans through coaching and mentoring.

Management : The project will strengthen financial and inventory management, and internal control procedures. Workshops on finance and inventory management, and human resource management will be conducted for all partners.

Resource Development: The project will assist partners to identify opportunities for diversification of resources and benefit from these opportunities.
Quality Assurance, Monitoring and Evaluation: Appropriate interventions will be implemented for each partner based on M&E findings. Midterm review will be conducted and results will be shared with stakeholders.

Communication strategy: The project will continue providing technical support to NACP and NIMR in implementation of the communication strategies developed.

Leadership and Management Training: Leaders and senior managers from each partner will receive leadership training. Tailor made leadership and management courses to identified senior MOHSW staff will be offered.

Strategic Activity Fund for Innovation (SAFI): Strategies to motivate Partner organizations who perform well in the implementation of capacity building interventions will be employed. Networking of TA providers will be facilitated also inter-organizational exchanges and study tours. Project's success stories will be disseminated via website, newsletter and breakfast meetings, national and international conferences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	75,281	0

Narrative:

MSH provides "Institutional Capacity Building Assistance to support Local Partners in developing their Leadership, Organizational, and Financial Management Capacity to Provide a Sustainable Response to the HIV Epidemic in the United Republic of Tanzania under PEPFAR. The TZ-ICB project specifically supports the first two goals of PEPFAR's strategy for the next five years: 1) to transition from an emergency response to promotion of sustainable country programs and 2) to strengthen partner government capacity to lead the response to this epidemic and other health demands. As a capacity building mechanism, MSH conducts similar strengthening activities across different budget codes. This package includes :

Organizational Review: The project will review achievements with NBTS in a participatory manner similar to the initial reviews. This exercise will inform areas of focus in the subsequent period. A two day workshop will be held.

Planning: The project will continue supporting interventions for strengthening both strategic and operational planning and build capacity to monitor implementation of plans through coaching and mentoring.

Coaching and Mentoring: The project will assign consultants to NBTS to provide ongoing backstopping as NBTS implements capacity building activities based on work plans developed during organizational reviews. Areas to be supported are leadership and management, organizational systems and structures, governance, management and execution and grants management and reporting. A TOT in coaching and mentoring will be conducted for supervisors and ICB staff.

Management (Human Resource, Financial, Inventory & Asset Maintenance); Mentors will be assigned to support NBTS in strengthening their financial and inventory management, and internal control procedures based on the financial management review findings. Special training workshops on finance and inventory management, and human resource management will be conducted twice a year.

Resource Development: The project will assist NBTS to identify opportunities for diversification of resources and benefit from these opportunities. In order to ensure that there is internal organizational capacity to attract additional resources within the target organizations, the project will provide refresher training on resource mobilization to NBTS staff.

Quality Assurance, Monitoring and Evaluation: Based on the M&E review findings, appropriate interventions will be implemented for NBTS; and practical, hands-on workshops on M&E and quality assurance will be organized. TZ-ICB will conduct a project midterm review and share results with

stakeholders. Leadership and Management Training: The project will continue to support leadership and management training employing training, coaching and mentoring, and MSH's web based courses. One, five-day workshop for leaders and senior managers from NBTS will be held twice a year. Strategic Activity Fund for Innovation (SAFI): Based on performance in implementing capacity building interventions, NBTS will receive rewards in the form of equipment or budget outlays. Additionally, the project will continue facilitating the networking of TA providers and inter-organizational exchanges and study tours. TZ-ICB success stories will be disseminated via website, newsletter and breakfast meetings, national and international conferences.

Implementing Mechanism Details

Mechanism ID: 7234	**Mechanism Name: SCMS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 41,383,617	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	41,383,617

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Supply Chain Management Systems (SCMS) supports the procurement and delivery of HIV/AIDS medicines and related commodities at the national to the local level, which contribute to the PF and GHI strategy goals for strengthening the supply chain management system. SCMS' M&E plan will be to improve product availability; strengthen logistics data collection and analysis capability within MOHSW; develop the capacity of Medical Stores Department (MSD) to manage and deliver health commodities;

improve data availability to support central level decision making; and strengthen commodity management capacity at health facilities.

Technical assistance is focused on transferring critical skills to host country counter parts and local institutions. Through the roll out of a mentoring tool kit, DHMTs and RHMTs will receive training on how to provide logistics supervision visits. Institutionalization of a TWG on national quantification for HIV commodities within the MOHSW structure has improved the capacity of supply chain management planning. SCMS also promotes cost efficient commodity sourcing through pooled procurement of partners in laboratory commodities.

By collaborating with USAID|DELIVER, a pre-service training of health commodities will be created. The development of a central logistics data repository leveraging technical expertise and resources across projects will help to further GHI goals. A partnership with MSD on enterprise resource planning (ERP) project, and an infrastructure expansion project funded with contributions from PEPFAR, GF and MSD, has provided opportunities to strengthen collaboration and increase funding efficiencies. In addition, the partnership has allowed MSD to demonstrate country leadership and ownership in both project's development.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	Medical Stores Department	2000000	GF granted MSD $2 million for warehouse construction. These funds were leveraged with $8 million from USG to develop three large scale warehouses instead of two smaller buildings on each of three sites.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	562,500
Human Resources for Health	2,581,250

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Malaria (PMI)
Military Population
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7234**		
Mechanism Name:	**SCMS**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	13,258,124	0
Narrative:			
SCMS will aim to strengthen the national logistics system by providing technical support to MSD, NACP, MOH, and implementing partners. Areas of technical support include ensuring in-country availability of health commodities and updating the three-year forecast and quantification for ARV drugs, test kits, and			

lab supplies while monitoring data quality from facilities.

Support of MOHSW's PMU model will be expanded to strengthen district-level health commodity procurement processes. For the TB and leprosy programs, revision of SOPs and training curricula will be rolled out to all CTCs in FY 2012. SCMS will support the national roll out of its previously piloted lab supply logistics system. The Supply Chain Monitoring Advisors (SCMAs) will continue working with MSD to monitor HIV/AIDS commodity stock levels in the zonal stores. In support of the GHI strategy, collaboration with USAID|DELIVER PROJECT will extend support to other commodities, such as anti-malarial drugs and contraceptives, as needed. Support by SCMAs will assist the expansion of additional PMTCT sites and continue to support the CTCs.

As an activity to continue improving the project, SCMAs will conduct stakeholder meetings to share information on challenges and solutions in commodity management. Routine meetings with partners will be facilitated by SCMS at the central and zonal/regional levels to review supply chain monitoring results and strengthen sustainability and country ownership of the SCMA program.

Support of MUHAS to test samples of OI drugs and other commodities for quality assurance will continue in FY 2012. Additionally, work with the Tanzania Food and Drug Authority (TFDA) in quality assurance, regulatory compliance monitoring, and customs clearance procedures will commence. SCMS will provide targeted infrastructure support to improve and expand storage capacity in district and regional facilities, which will include facilitating the disposal and recycling of expired products that currently congest facility stores.

SCMS will work with the Zanzibar Ministry of Health to support health commodity security, including capacity building in long-term forecasting, funding requirement analysis, procurement planning, pipeline monitoring, and procurement services for equipping new health facility stores in Zanzibar. Renovation of the MUHAS lab will improve the quality of testing. Implementation of MSD's new ERP system will strength and advance the URT's integrated information system.

GIS mapping of health facilities will be used to analyze and optimize MSD's storage and distribution resources. Continued support for the development of a URT eLMIS to serve as a central data warehouse for multiple sources of health commodity logistics data allows for greater access to data quantification, monitoring, and supervision of the supply chain. This effort will be coordinated with the USAID|DELIVER PROJECT initiative to establish a logistics management unit at MOHSW, which will form the central user group of the eLMIS system.

SCMC will continue to help manage planned and emergency commodity procurement in support of

Tanzania's AIDS Control Program for ARV drugs, drugs for opportunistic infections, lab reagents, and supplies and warehouse equipment. This is to inclued a newly initiated process for sourcing quality assured OI drugs from approved local venders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	2,933,411	0

Narrative:

COP 2012 funds will be used to procure MC kits for USAID's VMMC implementing partner, JHPIEGO. An additional $1,920,000 will be designated for MC kits through carryover funds, which will be strategically distributed to all USG/T VMMC implementing partners. $2,000,000 will be used for MC kits and Rapid test kits for VMMC programs with the DoD.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	100,000	0

Narrative:

SCMS will procure emergency blood safety supplies as directed by the the Medical Transmission Interagency Technical Team in consultation with the National Blood Program. These procurements will be based on identified need based on increased scale up of the National Blood Program in Tanzania.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,290,000	0

Narrative:

SCMS will procure $670,000 worth of test kits for CDC (320,000) and USAID (350,000) to augment support of NACP and PEPFAR ART programs in Tanzania. SCMS will also procure $620,000 worth of test kits for DoD programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	15,298,082	0

Narrative:

The Partnership Framework agreement between the URT and USG stipulates that USG will provide $10 million dollars a year throuigh 2013 for the procurement of ARVs. The USG and National Aids Control Program will make determinations on the ARVs to be procured through quarterly quantifications. SCMS will make the respective procurement as directed through this quarterly quantification process. Funding committements are being met through current pipeline within HTXD.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	HTXS	8,364,000	0
Narrative:			
Through DoD support, SCMS will procure $154,000 worth of test kits to augment support of NACP and PEPFAR ART programs in Tanzania. SCMS will procure $900,000 worth of lab reagents for DoD to support in country ART partners. SCMS will also procure $700,000 of treatment for OIs in adults for DoD programs.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	140,000	0
Narrative:			
SCMS will procure $140,000 in OI treatment for Pedriatic cases for DoD programs.			

Implementing Mechanism Details

Mechanism ID: 7235	**Mechanism Name: MEASURE DHS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: ICF Macro	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 61,332	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	61,332

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since the early 1990s, ICF Macro (formerly Macro International at MEASURE DHS) has been providing technical assistance to the National Bureau of Statistics (NBS) on the Mainland Tanzania and Office of the Chief Government Statisician (OCGS) in Zanzibar in the area of enabling the the two sister institutions

to undertake major national surveys especially Demographic and Health Survey (DHS) and HIV/AIDS and Malaria Indicator Survey (HMIS). Furthermore, ICF Macro supports the two institutions on undertaking disseminations of the key findings at various levels: national, zonal, regional, and district with corresponding information package which suit the various audiences. ICF Macro's ultimate goal is to sustain the skills of these national institutions which are mandated to undertake such national surveys. Its activities are in direct support of PF Goal 6 to improve the use of relevant and comprehensive evidence in HIV-related planning and decision-making as well as of GHI Ir 2 for Improved health systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	7235

Mechanism Name:	MEASURE DHS		
Prime Partner Name:	ICF Macro		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	61,332	0
Narrative:			
ICF Macro (formerly Macro International at MEASURE DHS) has a long experience in providing technical assistance to the United Republic of Tanzania particularly the National Bureau of Stastistics (NBS) and the Office of the Chief Government Statistician (OCGS) in Zanzibar since 1991 when the first Demographic and Health Survey (DHS) was conducted. Since then ICF Macro has continued to provide technical assistance to both NBS and OCGS through building their capacities in similar subsequent surveys in 1996, 1999, 2004, and 2009. For COP 2012, ICF Macro will build the capacity of both NBS and OCGS to disseminate the findings of the 2010 TDHS to two zones (to be selected), following the dissemination of the key findings at the national level in 2011. Technical assistance will increase the skills of decision-makers at the zonal level to understand and utilize the findings from the 2010 TDHS, which will further cascade down to regions and districts.			

Implementing Mechanism Details

Mechanism ID: 7238	**Mechanism Name: MEASURE Evaluation**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,956,231	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,956,231

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objectives for the data quality assessment (DQA) project are to assess strengths and weaknesses in data collection and to compile and report for a ‘to-be-determined’ number of IPs and selected grantees; increase the capacity of IPs to produce accurate and timely data for PEPFAR reporting; and to support health system strengthening through the use of high quality service data for program decision-making.   The objectives link to the sixth goal of the PF, which focuses on utilizing strategic and evidence-based data for informed decision-making

The project works nationally and is dependent on where USAID and DOD partners work, including the locations of services that are offered by the Department of Social Welfare.

The DQA project has streamlined its processes in an effort to reduce the amount of time in the field. Also, the DQA staff has worked to transfer skills, such as GIS to the local staff, to reduce the amount of TDY visits.

In terms of transitional efforts, the project is working with a local subcontractor and gradually building up their capacity by adding more activities to their SOW year after year.   For instance, within this fiscal year, the local subcontractor was responsible for leading one of the DQA teams.   Training support is also being provided to improve writing skills, particularly in report writing.   In terms of OVC work, collaboration with the FHI seconded M&E officers, as well as their DSW attached counterparts, has been a focus to increase M&E skills in the department.

The project conducts mini-DQAs of weaker performing partners to monitor if improvements have been made during the year.   Improvement to capacity building plans will now include performance indicators to measure the influences of mentoring and coaching activities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7238		
Mechanism Name:	MEASURE Evaluation		
Prime Partner Name:	University of North Carolina		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	350,000	0
Narrative:			

MEASURE Evaluation will conduct DQAs with two to three HBC partners from headquarters to service delivery points to strengthen the IP systems and, in turn, improve the quality of data being reported into the NACP system. Data trace and verification, along with M&E system assessments, will be conducted at the IP headquarters, regional/district/sub grantee offices, and the service delivery points. A trace and verify of HBC clients will also be conducted to ensure that services being received are outlined by the program. The DQA findings will be used to develop capacity building plans for each IP. MEASURE Evaluation staff will work with the IPs to implement the developed plans, providing mentoring where needed. Performance indicators will be developed and monitored for each IP to determine if the capacity building efforts are improving the IPs' systems.

MEASURE Evaluation will work with NACP to determine if any improvements may be needed for the national HBC record and reporting system. A plan will then be developed in conjunction with NACP to roll out the revised system, including working with partners' utilization of the system to incorporate capacity building efforts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	406,231	0

Narrative:
MEASURE Evaluation will continue to provide M&E technical assistance to DSW in FY 2012. Activities will include mentoring DSW appointed M&E person, supporting the MVC M&E TWG, training on the national tools and roll-out of participatory monitoring and evaluation approaches to the grass roots level, and training on data quality and data use. A mentoring plan will be developed in conjunction with the DSW M&E focal person that will be monitored over the course of the year, which will include performance indicators to track improvements. A training plan will be developed with DSW to train district level staff on national tools, data quality for the national system, and data use for decision- making at the district level. Through participatory M&E, MEASURE Evaluation will strengthen data collection, quality, and useage at the grass roots level, and in turn improve the data quality that is being submitted for the MVC DMS. MEASURE Evaluation will roll out participatory M&E to sampled districts and wards. Afterwards, supportive supervision at three month intervals post roll out will be conducted to monitor whether communities are continuing to implement the activity. During supportive supervision, technical assistance will be provided, where needed, to ensure communities are collecting quality data and using the data to make informed decisions at the community level. M&E technical assistance will continue to be provided to OVC IPs, including data quality, data use, and program evaluation and assessment. MEASURE Evaluation will engage in dialogue with OVC partners to determine their M&E technical assistance needs, whereby a plan will be developed with the partner to address those needs (some needs will be addressed directly by the partner and others by MEASURE Evaluation). Regarding the KIHUMBE (a home-based services provider group in Mbeya) job incubation model, MEASURE will work with KIHUMBE, the KIHUMBE M&E officer, and DOD to come up with a monitoring and assessment plan to supervise the implementation. In terms of the DMS, an improved system will be developed and initially rolled out to districts in FY 2012. With FY 2012 funding, MEASURE Evaluation will continue to conduct a staggered roll out of the improved system to districts and provide training and technical support, where needed. MEASURE Evaluation will have staff that can trouble shoot issues that arise and support district staff through training (classroom style and on-the-job). This overall activity works towards strengthening the national MVC system, including improving data quality, and increasing data use at the national and sub national levels, through mentoring and trainings. MEASURE Evaluation will also work to move the national MVC M&E agenda forward through participation in the MVC M&E TWG and assisting the DSW in implementing the MVC M&E TWG work plan.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	HVSI	1,200,000	0
Narrative:			
MEASURE Evaluation will conduct Round 5 of the DQAs during this funding cycle. Between 7-10 USAID IPs will participate in full DQAs, while three to four partners will participate in mini-DQAs. MEASURE Evaluation will continue to work with OVC partner sub grantees to strengthen their systems, ensuring quality data is collected for decision-making purposes and reporting requirements. Capacity building activities during this cycle will focus on the sampling process and fieldwork planning. JL Consultancy will lead at least two of the DQA teams (up from one in Round 4) and take more of a lead on report writing. This will require more involvement in the planning of the DQA and meeting with the IPs, including going with the DQA Project Manager during the initial meetings to discuss the DQA process and the IPs' M&E systems. MEASURE Evaluation will use the findings from the DQAs to develop capacity building plans for IPs and organize workshops. Based on the experience of the last few years, MEASURE Evaluation will shift to more individualized mentoring and coaching, developing plans with clear objectives, activities and anticipated outcomes and creating activity logs that will be maintained to track mentoring sessions with partners. Performance indicators will be developed to track progress over time and will be monitored either through mini-DQAs or informant interviews. An M&E 101 course for sub-national partners with low levels of M&E experience and low DQA scores will be conducted. MEASURE Evaluation will also continue to offer GIS 101 and 102 trainings and data demand and usage trainings. Through strengthening the USAID IPs M&E systems, MEASURE Evaluation indirectly strengthens the national M&E systems by ensuring that partners are reporting quality data into the systems. In addition, since many partners work with government counterparts, skills in data quality and evidence-based decision making can be transferred across to government counterparts.			

Implementing Mechanism Details

Mechanism ID: 7239	**Mechanism Name: MRH**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Mbeya Referral Hospital	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,550,908	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,550,908

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Mbeya Referral Hospital (MRH) is a tertiary care facility in the Southern Highlands of Tanzania that serves as a referral centre for Iringa, Mbeya, Ruvuma & Rukwa regions. The referral catchment population approximates six million people. The centre is also tasked with coordinating and overseeing HIV/AIDS care and treatment services in the zone, including pediatric andlLab management services, VMMC, and Maternal, Neonatal and Child Health. Specifically for VMMC, MRH trains MC providers and coordinates MC programming in both Mbeya and Rukwa regions.

As a government institution, MRH receives central URT government funding for its daily clinical and supervisory plans. USG funding leverages on this support. Increased efficiency and quality of services will enable the hospital to generate more revenue to improve quality of services.

MRH will continue improving the M&E system to ensure quality data collection, analysis and reporting using harmonized and standardised USG/URT tools. MRH will produce monthly reports and hold quarterly implementers' meetings to share information and evaluate ongoing program performance. To achieve maximum performance, MRH will continue coordinating HIV/AIDS interventions among relevant stakeholders in the zone (partners, MoHSW, donors, NGOs and LGAs).

To improve the HCW skills in the four regions of the Southern Highlands of Tanzania, MRH will continue to provide timely and strategic training, on-job mentorship and support supervision. To become more cost effective, the hospital will implement various strategies such as hospital data management systems, fostering quality at the hospital through accreditation, improving the work environment, and continually looking at areas for quality improvement.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	7239		
Mechanism Name:	MRH		
Prime Partner Name:	Mbeya Referral Hospital		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	90,645	0
Narrative:			
Mbeya Referral Hospital (MRH) is a referral hospital for the Southern Highland regions of Tanzania that include Mbeya, Ruvuma, Rukwa and Iringa regions and a population of over six million people. Its			

functions include direct clinical service, training, coordination and overseeing quality of care and treatment.

For COP 2012, activities will include a standard DOD package of care activities:

1) Provide integrated adult care and support services that are linked to other services such as ART, ANC, PNC, PMTCT, TB/HIV and HTC
2) Strengthen nutritional assessment, counseling and support (NACS) to PLHA at all CTCs
3) Strengthen community mobilization activities in collaboration with home/community based adult care and support provider, through individual, small groups and community sensitization messages to improve local support for efforts that address GBV and stigma and discrimination services
4) Conduct strategic in-service training and on-the-job mentorship to HCW to improve adult care and support services at the hospital
5) Improve M&E system through utilization of harmonized data collection, analysis and reporting tools and participate in quarterly zonal program performance meeting to discuss and share program performance
6) Integrate HTC services. including promotion of PITC and couple counseling into other services such as ART, family planning, PMTCT, ANC and PNC
7) Provide individual and group psychological, spiritual support as well as bereavement services to PLHA and their families, in collaboration with outreach partners and religious organizations
8) Provide STI diagnosis and treatment services integrated with other services such as family planning, ANC, PNC, ART, VMMC and PMTCT
9) Improve retention and adherence to care and treatment by strengthening PHDP counseling among all CTC staff
10) Link PLHAs with available support mechanisms including home/community -based HBC services

These activities will be implemented in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI). MRH is a government institution that receives central funding through the MOHSW budget, basket funding, and cost sharing mechanisms. Such resources will be used to leverage USG support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	94,677	0

Narrative:

MRH is one of five zonal hospitals in Tanzania. Its functions include direct clinical service, training, coordination and oversight of the quality of care and treatment in the Southern Highlands zone. MRH also establishes health service referral systems for a population of over six million people in four regions

(Mbeya, Iringa, Rukwa, and Ruvuma). MRH is also the government institution receiving financial and technical support from DOD to increase and strengthen local capacity to provide quality TB/HIV services.

With multiple donor support including PEPFAR, the Center for Infectious Disease (CID) was established in 2004. Presently, the Center accommodates an infectious disease clinic and a training facility with a referral level laboratory capacity. The CID supports a continued expansion of HIV/AIDS services including viral and TB resistance testing.

COP 2012 will be used to:

1) Scale-up TB/HIV services in the region through screening PLWHAs for TB and improving referral and integration of TB/HIV services into other programs such as ART, HTC and PMTCT.;
2) Strengthen laboratory services including sputum smear microscopy and quality assurance to ensure quality TB care services;
3) Strengthen quality TB/HIV services through technical support to districts and high-volume and satellite clinics, in-service training and on-job mentorship to HCWs on TB control practices and implementation of the three "I"s as well as establishment of TB/HIV coordinating bodies at district level;
4) Improve program coordination and M&E system through improved availability and use of standard National TB/HIV tools such as screening tools and clinical assessment forms as well as sharing and discussion of results to inform the program. MRH will support establishment of coordination bodies in regions and districts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	29,353	0

Narrative:

MRH is a referral hospital serving the sub-populations that are currently being serviced by Mbeya RMO. The referral catchment area includes Mbeya, Iringa, Rukwa, and Ruvuma regions, with a population of six million. MRH also offers specialized laboratory services such as viral load testing, PCR, and viral resistance testing.

Activites funded through COP 2012 will include:

1) Strengthening involvement of adolescents and children in PHPD services and support groups for better retention and adherence to treatment.
2) Community mobilization through individual, small groups and community sensitization messages to improve local support and increase child enrollment into care.

3) Improved data collection, analysis and reporting using harmonized tools, discussion of targets, and use results to inform program implementation.
4) Capacity building to improve skills of HCWs and CHWs through strategic in-service training, on-job mentorship and support supervision; improve facility infrastructure to improve care for children.
5) Integrated pediatric care and support services that are linked to other services such as ART, EID, OVC, HBC, TB/HIV, PMTCT and HTC.

These activities will be implemented in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI). MRH is a government institution that also receives central funding through MOHSW budget, basket funding, and cost sharing mechanisms. Such resources will be used to leverage on USG support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	374,771	0

Narrative:

Mbeya Referral Hospital (MRH) is one of five zonal hospitals in Tanzania. Its functions include direct clinical service, training, coordination and overseeing quality of care and treatment in the Southern Highlands zone, and establishing health service referral systems for a population of over six million people among the four regions of Mbeya, Iringa, Rukwa, and Ruvuma.

Under PEPFAR funding and multi-donor support, the Center for Infectious Disease (CID) was initiated and provides a forum for practical training for medical and laboratory staff to improve adult and pediatric HIV/AIDS care and treatment service. MRH has the following objectives:

1) Improve testing capability - The ability of the MRH laboratory to provide a range of diagnostic tests has been developed and is being further expanded. In TB diagnosis, the MRH TB lab has just been completed, thus establishing a reference center in the Southern Highlands that provides liquid culture and drug susceptibility testing. A microbiology lab where both aerobic, anaerobic culture, and blood culture will be performed has also been established; basic culture work is ongoing but this will be expanded. A molecular biology laboratory which has a capacity to do HIV viral load and early infant diagnosis by using PCR systems is now running. Future plans are to extend these services and to further offer HIV resistance testing using Siemens TruGene sequencing. In addition, the histopathology laboratory, which was unable to run due to defunct equipment, has now been newly equipped for diagnosis of HIV associated cancers.

2) Improving Quality Assurance - MRH has introduced daily Quality Assurance routines, running QC

samples and procedures, servicing and maintaining equipment and external proficiency testing programs from reputable schemes. In addition, it is now planned to Introduce quality indicators and quality indicator monitoring for all laboratories, such as ensuring turnaround times are adhered to and results are reported accurately and timely.

3) Accreditation Process - In FY 2009, MRH lab invited the College of American Pathology (CAP) accreditation system assessors for the first assessment toward accreditation. The overall quality was good, however the lab staff still needs to be certified on analyzers and all lab technicians need to have GCLP certification. To progress towards accreditation, there are now plans to enroll in CAP external quality assurance systems, which will help to ensure that all instruments, such as centrifuges, thermometers fridges, and freezers, are calibrated and validated and that all staff receives GLP training. The accreditation process is ongoing, though none of the labs in the Southern Highlands has yet to be accredited.

4) Number of testing Labs in Mbeya - In the Southern Highlands there are 38 testing labs in Rukwa and Ruvuma regions. Program personnel in these labs have been trained on quality assurance issues (forecasting, ordering, safety of personnel and buildings, documentation and reporting, planning, and budgeting). This has improved the performance of these labs as indicated by reduced stock-outs of reagent and turn-around time of test results.

5) Transitioning - MRH is the government institution receiving financial and technical support from DOD to increase and strengthen local capacity to provide quality HIV/AIDS laboratory services that will ensure sustainability of care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	677,115	0

Narrative:

Mbeya Referral Hospital (MRH) supports MC activities in the zone through on-site and campaign based approaches. Currently, there are eight sites providing routine MC on-site; during campaigns in Mbeya, all sites receive TA from MRH. A total of 51 MC clinicians have been trained (17 circumcision teams.

As the TA for MC in the Southern Highland regions of Tanzania, MRH will continue to train more MC clinicians in COP 2012 to increase the availability of MC services in Mbeya and Rukwa regions. In addition, linkages with other stakeholders in the regions involved in health education and promotion will be strengthened by improving peer education related to MC behavioral changes to increase MC acceptance.

To improve access and scale up of VMMC in remote areas, MRH will procure more reusable and/or disposable kits. To ensure quality and compliance with Infection Prevention and Control practices, autoclaving of reusable equipment will also be improved. MRH will also procure mobile MC units to improve availability of VMMC services in hard-to-reach locations.

MC services are provided as a comprehensive prevention package that includes counseling and testing, behavioral intervention to prevent new infections, and PHDP. Encouragement of female partner participation in MC services will also continue to be promoted to encourage family centered HIV preventive approach. A high proportion of clients accept HTC during campaigns and in Mbeya it was reported to be over 90%.

Linkages to other programs such as care and treatment as well as PHDP care and support will be strengthened. Under the Swahili slogan, "Menya Ganda" (Remove the Hood), print and electronic media messages will be provided to communities in the region as well as improving community participation in MC services for demand creation. Special efforts will be made to promote MC services through peer education and media to ensure that men over 25 years accept the services, as currently less than 5% of all clients are from this age group.

MRH will continue to support all regions in the Southern Highlands (Mbeya, Ruvuma, and Rukwa) to implement quality MC services. Program performance and quality assurance will be achieved through regular support supervision and on-job mentorship, use of harmonized data collection and reporting tools and assessment of adverse events from the procedure. MC data will also be analyzed to document best practices and average procedure time in the region and for each health facility. Additionally, MRH will continue to support integration of MC services into routine health care in all facilities in the Southern Highlands. The IP has also adopted the web-based JHPIEGO MC reporting, which has also been adopted by other USG agencies to ensure quality data and efficient reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,093,964	0

Narrative:

MRH is one of five zonal hospitals in Tanzania. Its functions include direct clinical service, training, coordination and oversight of the quality of care and treatment in the Southern Highlands zone. MRH also establishes health service referral systems for a population of over six million people in four regions (Mbeya, Iringa, Rukwa, and Ruvuma). MRH is also the government institution receiving financial and technical support from DOD to increase and strengthen local capacity to provide quality TB/HIV services.

With multiple donor support including PEPFAR, the Center for Infectious Disease (CID) was established in 2004. Presently, the Center accommodates an infectious disease clinic and a training facility with a referral level laboratory capacity. The CID supports continued expansion of ART and clinical care needs as well as provides a forum for practical training for medical and laboratory staff to improve adult and pediatric HIV/AIDS care and treatment service. CID also offers specialized laboratory services, such as viral load testing, PCR, and viral and TB resistance testing.

MRH began recruiting patients in January 2005. By the end of FY2011, MRH had a cumulative number of over 6,935 patients on ART. There are 5,671 patients currently on treatment and 841 new patients enrolled. Despite this achievement, loss to follow up has been a big challenge to the program, with a retention rate of 60.7% (APR 2011). Efforts to improve retention include linkages with CBOs to track patients in the community, use of support groups, and CHWs for adherence counseling and tracking of patients in their homes.

Activities:
1) Support provision of quality ART services and enrolment of more patients into Care and Treatment at the main MRH CTC and at satellite centers by procurement of CD4 machines, drugs, reagents, and other lab supplies for better patient monitoring;
2) Provide technical support, in coordination with Mbeya RMO, such as strategic in-service training to satellite clinics in order to decongest the MRH CTC;
3) Provide ongoing mentorship and support supervision to satellite facilities to support strategic scale up of care and treatment services in the zone;
4) Provide evaluation for malnutrition and nutritional counseling to all HIV positive clients;
6) Provide support to zonal facilities to ensure quality services and improve patients' clinical outcomes and program performance. With the assistance from DOD, MRH will improve administrative and financial reporting capacity to ensure effective budgeting, timely expenditure and financial reporting. A contractor will be retained to build RMOs capacity in budgeting and financial reporting.
7) Provide specialized technical support and guidance to the RMOs for identification and treatment of patients with treatment failure;
8) Conduct monthly zonal ART meetings with the Mbeya, Rukwa, and Ruvuma RMOs to discuss treatment roll out, identify areas of need, determine solutions, and coordinate resolution;
9) Function as the zonal training center in HIV related services for the Southern Highlands in support of NACP;
10) Support linkages and referrals to feeder programs and services, such as MCH, TB, PITC, and EPI;
11) Ensure strengthened integration of services focused on girls, women, and children into CTC;
12) Ensure that gaps identified during quarterly performance appraisals are incorporated into MRH work

plans and activities are implemented and monitored.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	190,383	0

Narrative:

MRH is a referral hospital that serves sub-populations that are currently being serviced by Mbeya RMO. Referral catchment area includes Mbeya, Iringa, Rukwa, and Ruvuma regions with a population of six million. It also offers specialized laboratory services such as viral load testing, PCR, and viral resistance testing.

MRH is tasked with coordinating and overseeing the quality of pediatric treatment services in the zone, but does not have pediatricians to undertake these specialized services, including HIV/AIDS treatment and care. In addressing the long-term need for specialists at the MRH and capacity within the zone, the hospital established partnership with Baylor International Pediatric AIDS Initiative (BIPAI). Currently, BIPAI serves as a treatment center and provides pediatric ART services and training for health workers in the zone. Additionally, pediatricians working with BIPAI conduct outreach services to mentor pediatric ART providers and provide specialized services where required.

MRH will provide quality integrated paediatric HIV care and treatment services through pediatric PITC, supply of pediatric drugs and commodities, diagnostics, adherence counseling, and strengthening linkages and referrals between pediatric care and treatment and other programs such as OVC and HBC. A continuum of care will be ensured through strengthened adherence counseling services by HCWs and CHWs
A target of 143 children is set for FY 2012. Local manpower and systems will be strengthened to improve specialized pediatric care and treatment. Targets will be monitored and discussed during zonal technical meetings and national partner meetings. Linkages to other services such as HBC, OVC, PITC, EPI, PMTCT, TB/HIV, and RCH will ensure more child enrollment into care and treatment. Infrastructural improvement will be improved to specifically address pediatric treatment needs. to improve retention into treatment, adherence counseling and technical support will be provided to groups such as adolescent peer educators.

The integration of Pediatric care and treatment services at MRH leverages national referral system to ensure quality and sustainability. The USG/T supported activities will continue to be incorporated into the regional health plans through national funding such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Implementing Mechanism Details

Mechanism ID: 7241	Mechanism Name: PAI-DOD
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: PharmAccess	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 150,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	150,000

Sub Partner Name(s)

Tanzania Peoples Defence Force		

Overview Narrative

The objective of this HIV Workplace Program is to increase HIV prevention by focusing on behavioral and biomedical drivers of the epidemic and to maintain and expand quality care, treatment and support services for 32,000 military personnel, dependents, and approximately 300,000 civilians from communities surrounding the Tanzanian People's Defense Force (TPDF) camps and clinics. Clinical services include VCT, care and treatment, HIV/TB, and PMTCT/RCH in most sites.

The program is planned and implemented by TPDF headquarters staff, clinics, colleges, community support groups, MOHSW, Home Affairs, and TACAIDS. Close collaboration with RHMTs and DHMTs have been established so that TPDF sites benefit from MOHSW resources. Sensitization of top commanders has increased efficiency of implementation and TPDF's preparedness to contribute to more of the costs of healthcare and pre-service training. PharmAccess (PAI) provides TA and manages the donor funds.

HSS is done through on-job training of HCWs and upgrading of more than 50 clinics countrywide. In FY 2012, the focus will be on less costly infrastructure maintenance and on-the-job mentorship. Future clinical and prevention trainings will be done by TPDF TOTs, while prevention trainings are now part of the standard curriculum in TPDF colleges. Gender and alcohol abuse are key elements of peer

education and ‘life-skills’ trainings.

TPDF headquarters and all sites have trained staff on electronic data-entry and M&E.   Data on progress of activities is shared with NACP and between HQ, PAI, and all TPDF clinics during quarterly meetings. Continued project monitoring and supervision to all sites requires a strong 4x4W car for which $60,000 is requested.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	7241		
Mechanism Name:	PAI-DOD		
Prime Partner Name:	PharmAccess		

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

PAI, using the health facilities as the point of contact, will use the trained community volunteers to provide HBC services (physical, psychological, spiritual, adherence counseling, social, and prevention services) to HIV infected adult, children, and their families.

The HBC providers will provide support after a needs assessment and prioritization is conducted. The PHDP components and nutrition assessment, counseling and supports (NACS) will be strengthened. PAI will support its clients to form associations and groups to maintain the strength of care and support services.

PAI will continue supporting TPDF throughout Tanzania, implementing HBC services by integrating and strengthening linkages with other services, such as CTC, VCT, PMTCT and other related programs, using quarterly coordinating meetings and standardized referral forms. Other linkages will include working closely with the LGAs and community organizations to improve services, local ownership, and sustainability. PAI will continue to establish patient support groups, or post test clubs, and PLWHAs will be supported to participate in planning committees and program implementation.

The IP will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage, impact of the PHDP program, and progress of activities which will be monitored by PAI and TPDF program managers. In addition, PAI will conduct quarterly supervision with spot checks to validate data and reported activities in order to provide constructive feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	150,000	0

Narrative:

PharmAccess International (PAI) is DOD's international implementing partner (IP). PAI works with the Tanzania People's Defense Force (TPDF) in DOD-supported PEPFAR activities in the military across Tanzania. Most servicemen and women live in barracks and around their camps, although their partners and families, usually women and children of servicemen, have to leave the barracks when the army

person dies. Previously, the main focus of DOD support in TPDF has been on care and treatment with limited support for OVC. However, the increasing need for support of OVC has become unavoidable as some orphaned and vulnerable children are forced, by circumstances, to live with relatives, family friends, and neighbors of their deceased parents within TPDF barracks or in communities nearby with fragile and inadequate support. Subsequently, most will never be enrolled in schools, while those already enrolled drop out due to lack of support and guidance.

In FY 2012, PAI will expand its OVC program to support eight zonal military hospitals to expand the provision of comprehensive OVC care package needed for reducing the impact of the disease.

This support will be modeled after a pilot program that PAI and TPDF have been implementing in Mbalizi Military Hospital in Mbeya, Southern Tanzania since FY 2009. Specifically, care providers in the five hospitals will be trained, eligible children identified, and provided with basic needs such as school materials (provision of uniforms, school fees, and stationary), assistance with medical needs where appropriate, and nutritional care and support. To alleviate the economic burden of HIV/AIDS, families and guardians will be involved in identifying and implementing suitable income generating activities (IGAs) to strengthen household incomes and transitioning to local OVC support systems. Children without parental support will be provided with foster parenting to ensure parental guidance and support under close follow-up of social workers and care providers at the eight military hospitals and nearby LGAs. Linkages will be established between national and community support mechanisms. Where support mechanisms are strong, children will be graduated into a system for long-term support.

Identification of eligible children will be done by the Department of Social Welfare (DSW) in TPDF. DSW will also facilitate the training of care providers in the respective hospitals if none exists and map other OVC services in the surrounding communities using the DSW identification tool.

TPDF will use the national Data Management System tool to collect data from the targeted beneficiaries and caregivers trained. Data will be entered and monitored through the national OVC database. M&E activities will be coordinated by the OVC coordinators at the hospitals with support from experienced local NGO's to create synergies and to avoid service duplication.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

The HIV/AIDS-TB collaboration component was incorporated in the TPDF HIV/AIDS workplace program in 2007. Currently, 25 clinics (eight hospitals and 17 health centers) serve as TB-DOT sites.

Twelve laboratories at new TB providing clinics will be upgraded, furnished, equipped with LED microscope, x-rays supported, and protective gears procured in case of shortages from the national supplies system. TB/HIV training, including x-ray interpretation, will be conducted for 50 health care providers from new sites and clinicians and nurses from continuing sites.

TB/HIV screening, using the MOHSW tool, is still low in military clinics. In FY 2012, usage of the tool will be strengthened through trainings, supportive supervision by staff from Lugalo and DHMTs, and by continuous promotion at the quarterly meetings. Quarterly meetings take place with representatives from all clinics, TPDF headquarters, experts from PAI, and other partner organizations. Each meeting focuses on specific themes, serves as a forum for mentorship, program developments are discussed, and best practices are shared. Initiation of cotrimoxale and INH prophylaxis for opportunistic infections (OIs) will be strengthened.

One TPDF hospital in Lugalo has been included in the national 3Is (intensive case finding, infection prevention, and isoniazid prophylaxis) pilot-program under MOHSW. Implementation of 3Is in other sites will start in seven TPDF hospitals in FY 2012 under the supervision of Lugalo staff.

Diagnosing TB among those in-patients with advanced AIDS (approximately 20% of patients) remains difficult as the routine diagnostic tests (AFB smear microscopy and/or chest X ray) are neither very sensitive nor very specific, therefore undiagnosed TB remains a major cause of mortality in this group. To enhance TB diagnosis in this group, there is a high need to invest in sophisticated TB diagnostic tests, such as liquid culture and line probe assays.

Community sensitization and counseling is needed in order to create an informed community regarding issues related to early health seeking behavior for management of OIs, such as TB. In collaboration with community HBC volunteers and leaders, sessions will be organized in a more effective manner.

Supportive supervision for quality improvement will be achieved through on site mentorship done in collaboration with RHMTs, DHMTs, TPDF, and PAI staff using MOHSW guidelines and tools. To cascade the process, there will be a series of orientations to HQ and eight military hospitals, including selected supervisors to build their supervision capacities.

Monitoring and evaluation is done through the national system using registers, monthly forms, and screening tools while data is collected electronically for processing and reported to RHMTs, DHMTs, TPDF HQ, and PAI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	0	0

Narrative:

PharmAccess supports approximately 332,000 military personnel, dependents and civilians. The IP implements pediatric care and support services to at least 3,200 children under 15 years of age in need of care and support within a network of 29 CTCs.

In FY 2012, planned activities include:
1) Strategic in-service training, on -job mentorship and support supervision of HCWs and CHWs including peer counseling and education to improve adherence and retention;
2) Strengthen infant feeding counseling, nutritional assessments and support, palliative care at facility and community levels;
3) Expand enrolment into pediatric care and support services through involvement of adolescents and children in PHDP services and support groups and community mobilization and sensitization through individual, small groups and community channels to engage the community in paediatric care and support activities, especially OVC and HBC programs;
4) Improve coverage of cotrimoxazole prophylaxis and management of opportunistic infections (OIs) among paediatric patients; and
5) Improve referrals of paediatric patients and linkages to other services e.g. ART, HTC, PMTCT, EID and TB/HIV;
6) Stakeholder engagement in pediatric care and support activities such as meetings to discuss targets and results;
7) Improvement of physical infrastructure to ensure child responsive services through renovations and creation of child-friendly environment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

PharmAccess (PAI) supports MC services in TPDF sites throughout Tanzania through on-site and campaign based approaches. Currently, three TPDF sites offer MC services in collaboration with PAI (Mbalizi Military Hospital in Mbeya, Makambako, and Lugalo), while three more sites are planned for FY 2012 in Mwanza, Shinyanga, and Tabora.

In FY 2012, more MC clinicians will be trained to increase the availability of MC services at TPDF sites. In addition, linkages with other stakeholders involved in health education and promotion will be strengthened through individual, small groups and community MC-related health education and SBCC to

increase MC uptake and adoption of appropriate preventive behaviors.

MC services are provided as a comprehensive prevention package that includes counseling and testing, behavioral interventions to prevent new infections, and linkage to care, treatment and other services. Encouragement of female partner participation in MC services will also be done to improve family-centered HIV preventive services.

Print and electronic media messages will be provided to communities in the region as well as improving community participation in planning and implementation of MC services in order to create demand for services.

To ensure the availability of quality MC services, performance of available trained clinicians will also be tracked through regular support supervision and on-the-job mentorship and analysis of MC data to document average time for MC.   PAI will also improve follow-up of clients to assess and document complications and compliance (both treatment and preventive measures).   In addition, other elements of service will be assessed and strengthened to improve quality of MC services.   PAI has adopted the web-based JHPIEGO MC reporting system, which should ensure availability of quality data.   National forms will be used to document program performance and ensure uniformity in data collection, handling, and reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

Under sexual prevention, PharmAccess (PAI) in collaboration with the Tanzania People's Defense Force (TPDF) will target youth in schools and other young adult men and women within the community through peer education.   Focus on key drivers of the epidemic, such as alcohol reduction, multiple concurrent partnerships, GBV and gender norms, and transactional and cross generational sex will be supported through the use of LGAs and peer educators (PEs).   This will be done through one-on-one and small group sessions.   PAI has developed peer health education materials with life-skills modules.   These modules will be used for peer education training sessions at least twice a month.

The AB activities will be implemented in all TPDF sites and surrounding communities.   With technical assistance from the government facilitators, the available training materials, facilitators, and PEs will be used to maintain standards and quality.   Quarterly and monthly meetings will be conducted to assess PE performance and to address challenges as well as provide feedback on lessons learned.

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

The AB program will link with other program areas such as HTC, care and support, treatment, and PMTCT. PAI will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the AB program. In addition, PAI will conduct quarterly support supervision visits with spot checks to validate data of the reported activities and provide constructive feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

PharmAccess (PAI), in collaboration with the Tanzania People's Defense Force (TPDF), will provide both static and mobile counseling and testing services in TPDF sites in the country covering all districts. These activities are client-initiated testing HTC, targeting the general population through static and mobile VCT and campaign activities.

The HTC activities will be implemented in all TPDF sites and surrounding communities. The IP will focus its HTC program activities in priority areas, such as couples counseling, VMMC through community sensitization, counseling for Positive Health Dignity and Prevention (PHDP) through HBC, and counseling and testing for nutritional support.

PAI will implement HTC and link related activities with other services, such OVC, CTC, VCT, and PMTCT and ensure that clients are referred appropriately to foster a continuum of care. Other linkages will include working closely with LGAs, health facilities, and community organizations to improve services and local ownership and sustainability. Community leaders and social service committees will actively be involved in planning and implementation to improve the quality of HTC services. PAI will continue to establish patient support groups, or post test, clubs as well as create community demand in high transmission areas.

The IP will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the PHDP program. PAI will work with TPDF to conduct quarterly supportive supervision to address challenges and understand the progress and impact of activities thus far. Quarterly and monthly meetings will be conducted to assess the HTC program performance as well as to address challenges and provide feedback on lessons learned.

PAI will continue to strengthen the existing referral system to cater to all clients who test positive, linking them to care and treatment and home-based care. PAI will strengthen the referral system by working closely with health facilities and develop patient tracking system to minimize lost to follow-up.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

PharmAccess (PAI), in collaboration with the Tanzania People's Defense Force (TPDF), will address HIV transmission through activities that are aimed at condom promotion, palliative care services (through Positive Health Dignity and Prevention), and other prevention messaging.

PAI will work in all TPDF and surrounding communities countrywide to assess the extent and type of GBV and gender norms that are prominent, seeking community assistance to address issues related to sexuality, gender roles, and cultural practices that increase vulnerability to HIV.

PAI is working to address HIV prevention among the youth, young adults, and adult males and females at-risk to HIV infection driven by peer pressure, poverty, concurrent multiple partnerships, and excessive alcohol use.

PAI will continue to implement the related activities through peer education, condom promotion and distribution, brief motivational intervention initiative, income generating activities, and strategic in-service trainings. Furthermore, PAI will work with TPDF to ensure integration of activities into other health service delivery platforms. The IP will link with other program areas, such as HTC, care and support, treatment, and PMTCT, through coordination meetings and use of OP focal persons.

PAI will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the OP program. In addition, quarterly meetings will be conducted to assess OP performance and address challenges as well as provide feedback on lessons learned.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

PharmAccess supports approximately 332,000 military personnel, dependents, and civilians. During FY 2010, PAI achieved the following: expansion of PMTCT services (from one facility in FY 2009 to 29 in FY 2010); increased trained providers, (all PMTCT sites have at least one trained PMTCT provider); increased coverage (16,058 pregnant women tested- 7.2 % were HIV positive and 2,822 received ART to reduce MTCT) APR 2010.

In FY 2012, PAI plans the following activities:

1) Strengthen and support Emergency Obstetric Care (EmOC) in all sites through training on national TOT model; linking services to nearby facilities and complementing procurement and availability of tests reagents, equipment and other essential supplies for maternal and neonatal survival, including blood;
2) Train health care workers at each new site using a “full site” model and support HCWs training and mentorship to provide quality PMTCT services as per national guidelines;
3) Strengthen and support M&E framework (DQA, integrated supportive supervision using standardized national tools) and BPE to ensure informed program implementation;
4) Support provision of integrated PMTCT services including TB/HIV, ART, Pediatric HIV, FP and Focused Antenatal Care (FANC) services as well as provision of MECR to achieve the goal of putting all women on MECR by 2013. This will include training MCH health care providers in ART and pediatric HIV management, providing guidelines and job aids, supporting EID logistics (transportation samples and DBS results) and other essentials such as CD4, biochemistry and hematology tests;
5) Improve facility infrastructure through renovations of MCH and labor wards and ensure friendly and comprehensive MCH services;
6) Provide PHDP counseling package based on the harmonized USG/URT tools; and
7) Improve community sensitization and demand creation to improve participation in PMTCT/RCH services including encouraging HIV positive women to bring in family members for testing.
8) Work with districts (CHMTs) to plan and implement decentralized integrated PMTCT services to improve MCH services in the military.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

The Tanzanian People’s Defense Force (TPDF) health facility network supports a total of over 32,000 enlisted personnel, estimated 60-90,000 dependents, and approximately 300,000 civilians from communities surrounding TPDF camps and clinics.

By the end of FY2011, PAI had a cumulative number of over 11,643 patients on ART with 2,413 new patients enrolled. Despite this achievement, loss to follow up has been a big challenge to the program, with a retention rate of 60.7% (APR 2011). Efforts to improve retention include linkages with CBOs to track patients in the community, use of support groups, CHWs (HBC workers and community-owned resource persons) for adherence counseling, and tracking of patients in their homes.

For FY 2012, activities include:

1) Provide quality and integrated care and treatment services in the military CTCs through mentorship, on job training and support supervision to HCWs & volunteers; renovate space at selected sites, strengthen linkages to other programs (MCH, TB, PITC, and EPI); strengthen the referral system between the TPDF, district, and regional health facilities; develop and apply QA/QC mechanisms including standard operating procedures (SOP);
2) Procure drugs, commodities, and other supplies for services and patient monitoring when not available through central mechanism;
3) Strengthen prevention for positives counseling among all staff providing treatment at CTC;
4) Improve M&E framework: provide support to regional facilities (continuous quality improvement, CQI) to ensure quality services and improve patients' clinical outcomes and program performance;) improve patient collection, analysis and reporting
5) Work with facility pharmacists in improving capacity in forecasting, stock management, and ordering;
6) Continue to provide evaluation for malnutrition and nutritional counseling to all HIV positive clients;
7) Discuss and review program performance through quarterly meetings with site representatives and experts in specific fields (ART developments, pediatrics, HIV/AIDS, TB, etc.);

Retention of health care workers in the military setting is high. The available and newly recruited health personnel will continue to provide sustainable care and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	0	0

Narrative:

PharmAccess (PAI) supports approximately 332,000 military personnel, dependents, and civilians. The IP implements pediatric care and support services to at least 3,200 children under 15 years of age in need of care and support within a network of 29 CTCs. FY 2012 funding will be used to scale-up quality of care and treatment services. PAI is tasked with coordinating and overseeing the quality of pediatric treatment services in the TPDF. These activities will be achieved through regular support supervision, training, and on-the-job mentorship. PharmAccess has a catchment area of all military forces, communities surrounding the barracks, and camps throughout the country.

PAI works in partnership with the USG regionalized treatment partners to improve pediatric care and treatment services. With FY 2012 funding, PAI will support pediatric PITC, supply of pediatric drugs and commodities, diagnostics, adherence counseling, strengthening linkages and referrals between pediatric care and treatment programs. CHWs will be supported to carry out adherence counseling, tracking of children lost to follow-up and linking children to health facilities and other community support groups to ensure a continuum of care.

Local manpower and systems will be strengthened to improve specialized pediatric care and treatment. In FY 2012, targets will be monitored and discussed during zonal technical meetings and national partner meetings. Feeder programs, including HBC, OVC, PITC, EPI, PMTCT, TB/HIV, and RCH will employ strategies to increase child enrollment into care and treatment programs. Infrastructural improvement will specifically address pediatric treatment needs. Technical support will be provided to adolescent support groups for peer counseling and education to improve retention into treatment and adherence to medications. Pediatric care and treatment services at PAI are integrated into existing health systems and services. The integration of these services leverages national referral system to ensure quality, sustainable care, and support. The USG/T supported activities will continue to be incorporated into the regional health plans through national funding such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Implementing Mechanism Details

Mechanism ID: 7242	**Mechanism Name: condom procurement**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Central Contraceptive Procurement	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Population Services International	Tanzania Marketing & Communications Company, LTD	

Overview Narrative

USG/T procures both male and female condoms through this mechanism for its social marketing programs implemented by PSI/Tanzania. Historically, condom procurement and distribution by the public sector has been problematic, often due to the unpredictability of donor support and the long lead times in planning for condom procurements in Tanzania. Socially-marketed condoms play a key complementary role to public sector channels and many USG/T partners promote and distribute these subsidized condoms.

To guide stakeholders in aligning their HIV prevention efforts with key drivers of the epidemic, the National Multi-sectoral Prevention Strategy has identified its first strategic objective and key priority as "Increased adoption of safer sexual behaviors and reduction in risk-taking behaviors." This objective is to be realized through expanding the scope and coverage of behavioral interventions across sectors, which includes a specific focus on increased availability and correct and consistent use of condoms.

During the five years of the Partnership Framework, USG/T articulated the goals of establishing 33,966 targeted condom outlets, increasing uptake of socially marketed condoms, and promoting private and public sector condoms in clinical settings. Furthermore, this project fits within the GHI Strategy of increasing the demand and utilization of preventive health services and products.

PSI/Tanzania, the distributor for the condoms purchased through this mechanism, utilizes tools that monitor their outlets as well conduct regular assessments to ensure condom availability.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Family Planning

Budget Code Information

Mechanism ID:	7242		
Mechanism Name:	condom procurement		
Prime Partner Name:	Central Contraceptive Procurement		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	0	0

Narrative:

USAID/T will provide branded male and female condoms, which will be distributed by Population Services International (PSI) through their well-established social marketing channels. Social marketing in Tanzania has evolved from its initial focus on the general public to a more targeted approach of addressing the needs of most at-risk populations (MARPs). These condoms will be distributed in areas believed to be high transmission locations, such as communities surrounding mines, agricultural estates and truck stops. Socially-marketed condoms will also be made available at places where high risk sex takes place, such as bars and guesthouses. These condoms will be distributed through an elaborate and extensive network of traditional (pharmacy) and non-traditional (bars, nightclubs, and hotels) points of sale. In an effort to coordinate with other USG/T funded programs that access MARPs, USG/T partners working in the project areas of operation will also be encouraged to distribute these condoms. In the current year, planned shipments for male and female condoms are estimated at $1,006,515.63.

Implementing Mechanism Details

Mechanism ID: 7244	**Mechanism Name: MHN**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Mbeya HIV Network Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,000,979	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	1,000,979

Sub Partner Name(s)

Anglican Diocese of the Southern Highlands	Caritas International	Igogwe Roman Catholic Mission Hospital
Iringa Residential and Training Foundation	Mango Tree	Moravian Mission Hospital in Mbozi
OakTree Foundation	Serve Tanzania (SETA)	Service, Health, Development and Education for People with HIV/AIDS

Overview Narrative

Mbeya HIV Network Tanzania (MHNT) supports and coordinates 17 HIV/AIDS community outreach sub-partners located in eight districts (Mbarali, Mbozi, Rungwe, Kyela, Ileje, Chunya, Mbeya rural, and Mbeya urban) in Mbeya region, covering a population of 2.7 million people.

In collaboration with DOD, and in support of both PF Goal 3 (Leadership) and GHI IR 1.2, MHNT supports capacity building of its sub-partners to enhance sustainability. Under COP 2012, MHNT will continue working with other stakeholders (partners, government and non-governmental institutions in the region) to have a concerted approach to HIV/AIDS care, treatment and support, as well as maximize resource utilization. In addition, MHNT will strategically support in-service training, on-the-job mentorship, and support supervision to CHWs and community volunteers.

MHNT will coordinate sub-partners to integrate and link HIV/AIDS care, treatment and support services to achieve desired program outcomes. It will collaborate with CMAC/WMAC/VMAC to support PHDP services in the communities, including IGAs, formation of support groups to ensure participation and uptake of services, and improved adherence to and retention in care and treatment programs.

MHNT will use trained M&E officers to monitor and evaluate program performance using harmonized and standardized data collection, analysis and reporting tools. In addition, monthly and quarterly reports will be prepared and shared among relevant stakeholders.

Mbeya is a vast region with difficult terrains and poorly developed road networks. Sub-partners are

located in all districts in the region, which make it difficult to travel without reliable transport. A 4WD vehicle for MHNT is required and being requested, for effective sub-partner support.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	20,364
Economic Strengthening	276,955
Education	132,368
Food and Nutrition: Commodities	285,100
Food and Nutrition: Policy, Tools, and Service Delivery	142,550
Gender: Reducing Violence and Coercion	20,364
Human Resources for Health	81,457
Water	10,182

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population

Budget Code Information

Mechanism ID:	7244		
Mechanism Name:	MHN		
Prime Partner Name:	Mbeya HIV Network Tanzania		

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	317,288	0

Narrative:

Physical, psychological, spiritual, social, and prevention services for HIV-infected adults, children, and their families are important for optimizing the quality of life. In addition, other services such as adherence counseling, “care for carers,” and a strengthened referral system are required. Through COP 2012, MHN through its sub-partners will provide quality HBC services to 25,836 clients in four districts (Chunya, Rungwe, Mbeya rural, and Mbeya City) in Mbeya region.

With COP 2012 funding, MHNT plans to:
- Strengthen non-cash economic support to PLWHAs with small-scale IGAs;
- Support the implementation of integrated HBC services that are linked to other HIV/AIDS services (OVC, ART, HTC, VMMC and PMTCT);
- Improve M&E system by supporting sub-partners in using harmonized and standardized data collection, analysis and reporting tools. MHNT will use M&E focal persons at the sub-partner level, managers in each district and staff from the head office to monitor and assess ongoing service provision. In addition, MHNT will conduct quarterly supervision with spot checks to validate data and reported activities and provide constructive feedback;
- Improve program coordination through quarterly coordination meetings to share and improve program performance;
- Strengthen local support and ownership by working with LGAs, health facilities, and community organizations to improve service quality and build sustainability;
- Improve adherence and retention into care and support services by strengthening PHDP services, establish patient support groups and post-test clubs, and support participation of PLWHAs in planning and implementation of program activities;
- Support sub-partners in improving the delivery of a Nutrition Assessment, Counseling and Support (NACS) component of the PHDP program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	63,571	0

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Narrative:

MHNT, through its sub-partners, will continue community mobilization through individual, small groups and community sensitization approaches to promote abstinence, delay of sexual debut, fidelity, and reduction of multiple and concurrent sex partners. Key drivers of the epidemic such as alcohol abuse, MCP, GBV and gender norms, and transactional and cross-generational sex will also be addressed through with key messages. Activities will be implemented in all eight districts of Mbeya region.

The program will target in-school youth, young adults, couples and at-risk populations such as fishing communities, mining and border areas, with key HVAB messages. At least two sessions will be conducted per week to reach the targeted 30,000 people.

Integration and linkages to HVAB activities with other care, treatment and support services, including PHDP and VMMC, will be promoted.
To reach in-school youth, MHNT sub-partners will involve schools and colleges in their catchment areas to ensure participation and utilization of services.

MHNT will also initiate dialogue with local government authorities and other stakeholders to gain local support. Support supervision, on-the-job mentorship and strategic training will be done to strengthen sub-partner capability to implement the program. Harmonized and standardized M&E tools will be used to improve data collection, analysis and reporting. Quarterly meetings will be held to share progress and challenges.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	312,583	0

Narrative:

MHNT sub-partners provide both static and mobile client-initiated HTC services in all eight districts of Mbeya region. MHNT serves a population with high HIV prevalence (9.2%) and managed to reach 27426 clients (105.8% of their total target) for COP 2011).

The focus of the HTC program is to offer testing and counseling as well as link clients to care, treatment and support services. MHNT advocates HTC services in couples, special populations (long distance truck drivers), and services are integrated into other programs such as VMC, ART, TB/HIV and PMTCT and HBC.

To ensure a continuum of care, people who test positive will be subsequently encouraged to engage in PHDP programs. This program also provides HBC providers with skills in adherence counseling to

improve adherence to treatment and retention into care, treatment and support programs.

Regular program monitoring will be done through standardized tools. Data collection, analysis and reporting on a quarterly basis will be done to ensure implementation of HTC program on an informed basis. MHNT will strengthen the referral system by working closely with health facilities and patient tracking to minimize loss to follow-up.

To ensure full involvement and local ownership, LGAs, CSOs, NGOs and other stakeholders will be regularly involved in the planning and implementation of HTC services. MHNT sub-partners will support establishment of patient support groups and post-test clubs as well as demand creation in the community, especially in high transmission areas. MHNT will conduct regular on-the-job mentorship and quarterly support supervision timely to address challenges and document progress and impact.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	307,537	0

Narrative:

MHNT implements HVOP activities in all eight districts of Mbeya region targeting at-risk populations. Although the magnitude and size of the populations are not well known, activities are aimed to address issues related to sexuality, gender and cultural practices that fuel the spread of HIV. The target populations will be at-risk youth, alcohol users, mobile populations (truck drivers, migrant workers, and mining workers) and people involved in transactional sex. MHNT will spend approximately 80% of the HVOP budget to implement activities targeting mobile populations specifically.

MHNT will distribute and promote correct and consistent use of condoms among sexually active adolescents and adults, including behavior change communication to address socio-cultural norms and behavioral practices that fuel the spread of HIV.

MHNT promotes establishment of PHDP services to ensure provision of quality adherence counseling, and involvement of PLWHAs in sexual prevention activities to reduce HIV transmission as well as facilitate identification of and involvement in income-generating activities to increase local ownership.

Activities will take address the socio-cultural context and drivers of HIV transmission. Community sensitization to address peer pressure, poverty, MCP and excessive alcohol use through community peer education schemes.

MHNT will provide strategic in-service trainings; supportive supervision and on-the-job mentorship to

strengthen capacity of its sub-partners. Lastly, MHNT sub-partners will work with LGAs to ensure integration of activities into other service delivery platforms. Sub-partners will provide services integrated and linked to other care, treatment and support such as HTC, PMTCT, ART and HBC. Program M&E system will be improved by using standardized and harmonized data collection, analysis and reporting tools. Use of M&E focal persons will be promoted. Program performance will be assessed and discussed among stakeholders (LGAs, CSOs, NGOs) during coordination meetings.

Implementing Mechanism Details

Mechanism ID: 7245	**Mechanism Name: RODI**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Resource Oriented Development Initiatives	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 849,294	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	849,294

Sub Partner Name(s)

Anglican Church of Tanzania	Caritas International	

Overview Narrative

Resource Oriented Development Initiatives (RODI) aims at improving the skills and competence of 12 local NGOs to implement, manage and provide quality services while ensuring that program activities adhere to national and organizational guidelines. RODI implements HIV/AIDS program in all four districts (Mpanda, Nkasi, Sumbawanga Rural and Sumbawaga Urban) and 52 wards of Rukwa Region, covering a population of 1.5M people.

RODI will continue with efforts to enhance local sub-partners' capacity to manage HIV/AIDS programs,

with a focus on sustainability.

In collaboration with other stakeholders (LGAs, other government institutions, NGOs and CSOs), RODI will leverage USG support to offer quality outreach services in Rukwa region. In addition, RODI will continue to recruit community volunteers, integrate its plans into CMAC/WMAC/VMAC, and support and coordinate PHDP services among PLHAs (such as IGAs, support groups, post-tet clubs). Linkages and integrated HIV/AIDS services will be strengthened to ensure quality and utilization.

The M&E system will be improved to ensure quality program monitoring and evaluation. This will be done through harmonized and standardized data collection, analysis and reporting tools and quarterly performance reports will be shared and discussed during coordination meetings.

The program has been incurring high maintenance costs from a 15 year old Toyota Land Cruiser. Consequently, the purchase of a replacement vehicle is being requested to assist in monitoring program activities throughout Rukwa region.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7245

Mechanism Name:	RODI		
Prime Partner Name:	Resource Oriented Development Initiatives		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	299,429	0

Narrative:

RODI offers community-based HBC services to HIV-infected adults and their families in all districts of Rukwa region. Services are provided through sub-partners according to the HBC guidelines and using HBC trained providers. The components of the home-based care and support include physical, psychological, spiritual, social, and prevention services. Prevention services include couples HTC, adherence counseling, condom promotion, family planning and risk reduction in at-risk communities (fishing communities). A total of 9,136 clients reached is targeted for COP 2012

RODI will use COP 2012 specifically to :
- Integrate HBC services and link them to other HIV/AIDS care, treatment and support services such as OVC, ART, HTC, VMMC and PMTCT;
- Improve data collection, analysis and reporting through use of harmonized and standardized USG/URT M&E tools. Sub partners will be encouraged to have M&E units with trained focal persons;
- Conduct quarterly coordination meetings to discuss and share program performance;
- Strengthen participation of relevant stakeholders (LGAs, health facilities, CSOs, NGOs) to support the implementation of HBC activities through individual, small groups and community sensitization approach;
- Support implementation of PHDP activities catering to PLWHA needs by involving PLWHA participation in planning committees and implementation of program activities. This aims to improve adherence and retention into care and support. In addition, sub-partners will be assisted to establish PLWHA support groups, post-test clubs and delivery of the Nutrition Assessment, Counseling and Support (NACS);
- Support identification and implementation of small-scale IGAs to strengthen the economic wellbeing of HIV-infected individuals and their families. No cash will be given to clients;
- Improve HBC providers' skills through strategic in-service training, on-job mentorship and support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	177,464	0

Narrative:

RODI, through its sub-partners, will promote abstinence, delay of sexual debut, fidelity, and reduction of multiple and concurrent sex partners to prevent the spread of HIV/AIDS. The HVAB program focus will be on couples, in-school youth and young adult men and women within the community and among at-risk

groups (fishing communities). Messages will also address the reduction of alcohol use, MCP, and transactional and inter-generational sex as well as GBV and gender norms that fuel the spread of HIV.

RODI aims to reach 9,000 people through the HVAB interventions. At least one education session will be conducted every week to reach this target.

Schools, colleges and communities will be sensitized to participate in HVAB activities through individual, small groups and community messaging. These activities will be implemented in all districts in the rukwa region.

The M&E framework will be improved through supportive supervision, mentorship and strategic in-service training. Tools will be harmonized and standardized to improve quality data collection, analysis and reporting. Quarterly meetings to assess performance will be conducted for informed program implementation. All activities will be linked to other services such as VMMC, HTC, PMTCT, HBC and ART.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	140,148	0

Narrative:

RODI serves a population with high HIV prevalence (4.9%) and managed to reach 86.3% of the target of 21,120 in FY2011. RODI sub-partners provide both static and mobile client-initiated HTC services in all four districts of Rukwa region.

With COP 2012 funding, RODI will:
1) Promote and provide couples counseling and testing;
2) Promote uptake of HTC among pregnant women to improve utilization of MTCT services;
3) Provide ounseling for PHDP through HBC;
4) Provide HTC services among MARPs (such as long distance truck drivers);
5) Promote HTC in VMMC as RODI operates in Rukwa, a priority region for scale up of VMMC services;
6) Improve record-keeping and quarterly reporting by using harmonized and standardized tools as well as quarterly supportive supervision to ensure quality and alignment with program objectives;
7) Strengthen integration and linkages of HTC services with other care, treatment and support programs (HBC, ART, VMMC and PMTCT). RODI will also support the establishment of patient support groups and post-test clubs and community demand-creation activities in high transmission areas, to ensure a continuum of care;
8) Improve local ownership, coverage and sustainability by working closely with LGAs, health facilities

and community organizations; 9) Create demand through community sensitization including community peer education schemes.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	232,253	0

Narrative:

RODI implements HVOP activities in all districts of Ruvuma Region. The target populations will be at-risk youth, alcohol users, mobile populations, specifically fishing communities and people involved in transactional sex. Although the magnitude and size of the populations are not well known, activities are aimed to address issues related to sexuality, gender and cultural practices that fuel the spread of HIV. RODI will spend approximately 80% of the HVOP budget to implement activities targeting mobile populations (fishing communities).

With COP 2012, RODI will:
- Conduct community sensitization through individual, small groups and community peer education schemes to address socio-cultural issues and drivers of the HIV epidemic, including peer pressure, poverty, MCP, transactional and intergenerational sex, age at sex debut and alcohol use;
- Distribute and promote correct and consistent use of condoms;
- Address excessive alcohol use through brief motivational intervention (BMI) approach;
- Support PHDP services in Rukwa and ensure participation of PLWHAs in planning and implementing activities as well as identifying and facilitating income-generating activities;
- Support QA/QC and quality improvement by improving the M&E system through quality data collection, analysis and reporting. This will be achieved through strategic in-service training, support supervision and on-job mentorship of M&E focal persons;
- Support linkage and integration of HVOP services with other HIV/AIDS service delivery platforms such as HTC, ART, VMMC, HBC, and PMTCT.

Implementing Mechanism Details

Mechanism ID: 7246	**Mechanism Name: SONGONET**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: SONGONET-HIV Ruvuma	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

PERAMIHO MISSION HOSPITAL	Service, Health, Development and Education for People with HIV/AIDS	Society for Women And AIDS in Africa

Overview Narrative

The Ruvuma Network of Organizations Working with HIV/AIDS (RUNOWA) coordinates and supports community outreach HIV/AIDS sub-partners in Ruvuma Region. RUNOWA was established in 2007 and registered in the same year. RUNOWA is situated in Ruvuma Region and covers all four districts in the region (Songea, Tunduru, Namtumbo, and Mbinga).

RUNOWA, in collaboration with DOD, is striving to build the capacity of local sub-partners to enhance country ownership and sustainability. RUNOWA will work closely with other partners and government institutions in the region to leverage its USG/T resources. In addition, RUNOWA will continue to recruit community volunteers, integrate with the council, ward, and village multi-sectoral AIDS committee (MAC/WMAC/VMAC), enhance income generating activities with PLHIV groups, and strengthen linkages between government and other stakeholders in order to improve the quality of services.

RUNOWA will continue to support an enhanced M&E system in Ruvuma through use of harmonised and standardized data collection, analysis, and reporting tools. M&E focal persons will ensure program monitoring and evaluation. Reporting will be done on monthly and quarterly bases. Results will be shared among stakeholders for informed program implementation.

In the spirit of GHI, integrated HIV/AIDS services will be promoted and linked to other services in the region, including care, treatment and support services (ART, Malaria, OVC, PMTCT, ANC, EPI, EID, HBC , HTC and VMMC) to ensure maximum uptake and coverage as well as a continuum of care.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7246**		
Mechanism Name:	**SONGONET**		
Prime Partner Name:	**SONGONET-HIV Ruvuma**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0
Narrative:			
Through HBC trained providers, SONGONET will offer physical, psychological, spiritual, social, and prevention services through its sub-partners to HIV-infected adults, children, and their families, in accordance with HBC guidelines. Other services will include adherence counseling, “care for carers,” and a strengthened referral system.			

Following a needs assessment, HBC providers will strengthen the PHDP components of its interventions and will enhance the delivery of a Nutrition Assessment, Counseling and Support (NACS). SONGONET will support its clients with economic strengthening activities, such as small IGAs, and will facilitate clients to form associations and groups to maintain the strength of their chosen income generating projects. No cash will be given to clients.

The services will be in all districts of Ruvuma Region. SONGONET sub-partners that implement HBC services will integrate and strengthen linkages with other HIV-related services, including OVC, CTC, HTC, VMMC, and PMTCT and other related programs using focal persons, quarterly coordination meetings, and referral forms. Other linkages will include working closely with LGAs, health facilities, and community organizations to improve services and build sustainability. PLHIVs will actively participate in planning committees and program implementation to improve adherence and retention into care and support. SONGONET will continue to establish patient support groups and post-test clubs.

Sub-partners will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the PHDP program. SONGONET will use managers located in each district and staff from the head office to monitor the services provided to clients. In addition, SONGONET will conduct quarterly supervision with spot checks to validate data and reported activities and provide constructive feedback. SONGONET sub-partners will reach a total of 9,468 clients with quality care and support services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

SONGONET, through its sub-partners, will utilize a peer education model to target in-school youth and young adult men and women within the community. SONGONET sub-partners will also work with schools and colleges in their catchment areas to focus on key drivers of the epidemic, such as alcohol abuse, MCP, GBV and gender norms, and transactional and cross-generational sex. Community dialogue will take place through one-on-one and small group interventions. SONGONET sub-partners will conduct peer education sessions at least twice a month to reach the targeted 14,000 people. These activities will be implemented in all districts in the region.

With support from URT facilitators, the available training materials, facilitators, and PEs will be used to maintain standards and quality. Quarterly monthly meetings will be conducted to assess PE performance and to address challenges as well as provide feedback on lessons learned. All activities will be linked to other critical services offered in the community, including HTC, care and support,

treatment, and PMTCT.

SONGONET sub-partners will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the program. In addition, SONGONET sub-partners will conduct quarterly support supervision visits with spot checks to validate data and reported activities and provide constructive feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

SONGONET sub-partners provide both static and mobile client-initiated HTC services in Ruvuma Region, covering all districts. SONGONET serves a population with high HIV prevalence (5.9%) and has managed to reach 101.4% of their total target of 14400 clients in FY 2011.

HTC program activities include a focus on couples counseling and testing, reaching MARPs (long distance truck drivers), promoting VMMC through community sensitization, counseling for PHDP through HBC, and identifying alcohol concerns through the brief motivational intervention (BMI) initiative.

SONGONET sub-partners will refer HTC clients appropriately to ensure a continuum of care by linking them to other HIV-related programs, including OVC, CTC, VMMC, and PMTCT services. Other linkages will include working closely with LGAs, health facilities, and community organizations to improve services and enhance sustainability. Community leaders and social service committees will be actively involved in both the planning and implementation of HTC services. SONGONET sub-partners will continue to establish patient support groups and post-test clubs as well as community demand creation activities in high transmission areas.

The IP will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the PHDP program. SONGONET will ensure its sub-partners conduct quarterly supportive supervision to address challenges and document progress and impact.

SONGONET sub-partners will continue to strengthen the existing referral system to cater for all clients who test HIV positive, linking them to care and treatment and home-based care services. SONGONET will strengthen the referral system by working closely with health facilities and develop patient tracking systems to minimize loss to follow-up.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	0	0
Narrative:			
Through its HVOP activities, SONGONET promotes condom use and provides PHDP services to its network of clients. Working through its sub-partners, SONGONET will work in all districts of Ruvuma Region to assess GBV and gender norms while simultaneously involve the community to address issues related to sexuality, gender roles, and cultural practices that increase vulnerability to HIV. SONGONET reaches the general population and seeks to address some of the socio-cultural context and drivers of HIV transmission, including peer pressure, poverty, MCP, and excessive alcohol use. SONGONET sub-partners will continue to utilize a peer education model, actively promote and distribute condoms, implement the brief motivational intervention to address alcohol use and abuse, facilitate income-generating activities, and provide strategic in-service trainings. Furthermore, SONGONET sub-partners will work with LGAs to ensure integration of activities into other service delivery platforms. Sub-partners will link with HTC, care and support, treatment, and PMTCT providers through coordination meetings and use of focal persons. SONGONET sub-partners will use standardized tools to improve recording and quarterly reporting. These tools will also track coverage and impact of the program. In addition, quarterly meetings will be conducted to assess performance and address challenges as well as provide feedback on the lessons learned. SONGONET will spend approximately 80% of the HVOP budget to implement activities targeting mobile populations (fishing communities).			

Implementing Mechanism Details

Mechanism ID: 7254	**Mechanism Name: MRMO**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Mbeya Regional Medical Office	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,099,019	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

GHP-State	2,099,019

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Mbeya Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region. Mbeya region has eight districts with 379 health facilities, among which 46 are CTCs. The estimated regional total population is 2,742,762, with an annual population growth rate of 2.4%. The main objectives of the Mbeya RMO are to improve the quality of HIV/AIDS interventions, ensure appropriate access to care and treatment services for PLHIV, address the needs of vulnerable populations, strategically scale-up quality care and treatment services, and build local capacity of other indigenous organizations to foster local ownership and sustainability.

Mbeya RMO supports TB/HIV collaborative activities, PMTCT through RCH platform, adult and pediatric HIV care and treatment, including EID, nutrition counseling and support, MC, and gender-based violence and women's empowerment. In addition, the program is linked to other programs such as malaria, TB, FP, child and maternal survival programs, and community mobilization and sensitization to improve health care seeking behavior.

Mbeya RMO will strive to improve quality of services and efficiencies through combined supportive supervision, on-the-job mentorship, and continuous quality improvement activities, strategically scaled-down support of in-service training, and decentralization of services to districts. Districts will be visited quarterly for supportive supervision. Routine monitoring and data collection and reporting will be undertaken using standardized national tools.

Mbeya is a vast region with difficult terrain and a poorly developed road network. A 4WD vehicle is needed to allow uninterrupted supportive supervision and on-the-job mentorship.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	7254		
Mechanism Name:	MRMO		
Prime Partner Name:	Mbeya Regional Medical Office		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	218,637	0

Narrative:

Mbeya is one of the regions with the highest HIV prevalence in the country of 9.2%. Mbeya Regional Medical Office (RMO) supports the implementation of facility- based adult care programs at the regional hospital and all CTCs at district and other hospitals in Mbeya regions. The services aim to extend and optimize quality of life for HIV-infected clients and their families throughout the continuum of illness by providing clinical, psychological, spiritual, social, and prevention services.

For COP 2012, Mbeya RMO will provide facility based HBC services to PLHAs and their families through the following activities which make up a standard DOD package of care activities:

• Provision of prevention and treatment of OIs and other HIV-related complications such as malaria and

diarrhea
• Nutritional assessment, counseling and support (NACS) to PLHA at all CTCs
• Provision of quality pain and symptom relief to PLHA, including improving technical support to community-based partners
• Provision of couples counseling and testing services that are integrated to other services such as, family planning, ANC, PNC, ART, VMMC and PMTCT
• Provision of risk reduction counseling and adherence counseling and support to PLHA
• Individual and group psychological and spiritual support, including bereavement services to PLHA and their families, in collaboration with outreach partners and religious organizations
• Provision of STI diagnosis and treatment services that are integrated into other services such as family planning, ANC, PNC, ART, VMMC, PMTCT
• Linkage of condom services to other services such as family planning, ANC, PNC, ART, VMMC and PMTCT
• Strengthened PHDP counseling among all staff providing treatment at CTCs to improve retention into care and treatment adherence
• Linkage of PLHAs with available support mechanisms including home/community -based HBC services
• Improved M&E framework by harmonizing data collection tools, data recording and reporting. Quarterly performance appraisals meeting will be conducted to discus program data and share results with home/community based HBC partners in Mbeya region
• Provision of supportive supervision and on-the-job mentorship to facility based adult care and support HCW to district hospital and support CHTMs/DHMTS to provide timely support supervision to adult care and support services in lower level facilities/

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	69,649	0

Narrative:

Mbeya Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, supporting 293 RCH sites and providing supervision to the regional hospital and district level facilities. Mbeya is one of the regions with the highest HIV prevalence in the country of 7.9%. It is estimated that there are 200,000 PLHIV in need of services in this region.

Mbeya RMO began full recruitment of patients in 2005 and by the end of FY 2010, the region had a cumulative number of over 19,000 patients on ART with 4,200 new patients enrolled. Despite this achievement, loss to follow up has been a major challenge to the program, with a retention rate of 81.8% (APR 2010). Efforts to improve retention include linking with CBOs to track patients in the community, use of support groups, CHWs (HBC workers and community-owned resource persons) for adherence

counseling, and tracking of patients in their homes.

For COP 2012, Mbeya RMO's TB/HIV portfolio will include the following activities:

1) Continue TB screening for PLHIV attending care and treatment clinic. Those found with active TB will be referred to TB clinics for treatment;
2) Strengthen and scale-up implementation of the three "I"s in the region;
3) Support establishment of TB/HIV coordinating bodies at all levels within the region to oversee the implementation of TB/HIC collaborative services;
4) Ensure availability and use of standard National TB/HIV tools, such as screening tools and clinical assessment forms;
5) Strengthen the implementation of TB infection control practices in care and treatment settings to prevent transmission of TB among PLHIV as well as health care providers;
6) Strategic in-service training of HIV clinic staff on TB infection control practices and implementation of the three "I"s;
7) Continue strengthening of laboratory services including sputum smear microscopy and quality assurance to ensure quality TB care services;
8) Provide supportive supervision and mentorship to satellite CTCs within the region; and
9) Provide technical support to the districts for integration of ARV services in high-volume TB clinics.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	17,545	0

Narrative:

HIV prevalence in Mbeya region is 7.9%, with at least 15,000 children under 15 years of age in need of care and support. All health facilities provide these services. FY 2012 funding will be used to scale-up cotrimoxazole prophylaxis, infant feeding counseling, nutritional assessments and support, management of OIs, palliative care, psycho-social support, home-based care services, , age-specific counseling and improve referrals and linkages. These activities will be achieved through community mobilization, training, and on-the-job mentorship and implemented in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI).

Local manpower and systems will be strengthened to improve care for children. For COP 2012, male and female children will be reached. Targets will be monitored and discussed during zonal technical meetings and national partner meetings. Home-based care and OVC service providers will employ strategies to increase child enrollment into care. Infrastructural improvements will specifically address pediatric needs.

Mbeya RMO will strengthen the existing efforts in pediatric care and support to improve involvement of adolescents and children in PHDP services and formation of support groups. Technical support will be provided to these groups for peer counseling and education to improve retention into treatment and adherence to medications.

Mbeya RMO provides comprehensive MCH services including screening, diagnostic services, and provision of ARVs to HIV-positive mothers and children under one roof. The integration of these services leverages on the national referral system to ensure quality, sustainable care, and support. The USG/T-supported activities will continue to be incorporated into the regional health plans through national funding such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	432,769	0

Narrative:

Mbeya Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs in Mbeya region, supporting 293 RCH sites and providing supervision to the regional hospital and district level facilities. At 7.9% HIV prevalence, Mbeya is among the regions with highest HIV prevalence in the country. Quality PMTCT services are critical given the high ANC HIV prevalence of 12.6%.

Mbeya RMO will work with DHMTs and CHMTs to plan and implement decentralized integrated PMTCT services to improve MCH services in the region. As per DOD guidance, a package of standard interventions will be implemented as listed below:

1) Complement Emergency Obstetric Care (EmOC) package by linking with district authorities and health programs that support EmOC and establish needs; supporting training in EmOC through a national TOT model to roll out EmOC services in respective districts;
2) Integrate ART and TB/HIV services into PMTCT sites. This will include supporting PMTCT sites to provide ART and More Efficacious Combination Regimens (MECR) by training MCH health care providers in ART and pediatric HIV management, providing guidelines and job aids, and providing CD4, biochemistry, hematology machines. Additionally, linkage and integration of PMTCT and EID services into MCH will ensure that exposed and infected infants are identified early and linked to Care, Treatment and Support;

3) Complement FP and Focused Antenatal Care (FANC) package by linking/liaising with districts

authorities and health programs that support FP and FANC and establish needs and conducting training in FP and FANC through a national TOT model to roll out FP and FANC service in respective districts;
4) Procure drugs, reagents, and other essential supplies if not available through central procurement mechanisms;
5) Strengthen and support monitoring and evaluation and BPE, document lessons learned including PMTCT costing studies, and support use of data to assess site specific services and develop a plan of action to address problems;
6) Improve facility infrastructure through renovations of MCH and labor wards and ensure that they are functional and offer friendly services to mothers and children;
7) Promote infant feeding counseling options (AFASS criteria), linking mothers to safe water programs in the region. For those choosing to breastfeed, the program will counsel them to exclusively breastfeed with early weaning. Infant feeding and nutritional interventions during lactation period will be promoted;
8) Support national efforts to standardize EID logistics (transportation samples and DBS results);
9) Provide PHDP counseling package based on the USG-developed approach in Tanzania; and
10) Improve community sensitization and demand creation to improve participation in PMTCT/RCH services, including encouraging HIV positive women to bring in family members for testing.
11) Continue training and mentoring of HCWs to provide quality PMTCT services according to the new national PMTCT guidelines, including training HCWs at each new site using a “full site” model;
12) Support Mbeya Referral Hospital (MRH) to train ANC and laboratory staff for the entire Southern Highlands in collection of DBS for infant diagnosis and send DBS to MRH and USG/T lab partners;
13) Build capacity of regional and district health teams to plan, execute, and monitor PMTCT activities, and support DHMT to include PMTCT activities in council health plans and budget.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,210,448	0

Narrative:

Mbeya Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, providing supervision to the regional hospital and district level facilities. Mbeya is one of the regions with the highest HIV prevalence in the country of 7.9%. It is estimated that there are 200,000 PLHIV in need of services in this region.

Full recruitment of patients in the region started in 2005, and by the end of FY 2011 the region had a cumulative number of over 41,000 patients on ART with 93730 new patients enrolled. Loss to follow up, however, has been a major challenge to the program. Based on the APR 2010 data, the proxy retention rate is approximately 73 % (APR 11). Measure to address this problem include linking with CBOs to track patients in the community, consistent and improved adherence counseling at all CTC sites and use

of CHWs (HBC workers and community-owned resource persons) for adherence counseling, use of support groups, and tracking of patients in their homes.

For COP 2012, planned activities are:

1) Support provision of integrated care and treatment services: renovate selected facilities in the region; provide strategic in-service training, support supervision and mentorship to HCWs, linkages and integration of care and treatment services into other programs (e.g. MCH, TB, EPI, and PITC);
2) Improve M&E system by supporting CQI in CTCs and electronic data capture: solar power will strategically be installed in high volume sites to improve electronic data collection, analysis and reporting. Gaps identified during quarterly performance appraisals will also be incorporated into regional work plans; RHMT and CHMTs in the region will be strengthened for better service coordination; Participate in zonal ART meetings organized by Mbeya Referral Hospital.
3) Improve budgeting and financial performance by strengthening administrative and financial capacity. A contractor will be retained to build RMOs capacity in budgeting and financial reporting.
4) Work with the DHMT and facility directors in developing and implementing facility-based work plans and facility pharmacists to improve forecasting, stock management and ordering;
5) Improve patient identification and monitoring by procuring lab equipment and reagents including new CD4 machines and ensure regular maintenance. Also procure drugs and other commodities when not available through a central mechanism;
6) Improve M&E framework by harmonizing data collection tools, data recording and reporting, ensuring gaps identified during quarterly performance appraisals are incorporated into regional work plans. To achieve this, solar power will be installed in selected facilities to improve electronic data management.
7) Strengthen PHDP counseling among all staff providing treatment at CTCs, and link PLHAs with available support mechanisms;
8) Improve infection prevention and control at high volume sites. This will be achieved through improved waste separation and disposal that will include building efficient and environmentally friendly incinerators;
As part of Tanzania’s decentralized health care approach, Mbeya RMO is the highest ranked local MOHSW representative in the region. Through its Regional AIDS Control Program and strong working relationship with District Medical Officers (DMOs), Mbeya RMO leads planning and execution of health services for the region.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	149,971	0

Narrative:

HIV prevalence in Mbeya region is 7.9%, with at least 15,000 children under 15 years of age in need of care and support. FY 2012 funding will be used to scale-up the quality of pediatric care and treatment services. Mbeya RMO is tasked with coordinating and overseeing the quality of pediatric treatment services in the region, in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI), based at MRH. Currently, BIPAI provides pediatric outreach care and treatment services as well as pediatric ART services, training, and mentorship for health workers in the region.

Mbeya RMO will support provision of comprehensive, integrated and quality pediatric care and treatment services in the region through strategic in-service training, supportive supervision and on-job mentorship to HCWs. supply of pediatric drugs and commodities, adherence counseling, and linkage of care and treatment services with community support groups to ensure a continuum of care. Peer counseling and education to improve retention into treatment will be promoted through technical support to adolescent support groups.
Care and treatment services will be integrated into other services (HBC, OVC, PITC, EPI, PMTCT, TB/HIV, and RCH) to increase child enrolment. Improvement of facility infrastructure will address pediatric needs.

Mbeya RMO will strengthen the QA/QC system in data collection, analysis and reporting. Targets and results will be discussed among stakeholders (Local government, donors, NGOs, CSOs) and used to inform the program.

The integration of these services leverages the national referral system to ensure quality and sustainability. Mbeya RMO will continue to incorporate the regional health plans into existing funding mechanisms such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Implementing Mechanism Details

Mechanism ID: 7256	**Mechanism Name: RKRMO**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Rukwa Regional Medical Office	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,000,688	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	2,000,688

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Rukwa Region is located in the remote southwestern part of Tanzania between Lakes Tanganyika and Rukwa. The transport infrastructure is poorly developed with gravel roads that are usually impassable during rainy season.

Health services to the catchment population of approximately 1 million people are provided by URT, FBOs, and the private sector. There are 234 health facilities in the region, including four hospitals, 31 health centers, 199 dispensaries, and two training institutions. These facilities are relatively unevenly distributed, although approximately 70-85% of people live within five kilometers of a primary health facility.

Rukwa Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, providing funding and supervision to the regional hospital and district level facilities. The region has created a monitoring and evaluation plan that ensures planned interventions are implemented in a timely and cost-effective manner. Regional Health Management Team (RHMT) and Council Health Management Teams (CHMTs) are responsible for implementation and the monitoring and evaluation of the HIV/ AIDS activities, thus strengthening the local capacity. The region has been working with CHMTs and all stakeholders to help the councils incorporate health interventions into their routine plans.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	7256		
Mechanism Name:	RKRMO		
Prime Partner Name:	Rukwa Regional Medical Office		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	155,986	0

Narrative:

Rukwa Regional Medical Office (RMO) supports the implementation of facility-based activities aimed at extending and optimizing the quality of life for HIV infected adults and their families through clinical, psychological, spiritual, social, and prevention services throughout the continuum of illness.

For COP 2012, the following adult care and support services make up a standard DOD package of care:

1) Strengthen facility-based adult care and support services through strategic in-service training, supportive supervision and on-the-job mentorship of HCWs offering adult care and support services at the regional and district hospitals n Rukwa region. Rukwa RMO will also support CHMTs/DHMTs to provide similar services in lower-level facilities.
2) Strengthen facility-based PHDP counseling to improve adherence and retention of PLHAs into care

and support services
3) Support linkages of facility-based and home/community adult care and support services through use of community health workers (CHWs) and regular coordination meetings with outreach service providers.
4) Provide prevention and treatment of OIs and other related infections such as Malaria and Diarrhea.
5) Provide nutritional counseling and support (NACS) to all patients attending ART services at CTCs
6) Strengthen integration of adult care and support services into other HIV/AIDS care, support and treatment services in the region, such as ART, PMTCT, HTC, VMMC, and OVC.
7) Improve the M&E framework in the region by harmonizing data collection, analysis and reporting tools. Program targets and results will be discussed and shared for informed program implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	76,624	0

Narrative:

Rukwa region has a population of over 1 million people with the prevalence of 4.5%. It is estimated that there are 50,000 HIV positive people in need of services in this region. The Rukwa Regional Medical Office (RRMO) implements TB/HIV program based on the country TB treatment policy, coordinated by the National TB and Leprosy Program (NTLP). It is committed to providing quality TB/HIV services, both at the facility and community levels. TB treatment in Tanzania follows the WHO-recommended DOTS strategy. Although initially Tanzania had achieved significant success in TB care and treatment, the advent of HIV has significantly increased the number of cases and challenges of TB management. Low levels of awareness, lack of basic knowledge about TB and low case detection rate, especially among the HIV co-infected patients, have negatively impacted on the previous successes.

With COP 2012 funds, the TB/HIV portfolio of the Rukwa RMO will include the following activities:
1) Improve regional efforts to provide quality TB/HIV services by providing technical support to districts and high-volume and satellite clinics, in-service training and on-the-job mentorship to HCWs on TB control practices and implementation of the three "I"s as well as establishment of TB/HIV coordinating bodies at district level;
2) Scale-up TB/HIV services in the region through TB screening for PLWHAs and integration with other programs such as ART, HTC and PMTCT;
3) Strengthen monitoring and tracking system to improve program performance, including availability and use of standard National TB/HIV tools, such as screening tools and clinical assessment forms;
4) Continue strengthening of laboratory services including sputum smear microscopy and quality assurance to ensure quality TB care services; 5) Increase and strengthen regional and district capacity to provide quality TB/HIV services, in partnership with other stakeholders and with technical and financial support from DOD.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	5,924	0

Narrative:

HIV prevalence in Rukwa region is 4.5%, with at least 5,000 children under 15 years of age in need of care and support within a network of 20 CTCs.   All health facilities provide pediatric care and support services at varying levels.

Rukwa RMO will use COP 2012 funding to:

1) Strengthen provision of integrated pediatric care and support services that are linked to other services such as ART, OVC, HBC, TB/HIV, MCH, EPI, PMTCT and HTC;
2) Scale-up cotrimoxazole prophylaxis and management of Opportunistic Infections (OIs);
3) Strengthen quality of pediatric care and support services by improving skills of HCWs and CHWs in infant feeding counseling, nutritional assessments and support, palliative care, psycho-social support through strategic in-service training, on-the-job mentorship and support supervision;
4)   Improve M&E system by harmonizing data collection, analysis and reporting tools. Encourage that targets and results are discussed and shared for informed program implementation.
5) Strengthen local ownership through community mobilization, and improve involvement of adolescents and children in PHDP services and formation of support groups in order to improve retention and adherence;
6) Renovate selected health facilities to ensure pediatric-friendly services.

To ensure program sustainability, Rukwa RMO leverages on local resources such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	347,931	0

Narrative:

Rukwa RMO will support VMMC activities in Rukwa region through routine on-site MC services and campaign approaches.   Currently, only routine on-site VMMC services are conducted, although two campaigns are planned during the current fiscal year.   With technical assistance from Mbeya Referral Hospital, a total of 17 MC clinicians have been trained (five teams). More clinicians will be trained ifor COP 2012 to perform more MC procedures.

In order to increase MC uptake, Rukwa RMO will provide a comprehensive MC package that includes

HTC, client-appropriate behavioral messaging and referral to HIV care and treatment services, as well as on-site PHDP services for those found HIV-positive.   Female partner participation will also be promoted to encourage a family-centered HIV prevention approach. Moreover, to improve MC coverage and leverage on available resources, linkages will be established with other stakeholders involved in HIV education and promotion. Print and electronic media messaging will be employed, including individual, small groups and community sensitization in order to create demand for MC services.

Availability of electricity in remote areas of Rukwa is erratic. To overcome this challenge, disposable MC kits will be the preferred option. Additionally, mobile MC units will be procured to improve availability of VMMC services in the region and in the new region of Katavi which was recently curved from Rukwa . Rukwa RMO will strengthen the M&E capacity in the region to ensure availability of quality MC services, monitor performance of available clinicians, and follow up on clients to assess and document complications and compliance (both treatment and preventive measures) through regular support supervision, on-the-job mentorship, and analysis of MC data to document average time for MC in the region as well as for each health facility.

Support to CHMTs will be provided so as to integrate MC services into routine health care services in all districts in the region.   Rukwa RMO has also adopted the web-based JHPIEGO MC reporting system, which should ensure availability of quality data.   For uniformity in data documentation and reporting, available tools will be harmonized.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	680,520	0

Narrative:

Rukwa Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, supporting 165 RCH sites providing supervision to the regional hospital and district level facilities.   Quality PMTCT services in the region are critical given the HIV prevalence of 7.1% among pregnant women.

To improve MCH services in the region, Rukwa RMO will plan and implement decentralized integrated PMTCT services in collaboration with Council Health Management Teams (CHMTs).

Under DoD guidance, a package of standard interventions will be implemented in COP 2012:

1) Improve Emergency Obstetric Care (EmOC) package by: linking services within government and non-governmental health facilities. Provider skills in EmOC will also be strengthened through strategic

on-job training using the national TOT model;
2) Train health care workers at each new site using a “full site” model;
3) Support improvement of the M&E framework (DQAs, integrated supportive supervision using standardized national tools) and BPE to ensure informed program implementation;
4) Support and strengthen provision of integrated services: TB/HIV, ART, Pediatric HIV, FP and Focused Antenatal Care (FANC) services as well as provision of More Efficacious Combination Regimens (MECR) to achieve the goal of putting 95% of all women on MECR prophylaxis in 2012 and 100% by 2013. This will include training MCH care providers in ART and pediatric HIV management according to national guidelines, including supporting EID logistics (transportation of samples and DBS results);
5) Support renovation of selected sites to offer friendly MCH services and provide comprehensive RCH services;
6) Support participation and uptake of PMTCT/RCH services through individual, small groups and community sensitization and provision of PHDP counseling services.
7) Scale-up PMTCT services to ensure that 80% of all women attending ANC receive HTC, 80% of HIV positive women receive MECR prophylaxis;
9) Provide comprehensive PHDP counseling services to PLHIV;
10) Improve HCWs PMTCT knowledge and skills through strategic in-service training, mentorship and supportive supervision;
11) Improve EID services in the region through training of ANC and laboratory staff, DBS collection and logistics and ensure provision of cotrimoxazole prophylaxis to all HIV exposed and infected children;
12) Complement procurement of drugs, reagents, and other essential supplies in case of stock-outs;
13) Promote good infant feeding and nutritional practices during lactation, and promote infant feeding counseling options;
14) Support CHMTs to include PMTCT activities in council health plans and budgets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	513,681	0

Narrative:

Rukwa region has a population of over 1 million people with a prevalence of 4.5%. It is estimated that there are 45,000 HIV positive people in need of services in this region.

Full recruitment of patients in the region started in 2005. By the end of FY2011 the region had a cumulative number of over 14, 698 patients on ART with 2,502 new patients enrolled. Despite the follow-up challenges, the proxy retention rate was 91.5% (APR 2011). Efforts to improve retention include linkages with CBOs to track patients in the community and use of support groups and CHWs for adherence counseling and tracking of patients in their homes.

For COP 2012, Rukwa RMO will implement the following activities:

1) Improve quality of HIV care and treatment services in the region through on-the-job training, mentorship and support supervision;
2) Strengthen service integration (MCH, TB, PITC, and EPI) and linkages as well as referrals to improve availability and accessibility;
3) Work with the RHMTs to strengthen administrative and financial capacity of partners to improve program execution. Additionally, DHMT and facility directors will be assisted to develop and implement facility based-work plans. In addition a contractor will be retained to build RMOs capacity in budgeting and financial reporting. As another region has been curved out of Rukwa (Katavi region), Rukwa RMO, with support from DOD, will support the establishment of administrative, management and physical structures in the new region;
4) Complement procurement of drugs, CD4 machines, reagents and other supplies for patient monitoring when not available through central mechanism; improve pharmacists' capacity in forecasting, stock management, and ordering. Besides improving the quality of care, these measures will also improve lab efficiency;
5) Strengthen prevention for positives counseling among all staff providing treatment at CTC;
6) Continue to provide evaluation for malnutrition and nutritional counseling to all HIV positive clients;
7) Improve M&E system by supporting CQI in CTCs and electronic data capture. To achieve this, high volume sites will be selected strategically and installed with solar power to improve electronic data collection, analysis and reporting. Gaps identified during quarterly performance appraisals will also be incorporated into regional work plans; RHMT and CHMTs in the region will be strengthened for better coordination of Care and Treatment services;
8) Participate in zonal ART meetings with Mbeya Referral Hospital to discuss treatment roll out, identify areas of need, determine solutions and coordinate resolution;
9) Renovate space at selected CTC sites and build efficient and environmentally friendly incinerators at high volume sites to improve service quality and waste management respectively.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	220,022	0

Narrative:

HIV prevalence in Rukwa region is 4.5%, with at least 5,000 children under 15 years of age in need of care and support services. COP 2012 funding will be used to scale-up the quality of pediatric care and treatment services. Rukwa RMO is tasked with coordinating and overseeing the quality of pediatric treatment services in the region, in collaboration with Baylor International Pediatric AIDS Initiative

(BIPAI), based at MRH. These activities will be achieved through support supervision, community mobilization, training, and on-the-job mentorship. Rukwa RMO has a catchment area that includes five districts with a population that exceeds 1 million people.

Rukwa RMO will support provision of quality paediatric care and treatment services in the region including expansion of pediatric PITC, supply of pediatric drugs and commodities, improved supply of diagnostics, adherence counseling, and strengthening linkages and referrals. Adherence counseling and tracking of children lost to follow-up, and linking children to health facilities will be strengthened through CHWs and other community support groups. Infrastructural improvement will be made to address pediatric care and treatment needs.

To strengthened the regional M&E system, data collection tools will be harmonized and data analysis and reporting done. Results will be utilized to inform the program and discussed in zonal technical and national partner meetings

To ensure availability and accessibility of services, paediatric care and treatment services will be integrated into other services such as HBC, OVC, PITC, EPI, PMTCT, TB/HIV to increase child enrollment into care and treatment. The integration of these services leverages national referral system to ensure quality, sustainable care, and support. The USG/T supported activities will continue to be incorporated into the regional health plans through national funding such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Implementing Mechanism Details

Mechanism ID: 7257	**Mechanism Name: RRMO**
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: Ruvuma Regional Medical Office	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,354,491	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,354,491

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Ruvuma Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, providing supervision to the regional hospital and district level facilities. Ruvuma RMO coordinates HIV activities among DOD-supported partners in the region. The program will be rolled equally throughout all five districts. The target populations consist of PLHIV, their partners, and children as well as caretakers of orphans born to HIV-positive mothers. The program areas implemented include PMTCT, care and treatment services for adults and children, and TB/HIV.

Ruvuma RMO region has a population of over 1.3 million people with an HIV prevalence of 5.9%. It is estimated that there are 80,000 HIV positive people in need of care and treatment services in this region.

Ruvuma RMO will continue to strengthen its integrated platform, which closely ties with the USG/T GHI Strategy, where multiple essential health services are provided under one roof. The quality of ART services is also a key priority for both Ruvuma RMO and the Partnership Framework. This requires strong oversight and supervisory visits from facilities to the communities. As such, Ruvuma RMO will procure one vehicle, which is critical for conducting outreach efforts and proper supervision. The vehicle will be allocated to Songea Municipality, but can be accessed by other districts including the RMO office when a need arises.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	7257		
Mechanism Name:	RRMO		
Prime Partner Name:	Ruvuma Regional Medical Office		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	206,512	0

Narrative:

The HIV prevalence in Ruvuma region is 5.4%. Within the facility-based setting, Ruvuma RMO provides care and support services to adult patients infected with HIV and their families in order to extend and optimize the continuum of care.

For COP 2012, the activities include:

• Strengthen regional capability to provide adult care and support services through strategic in-service training, mentorship and supportive supervision to improve HCWs and CHWs skills in adult care and support services;
• Support scale-up of management of OIs including provision of cotrimoxazole prophylaxis;
• Provide palliative care including pain and symptom relief to PLHA;
• Strengthen the provision of comprehensive care and support services including psycho-social, spiritual and bereavement services to PLHA and their families;
• Provide nutritional assessments and support (NACS) to all patient seeking care at CTCs in the region;
• Support linkages and integration of adult care and support services into other services such as ART, OVC, home/community adult care and support, TB/HIV, MCH, EPI, PMTCT and HTC as well as strengthening the referral systems to ensure that patients get appropriate care timely;

• Improve regional M&E system by using harmonized data collection, analysis and reporting tools and discuss and share program performance with outreach adult care and support partners to ensure program coordination among stakeholders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	75,722	0

Narrative:

Ruvuma Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout its region, providing supervision to the regional hospital and district level facilities. Ruvuma RMO will strategically scale-up TB/HIV services in the region.

For COP 2012, the TB/HIV portfolio for Ruvuma RMO will include the following activities:

1) Improve quality and scale-up of TB/HIV services in the region through provision of technical support to districts and high-volume clinics, in-service training and mentorship to HCWs on TB control practices and implementation of the three “I”s;
2) Strengthen laboratory services including sputum smear microscopy and quality assurance for quality TB care services;
3) Strengthen case detection among PLWHAs attending care and treatment clinics through screening;
4) Improve patient referrals and integration of TB/HIV services into other programs e.g. ART, HTC, and PMTCT;
5) Improve district M&E framework by ensuring availability and use of standard National TB/HIV tools, such as screening tools and clinical assessment forms;
6) Support establishment of regional and district TB/HIV coordinating bodies to oversee the implementation of TB/HIV services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	14,681	0

Narrative:

HIV prevalence in Ruvuma region is 5.4%, with at least 3,400 children under 15 years of age in need of care and support within a network of 25 CTCs. All health facilities provide these services. Through DOD support, Ruvuma RMO will assist in the roll-out of pediatric HIV treatment services to strategically selected additional health facilities. For COP 2012, the activities include:

1) Scale-up the provision of cotrimoxazole prophylaxis, infant feeding counseling, nutritional assessments and support, management of OIs, palliative care, psycho-social support, and improve referrals;

2) Strengthen regional capability to provide pediatric care and support services through strategic in-service training, mentorship and support supervision to improve HCWs and CHWs skills in management of pediatric HIV/AIDS;
3) Support linkages and integration of pediatric care and support services into other services such as ART, OVC, HBC, TB/HIV, MCH, EPI, PMTCT and HTC;
4) Improve the regional M&E system through data collection, analysis and reporting, and ensure harmonization of M&E tools as well as program coordination among stakeholders;
5) Improve pediatric care and support infrastructure to provide pediatric friendly services;
6) Strengthen community mobilization, including involvement of adolescents and children in PHDP services and formation of support groups to gain participation and create local ownership.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	720,584	0

Narrative:

Ruvuma Regional Medical Office (RMO) supports the implementation of PMTCT services in the region, supporting 220 RCH sites and providing supervision to the regional hospital and district level facilities. Ruvuma RMO will scale-up and integrate PMTCT with prevention, care, treatment and support services in the region. With an ANC HIV prevalence of 11.3%, quality PMTCT services are critical.

With COP 2012 funding, Ruvuma RMO will implement the following PMTCT activities under the guidance of DOD standard package:

1) Complement Emergency Obstetric Care (EmOC) package by linking with DHMTs and CHMTs to establish EmoC needs and supporting its implementation through a national TOT model in respective districts;
2) Integrate ART and TB/HIV services into PMTCT sites. This will include supporting PMTCT sites to provide ART and More Efficacious Combination Regimens (MECR) by training MCH health care providers in ART and pediatric HIV management, providing guidelines and job aids, and providing CD4, biochemistry, hematology machines;
3) Complement FP and Focused Antenatal Care (FANC) package by linking/liaising with DHMTs and CHMTs to support FP and FANC. Training in FP and FANC will be done in respective districts based on the national TOT model;
4) Procure drugs, reagents, and other essential supplies if not available through central procurement mechanisms;
5) Strengthen and support monitoring and evaluation and BPE, document lessons learned including PMTCT costing studies, and support use of data to assess site specific services and develop a plan of

action to address problems;
6) Improve facility infrastructure through renovations of MCH and labor wards and ensure that they are functional and offer friendly services to mothers and children;
7) Ensure linkage and integration of PMTCT and EID into MCH services to improve identification and linkage of all HIV exposed and infected infants (HEI) into Care, Treatment and Support. This will also ensure that all HEI are initiated on cotrimoxazole prophylaxis as appropriate;
8) Promote infant feeding counseling options (AFASS criteria), linking mothers to safe water programs in the region. For those choosing to breastfeed, the program will counsel them to exclusively breastfeed with early weaning. Infant feeding and nutritional interventions during lactation period will be promoted;
9) Support national efforts to standardize EID logistics (transportation samples and DBS results);
10) Provide PHDP counseling package based on the USG-developed approach in Tanzania; and
11) Improve community sensitization and demand creation to improve participation in PMTCT/RCH services, including encouraging HIV positive women to bring in family members for testing.
12) Continue training and mentoring of HCWs to provide quality PMTCT services according to the new national PMTCT guidelines, including training HCWs at each new site using a “full site” model;
13) Train ANC and laboratory staff in DBS sample collection for early infant diagnosis;
14) Build capacity of regional and district health teams to plan, execute, and monitor PMTCT activities, and support DHMT to include PMTCT activities in council health plans and budget.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,158,015	0

Narrative:

Ruvuma Regional Medical Office (RMO) supports the implementation of prevention, care, and treatment programs throughout the region, providing supervision to the regional hospital and district level facilities. Ruvuma RMO will strategically scale-up HIV/AIDS care and treatment services in the region to an estimated 80,000 PLHIV.

Ruvuma RMO began full recruitment of patients in 2005 and by the end of FY 2011; the region had a cumulative number of over 14,777 patients on ART with 2,589 new patients enrolled. Despite this achievement, loss to follow up has been a major challenge to the program with a proxy retention rate of 69.8% (APR 2011). Efforts to improve retention include linking with CBOs to track patients in the community, use of support groups, CHWs (HBC workers and community-owned resource persons) for adherence counseling, and tracking of patients in their homes.

For COP 2012, the following activities will be performed:

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

1) Strategically scale up quality care and treatment services in the region, including improvement of physical infrastructure through renovation of CTC facilities, strategic on-job training, support supervision and mentorship;
2) Complement procurement of drugs, commodities, CD4 machines, other lab equipment and supplies to ensure timely initiation into treatment, improve lab efficiency as well as quality of care, treatment and support;
3) Improve patient record and data collection while working with DOD, DHMT, and facility staff to analyze data to improve service quality. To achieve this, high volume sites will be identified and solar power installed to ensure regular power supply for electronic data recording, storage and reporting. This will also improve laboratory efficiency. Gaps identified during quarterly performance appraisals will be incorporated into regional work plans.
4) Work with the DHMT and facility directors in developing and implementing facility-based work plans;
5) Strengthen PHDP counseling among all staff providing treatment at CTCs and linkage of PLHA to available support mechanisms;
6) Continue supporting linkages and service integration focused on special groups (girls, women, and children) and improved referrals, programs and services such as MCH, TB, EPI, and PITC;
7) Strengthen administrative and financial management capacity to improve execution. Specifically, work with facility pharmacists to improve capacity in forecasting and stock management. In addition a contractor will be retained to build RMOs capacity in budgeting and financial reporting.
8) Continue to provide evaluation for malnutrition and nutritional counseling to all PLHIV clients;
9) For better infection prevention and control, improve waste management at high-volume facilities including provision of efficient and environmentally friendly incinerators;

Ruvuma RMO will also participate in zonal ART meetings with Mbeya Referral Hospital to discuss treatment roll-out, identify areas of need, determine solutions, and coordinate resolutions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	178,977	0

Narrative:

HIV prevalence in Ruvuma region is 5.4%, with at least 3,400 children under 15 years of age in need of care and support within a network of 24 CTCs. COP 2012 funding will be used to scale-up the quality of pediatric care and treatment services. Ruvuma RMO is tasked with coordinating and overseeing the quality of pediatric treatment services in the region, in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI), based at MRH. These activities will be achieved through support supervision, community mobilization, training and on-the-job mentorship. Ruvuma RMO has a catchment area that includes five districts with a population of over 1.3 million people.

COP 2012 funding intends to reach 499 children, with a plan to roll out care and treatment services to 32 additional health facilities, bringing the total number of facilities to 60. Planned activities for COP 2012: 1) Provide quality pediatric care and treatment services through strategic on-the-job training, mentorship and support supervision to HCWs, improved pediatric PITC, procurement and logistics fo+B39r diagnostics and pharmaceutical supplies, and infrastructural improvement to specifically address pediatric needs 2) Integrate pediatric HIV care and treatment services into other services (HBC, OVC, PITC, EPI, TB/HIV, RCH and PMTCT); 3) Provide comprehensive adherence counseling by HCWs, CHWs and support groups; 4) Strengthen linkages and referrals between pediatric care and treatment programs to improve child enrollment; 5) Improve M&E system through use harmonized data collection and reporting tools, analysis and use of data to inform the program and tracking of children lost to follow-up. Targets will be monitored and discussed during zonal technical meetings and national partner meetings. Pediatric care and treatment services at Ruvuma RMO are integrated into existing health systems and services. The integration of these services leverages national referral system to ensure quality, sustainable care, and support. The USG/T supported activities will continue to be incorporated into the regional health plans through national funding such as central funding through MOHSW budget, basket funding, and cost sharing mechanisms.

Implementing Mechanism Details

Mechanism ID: 7287	**Mechanism Name: SolarAid - PPP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: SolarAid	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

There is a serious energy crisis in Tanzania as only one-quarter of the country, mainly the urban areas, is connected to the national electricity grid. Due to low water levels in the hydro dams, blackouts and power rationing are frequent and has forced the Tanzania National Electrical Supply Company (TANESCO) to rely on gas powered generators and other sources of power. About 80% of the population lives in the rural areas where energy requirements are mostly met by wood fuel, resulting in deforestation. The URT is encouraging investments that will expand electrical generating capacity. The lack of electricity capacity has a direct impact on health provision at rural hospitals and clinics. Electronic power is usually required for lighting facilities during evening hours, to maintain cold storage for vaccines, blood, and other medical supplies, to power basic lab equipment and computers for health records management, to support limited minor surgical procedures, and to recharge mobile phones so that medical professionals are able to consult with their counterparts in urban and peri-urban areas. The importance of electricity for simply maintaining communications with patients is a critical and often an overlooked aspect in healthcare.

In accordance with the first Intermediate Result of the GHI strategy, this activity will contribute to the USG/T and the URT's system strengthening goal of increasing access to quality maternal and child health services. More reliable electrical power will ensure that all essential health services are provided more efficiently and promptly to rural populations. This activity will promote micro-solar systems among vulnerable households.

This program will be implemented in selected sites in Iringa and Mbeya

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	7287		
Mechanism Name:	SolarAid - PPP		
Prime Partner Name:	SolarAid		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

This TBD is a public-private partnership (PPP) activity with SolarAID/Tanzania. SolarAID provides solar power to rural health facilities (especially maternity wards, labs, theatres) and staff houses, which contributes to staff retention. This activity also creates income-earning activities for groups supporting PLHIV and microenterprises for youth who sell solar portable lights to their communities.

SolarAID will use these funds to implement various activities, such as matching the procurement and installation of solar energy systems to 20 rural health facilities with 800 watt systems, 50 rural health facilities with 15-100 watt solar systems, and subsidize solar household systems for rural health professions to improve lighting, diagnostic testing, storage of medicines, and communication and data management systems. The funds will also be used to promote the micro-solar income generation activities, particular for vulnerable families and youth with a reach of up to 5,000 rural households utilizing small solar systems.

Training of local individuals who live in proximity to the selected solar system sites will be supported. Individuals will be trained to conduct local maintenance and monitor the functioning of installed systems, which will extend the longevity of the functioning of the system and reduce long-term up-keep costs. In addition, maintenance of the solar energy systems will be included into districts plans through specific memorandums of understanding (MoUs) with selected district councils. A communication strategy will be developed for solar systems and alternative energy sources in Tanzania to support rural health facilities that are off grid. The communication strategy is intended to leverage other donors and private sector investments to consider alternative energy solutions that will benefit rural health facilities and contribute to the system strengthening goals of the GHI strategy. There are no PEPFAR next generation indicators (NGI) for this activity, although there are other indicators against which SolarAid must report progress.

Implementing Mechanism Details

Mechanism ID: 7629	**Mechanism Name: Warehouse Construction**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: AME-TAN Construction	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,550,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,550,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Pharmaceutical and health commodities security in Tanzania is directly affected by the supply chain infrastructure capabilities. Being able to quickly develop and implement new warehouse projects in critical distribution sites throughout the country is necessary for stable commodities supply. In addition

adequate professional pharmaceutical management at facilities by trained professionals is also critical to ensure appropriate and rational use of medicines as supported in the PEPFAR and GHI goals.

These funds will be used to develop pre-fabricated structural warehouse and storage unit deployment at sites identified by URT Medical Stores Department (MSD), USAID, and Coca-Cola's 'last mile' project. In addition funds will be used to rapidly procure, deploy and assemble ISO certified pre-fabricated insulated structural panel clinics and staff housing for remote areas to promote the scale up of the MTCT program. In some instances, when appropriate and necessary, other approved building material such as concrete may be used. Selection of sites is on going based on rapid scale up decisions made within the MTCT program. This construction method has been shown to be more cost effective than traditional concrete construction allowing for increased infrastructure support. Currently, USAID is working with local organization to provide the construction and assemble support for the pre-fabricated panels. USAID is also working with a host country private sector company that has begun manufacturing pre-fabricated insulated panels in country, which will reduce the cost to the program even further. Each project is managed by a USAID activities manager, however, for large scale projects a project manager and local engineer provides additional oversight.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	1,550,000
Education	400,000
Human Resources for Health	400,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources

Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	7629		
Mechanism Name:	Warehouse Construction		
Prime Partner Name:	AME-TAN Construction		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	1,150,000	0
Narrative:			
Pharmaceutical and health commodities security in Tanzania is directly affected by the supply chain infrastructure capabilities. Being able to quickly develop and implement new warehouse projects in critical distribution sites throughout the country is necessary for stable commodities supply. These funds will be used to rapidly procure, deploy, and assemble ISO certified pre-fabricated insulated structural steel and panel warehouse and storage units at sites identified by URT Medical Stores Department (MSD), USAID, and the Coca-Cola “Last Mile” project in support of PEPFAR and GHI goals. This construction method has been shown to be more cost effective than tradition concrete construction, allowing for increased infrastructure support.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	400,000	0
Narrative:			
Adequate professional pharmaceutical management at facilities by trained professionals within adequate facilities is critical to ensure appropriate and rational use of medicines in support of PEPFAR and GHI goals. These funds will be used to rapidly procure, deploy, and assemble ISO certified pre-fabricated insulated structural panel storage units. Clinics and staff housing for remote areas and pre-service dormitory space will help to promote the scale up of the MTCT program. Selection of sites is on going based on rapid scale up decisions made within the MTCT program.			

Implementing Mechanism Details

Mechanism ID: 9453	Mechanism Name: MAISHA
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,404,438	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	3,404,438

Sub Partner Name(s)

D-Tree International		

Overview Narrative

MAISHA's goal is to build local and national human and material capacity to reduce maternal and newborn mortality and decrease the transmission of HIV from mother to child.

MAISHA and its partners collaborate with MOHSW on a national scale to achieve the national targets for MDGs Four and Five. MAISHA aligns with Tanzania's national health policies and strategies and USG's GHI initiative by building strong integrated service delivery platforms for key maternal and newborn health (MNH) interventions, contributing to building a sustainable health system, and leveraging other funds and efforts to increase the project's over-all impact.

MAISHA will assist MOHSW to strengthen the basic emergency obstetric and newborn care (BEmONC) and focused antenatal care (FANC) platforms through developing national and local resources for BEmONC and FANC, while advocating and coordinating with DHMTs and other key stakeholders to ensure funding is allocated for supporting quality service delivery. MAISHA is strengthening the PMTCT platform to address gaps in integrating MNH services for HIV positive women and children through a number of interventions, including establishment of cervical cancer prevention, improved postnatal care, and improving community health workers services. By working directly to provide technical assistance to PMTCT partners, MAISHA will continue to build capacity of the local communities to the national level.

MAISHA also supports national infection prevention efforts as well as improvements in the quality of pre-service nursing/midwifery and medical education.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	50,000
Human Resources for Health	1,700,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**9453**		
Mechanism Name:	**MAISHA**		
Prime Partner Name:	**JHPIEGO**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0
Narrative:			
With FY 2011 funds, MAISHA is supporting MOHSW to review its overall community health strategy.			

Efforts to help determine the overall SOW for the national CHW that MOHSW hopes to produce in line with the MMAM is also being conducted. It is anticipated that this SOW will build upon the existing integrated MNCH community guidelines and add elements that will optimize the quality of life for patients, such as providing community home-based care for people living with HIV. Once strategies and policies are confirmed, FY 2012 funding will be used to complement and expand the PMTCT funded CHW component of the integrated PMTCT facility/community program in Morogoro and Iringa. Integration of selected home-based care services into the messaging and services provided by MAISHA-supported CHWs will also be targeted within these communities. This funding will enable existing CHWs to be trained in the new HBC components, while also supporting more CHWs to receiving the comprehensive training package (integrated MNCH and HBC).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	600,000	0

Narrative:

The lack of standardization in pre-service training, particularly in the areas of performance and learning assessments, curriculum development, and training packages in medical schools undermines Tanzania's ability to train qualified health professionals to handle the management and technical challenges of the health system.

MAISHA's program will work with the medical schools to address issues of standardization by instituting a quality improvement approach, enabling faculty to conduct regular qualitative self-assessments that will help determine the level of standard educational practices being provided, including highlighting any gaps and other issues that may exist. Capacity building efforts of faculty members to improve their skills in designing, developing, implementing, and monitoring the processes and test items for student assessments will continue to be a focus. Following up on last year's workshops that were conducted, complimentary materials will be incorporated into FY 2012's workshops to further expand the faculty members' knowledge and build upon previously acquired skills. The MAISHA Program and the Tanzanian medical schools together will develop standardized HIV-related content to become integrated into the medical schools curriculum. The institutionalization and strengthening of the skills labs developed in previous years, along with supporting the implementation of the nationally approved skills lab coordination training package will help to ensure the proper use and maintenance of the equipment. Limited support will be made available to the Medical Association of Tanzania with the goal of strengthening the association's capacity.

Implementing the strategy of GHI, various funding sources will be leveraged through GHCS, the

President's Malaria Initiative, along with PEPFAR funding, in order to coordinate the efforts of working with all nursing schools in Tanzania. Specific technical areas, such as BEmONC, FANC, interpersonal communications, and IPC, will be developed to compliment one another in the nursing/midwifery pre-service education, thereby building the technical knowledge and teaching skills of educators in strengthening the overall nursing education. Specifically with PEPFAR funding, the MAISHA program will continue to bolster the quality of nursing education using a continuous quality improvement approach that has been adopted nationally for all cadres. In consultation with MOHSW, skills labs that were established last year will be strengthened with the possibility of developing more skills labs at additional schools.

In order to increase the project's impact, MAISHA will work in a consortium with other organizations to implement health systems strengthening and quality improvement work. Activities will take place in schools within MAISHA's designated zones (Lake, Eastern, and Southern).

Development of a national CHW program will continue with the MOHSW to further a sustainable health system. Much of the work will center around defining job descriptions, contributing to MNCH component of curriculum and job aids, and strategies for development of trainers and supervisors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	320,117	0

Narrative:

With FY 2012 funding, the MAISHA program will continue to support the MOHSW's efforts to increase the skills and knowledge of healthcare providers and managers in infection prevention control (IPC). In addition, assuring quality improvement of IPC practices to help prevent medical transmission of HIV at health facilities is another key priority. Focus facilities include the six hospitals affiliated with Tanzania's medical schools, as well as health centers and dispensaries currently being supported under MAISHA for quality BEmONC and FANC service delivery.

Conducting quarterly self-monitoring assessments will be a main component of institutionalizing the development of quality improvement teams at each medical school hospital. These assessments will be critical to supporting the facilities' ability to use pertinent information that will help develop specific action plans to address current and emerging gaps within each facility. External assessments will also be conducted, giving the MOHSW visibility to the gradual improvements made, thereby allowing for recognition to be made to the highest performing facilities.

At the MAISHA targeted facilities, HMIN funds will be used to support renovation of incinerators and

establishment of placenta pits.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,284,321	0

Narrative:

MAISHA will continue to support integrated PMTCT facility/community programs in Morogoro, Iringa, Lindi, Mtwara, Arusha and Kilimanjaro while scaling up in up to two additional regions where the MAISHA program is more mature. This program focuses on establishing postnatal care at health facilities where FANC and BEmONC services are being strengthened by MAISHA. This activity adds a CHW aspect to facilitate facility/community linkages to address missed opportunities, particularly focusing on HIV positive women. In Morogoro, Iringa, Lindi, and Mtwara, MAISHA will continue to support existing programs. In the two new regions, new components will be introduced to RHMTs and DHMTs, and MAISHA will work with facilities and their associated communities for strengthened BEmONC and FANC. Jhpiego will continue its partnership with D-Tree to incorporate mobile phone technology at both facility and community level, ensuring standardization and quality of care, as well as to support facility/community linkages.

Initiation and scaling of BEmONC and FANC will continue to require TA to regional PMTCT partners. To support these efforts, MAISHA will help to conduct assessments at sites identified by the RHMT for strengthening, conduct supportive supervision visits to assess quality of FANC, BEmONC, Post-natal care/Post-partum family planning, and CECAP services, as well as support data collection. MAISHA will also provide guidance on procurement of equipment and supplies as identified through assessments and supervision visits.

Since FY 2010, MAISHA has also been providing TA to MOHSW to implement national and regional cervical cancer prevention activities. MAISHA aims to continue building local capacity for the implementation of prevention efforts by continuing support for cervical cancer screening activities in Morogoro and Iringa regions; in consultation with the MOHSW, possibly expanding to additional sites within the Morogoro and Iringa regions; increasing community awareness and demand for screening services; strengthening referral services; and providing TA to regional PMTCT partners for initiation and scale-up of cervical cancer prevention services in their respective regions.

Women who access HIV services, such as ART and PMTCT, will continue to be offered cervical cancer screening services in addition to being linked to other appropriate services, such as HIV prevention, care, treatment, and support services. Orientations on cervical cancer prevention will be provided for all CTC providers, increasing awareness and encouraging CTC providers to refer all women to be screened. In

an effort to implement MOHSW national PITC efforts, women who present directly at the RCH clinic for cervical cancer screenings who have not yet been tested for HIV will be tested for HIV as part of the over-all screening process. Monitoring systems have been developed and implemented to assure the quality of cervical cancer prevention services. The project will continue to place a large emphasis on the collection and use of service delivery data. A M&E workshop will be held for trained providers, focused on strengthening their capacity to collect accurate and complete data. Ongoing discussions with MOHSW will continue in an effort to ensure reports on specific indicators are shared on a routine basis. Service delivery data will also be shared quarterly with USAID and used for program monitoring and re-direction, as necessary.

Implementing Mechanism Details

Mechanism ID: 9455	**Mechanism Name: MOHSW**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 751,943	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	751,943

Sub Partner Name(s)

JHPIEGO	University of Washington	

Overview Narrative

COP 2012 funds will be going to support multiple programs of the Ministry of Health and Social Welfare (MOHSW), all of which contribute to health systems strengthening specifically in the areas of human resources and strategic information, respectively Goals 5 and 6 of the Partnership Framework. Working closely with government employees and structures, this mechanism seeks to build up local talent and

systems

The goal of Field Epidemiology and Laboratory Training Program (FELTP) is to strengthen capacity of public health workforce in Tanzania to collect and use surveillance data and manage programs including national HIV/AIDS/TB/Malaria and strengthen laboratory support for surveillance, diagnosis, treatment, and HIV screening for blood safety. Activities cover all of Tanzania and target in-service health professionals. Local staff will be recruited to keep personnel costs down. This program maintains a close partnership with the MOHSW who leads biannual steering committee. Monitoring and evaluation takes place through the EPITRACK software.

The goal of Health Management Information System (HMIS) program is to improve and strengthen HMIS and information usage at all levels of healthcare delivery system. HMIS monitoring indicators are used to monitor progress and achievements.

The goal of the Infection Prevention and Control - Injection Safety Program (IPC-IS) is to prevent infection transmission through exposure to blood and other body fluids and other infections in healthcare services provision settings. The program covers 32 council health management teams from six regions to ensure sustainability, monitored primarily through supportive supervision.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	126,943

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Malaria (PMI)

Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	9455		
Mechanism Name:	MOHSW		
Prime Partner Name:	Ministry of Health and Social Welfare, Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	225,000	0

Narrative:

MOHSW M&E section, along with the HMIS section in particular, is working together to strengthen the national health monitoring and evaluation systems and processes to improve evidence based decision making across the sector. The HIV program in Tanzania, the work of all PEPFAR partners, and their combined ability to evaluate and monitor the effective implementation of programs is dependent on a strong national M&E system for the health sector.

To coordinate a wide range of investments, MOHSW has created an M&E Strengthening Initiative. This initiative brings together a wide range of funding and implementing partners under the leadership of MOHSW to strengthen M&E within the sector. This initiative includes substantial inputs from Global Fund, the Netherlands, and PEPFAR through CDC.

Other PEPFAR partners also contribute to this initiative. Research Triangle Institute (RTI) is contributing technical assistance to MOHSW, which will help improve MOHSW's ability to implement the activities described in the initiative. CDC Foundation is working closely with MOHSW under the M&E Strengthening Initiative to leverage m-health potential to improve the M&E systems in Tanzania. NIMR GIS/WAN activities and IHI SAVVY activities also support the M&E Strengthening Initiative.

The HVSI activities implemented within this mechanism support goal number 5 of the Tanzania PEPFAR five-year implementation framework. More specifically, the PEPFAR funding will support the MOHSW

capacity to coordinate and manage the M&E TWG, the P4H project, the NIMR GIS and master facility list, the data warehouse technical support, SAVVY, and the National Sentinel Surveillance System.

In FY 2012, MOHSW HMIS team will make use of the PEPFAR funds to support the following deliverables and milestones:
(1) $75,000 to be programmed by the MOHSW ICT team to procure equipment and support the expansion of ICT services in regional hospitals. This includes the initiation of internet connectivity, capacity building, and creation of local area networks for regional hospitals. This funding is a continuation of the activities that were previously implemented through NIMR;
(2) $110,000 for the MOHSW HMIS team to coordinate and manage M&E TWG, m-health project, SAVVY, and the National M&E Strengthening Initiative, while building the management and coordination capacity within MOHSW M&E team to manage a wide range of priorities and objectives; and
(3) $40, 000 will be allocated for activities to be implemented by both the MOHSW epidemiology and disease control section and the HMIS section to expand the use of the IDSR system, prepare routine data dissemination products with information from the IDSR system, and initiate steps towards transition of ownership, management, and sustaining costs associated with the IDSR system to the MOHSW.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	126,943	0

Narrative:

Tanzania is faced with the challenge of inadequate human resources for health services. The lack of adequately trained personnel is often the most significant rate-limiting step in providing quality health and clinical services. MOHSW has also identified a need at the national, regional, and district levels to develop a cadre of competent field epidemiologists and public health laboratory managers and technologists who will help to strengthen surveillance and the public health response of priority communicable diseases, especially HIV/AIDS. To address this need, MOHSW established a short course on Field Epidemiology and Laboratory Training Program (FELTP) in Tanzania which complements the FELTP two year graduate course that strengthens integrated disease surveillance systems (IDSR) in Tanzania.

The two week short course has been a very successful program, which allows for a three month field study of participants in their working places after the course. Over the last two years, the FELTP short course, has successfully built the capacity of the ministry health personnel in areas of epidemiology, biostatics, disease surveillance, TB, HIV, M&E, quality assurance, and outbreak management. In addition, it has strengthened the capacity of regions and districts to respond to public health

emergencies, such as outbreaks, natural disasters, and other unusual public health events, including those that could be a result of chemical or biological pollution. A number of health personnel (clinicians, laboratory technologists, and health officers) from various districts have also been trained.

In FY 2012, the program will continue to conduct short courses for selected health personnel from the districts who are not covered by the graduate course in areas of epidemiology, biostatistics, disease surveillance, TB, HIV, M&E, quality assurance, and outbreak management. The focus will also be implementation of the newly developed five-year strategic plan for short courses, which has been finalized in FY 2011. This will include improving quality of the supervision to trained cohorts while continuing to strengthen linkages with the graduate course and other various departments within MOHSW as a way to promote sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	400,000	0

Narrative:

The goal and objectives of the IPC program is to prevent transmission of HIV and other blood borne pathogens through exposure of blood and other body fluids as well as other infections. The key program objectives include capacity building of Regional Health Management Teams (RHMT), Council Health Management Teams (CHMT), Health Management Teams (HMT), and Quality Improvement Teams (QIT) to implement policy guidelines and standards for Infection Prevention and Control – Injection safety (IPC-IS); Train health care workers (HCWs) who are involved in phlebotomy activities; improve and strengthening quality assurance and quality improvement (QA/QI) activities; ensure the availability of commodities and supplies; advocate for IPC-IS program support with key stakeholders; promote HCWs safety in all public and private health facilities; and ensure safe and appropriate health care waste management (HCWM) and sharps management in all health care settings.

For COP 2012, the Ministry of Health (MoHSW) in collaboration with other Implementing partners in IPC-IS will develop and disseminate IPC related policies, guidelines, standards and packages at national level (including PEP, HCWM and safe phlebotomy as content areas). The coverage and scope of capacity building activities for COP 2012 will focus on strengthening a total of 32 health management teams in six regions of Tanzania Mainland. These teams will include RHMTs and CHMTs, as well as QITs. The plan is to ensure that all facilities have a functional QIT that will coordinate IPC-IS issues as well. MOHSW will put more emphasis on integration of all programs that have quality components.

The MOHSW, will support HCWM systems at selected health facilities with high volume of HIV patients enrolled in HIV care and treatment services, including PMTCT, HTC and MC. In collaboration with

partners the MOHSW will facilitate the development of a recognition mechanism/plan for high scoring/achieving facilities through a formal system of recognition for facilities that achieve at least 80% of standards. This is a critical element in order to sustain motivation and maintain the QI process at the facilities. The HSIU will continue strengthening the PEP M&E system in collaboration with the HMIS unit. The emphasis will be to create a reporting system for PEP and other health care associated infections from facilities to the national level. The program will provide technical assistance to RHMTs and CHMTs for effective supervision of IPC-IS and HCWM activities at facility levels. In order to ensure the availability of the commodities and supplies for IPC-IS, the MOHSW will establish the technical working group (TWG) comprised of HSIU, Tanzania Food and Drug Authority (TFDA), Medical Stores Department (MSD), PSU, and environmental health unit. The TWG will work to support the systems and logistic for procurement and supply. The MOHSW, will focus on integrating IPC-IS trainings into the existing pre-service training curriculum for health training institutions and advocate for inclusion of IPC-IS activities in Medium Term Expenditure Framework (MTEF), regional health plans (RHP), and the Comprehensive Council Health Plans (CCHP) to ensure sustainability.

Implementing Mechanism Details

Mechanism ID: 9595	**Mechanism Name: NIMR**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Institute for Medical Research	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 33,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	33,000

Sub Partner Name(s)

Rungwe District Council		

Overview Narrative

Several activities will be carried out through the different sub-programs. The HRH sub-program will continue to implement operations research on HRH, disseminate findings, and advocate for utilization of research findings at all levels. In addition, the HRH sub-program will continue training and providing technical support to CHMTs on proposal development, execution of research activities on approved proposals, and producing an HRH bi-annual newsletter. The sub-program will also provide orientation for reviewers who evaluate research protocols with participation in MOHSW activities.

The GIS sub-program will continue to improve the national health facility GIS database and update the national health facility master list, which will be a collaborative activity with MOHSW and other PEPFAR partners. The database will be expanded to accommodate prioritized location-based health information. In addition, the sub-program will improve accessibility of the collected information through utilization of various web technologies.

WAN sub-program will continue establishing connectivity for new sites while providing technical support to sites. The support will ensure that all sites are connected to MOHSW HQ by utilizing fibre optic cable or other means of communication. Security reinforcement of servers at MOHSW and to sites will be addressed.

During FY 2012, HLAB sub-program will improve quality of laboratory services offered. Areas of interest will include office maintenance and communication, in addition to laboratory fixtures and fittings to address preventive maintenance services.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	33,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

<table>
<tr><th>Mechanism ID:</th><th colspan="3">9595</th></tr>
<tr><th>Mechanism Name:</th><th colspan="3">NIMR</th></tr>
<tr><th>Prime Partner Name:</th><th colspan="3">National Institute for Medical Research</th></tr>
<tr><th>Strategic Area</th><th>Budget Code</th><th>Planned Amount</th><th>On Hold Amount</th></tr>
<tr><td>Governance and Systems</td><td>HLAB</td><td>0</td><td>0</td></tr>
<tr><td colspan="4">Narrative:</td></tr>
<tr><td colspan="4">The National Health Laboratory Quality Assurance and Training center (NHLQATC) is the national premier reference laboratory with the overall responsibility for oversight, coordination, and training on laboratory quality systems for both public and private health laboratory services. It also serves as the HIV reference laboratory, health laboratory resource center, and disease surveillance and response center in the country. The goal of this support is to ensure that the NHLQATC working environment is conducive for optimum performance of its core functions.

With FY 2012 funds, NIMR will pay maintenance of the physical infrastructure and all daily NHLQATC running expenses, including contract cleaning, fuel for the backup generator, servicing of air-conditions/chillers, cold rooms, water, servicing of the elevators, and minor repair work.

The training component of the NHLQATC is currently lacking sufficient classroom capacity to accommodate larger groups of trainees, including relevant training tools. FY 2012 funds will continue to identify and improve training rooms in the NIMR building through renovation and purchasing of training tools.

Selection of suitable service providers will be through a transparent and open system, as per URT procurement rules and regulations.</td></tr>
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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	10,000	0

Narrative:

Geographical Information System (GIS) is proficiently used to document geographic disparities and inform policy and program development; thereby contributing in a powerful way to the prevention and management of diseases. NIMR, on behalf of MOHSW, has established a comprehensive health facility list that includes all facilities ranging from dispensaries to hospitals in Tanzania.

NIMR will help MOHSW develop standards for establishing the master facility database, which is compatible with other MOHSW HMIS systems. In collaboration with MOHSW M&E Unit, NIMR will continue updating the master facility list as well as develop an efficient process for continual updates to the master facility database. NIMR will integrate the master facility list with MOHSW online health facility registry system, allowing for easy access by MOHSW personnel and all other stakeholders.

NIMR will establish mechanisms to monitor the update process of the master facility. Random visits will be made to various district facilities to compare any changes that may have been done by district personnel.

Working with MOHSW m-health project to introduce GIS into IDSR systems, NIMR will help map areas where disease outbreaks occur. Information can then be used to analyze disease patterns and help control and eradicate outbreaks which are caused by environmental or climate changes.

NIMR will continue to assist MOHSW and other programs (NTLP, NACP, NMCP, and the National Vaccine Program) on basic GIS training, spatial data analysis, and integration of GIS as part of the data these organizations use when they do their service planning as well as when making various decisions based on evidence. NIMR will also help to advocate for the use of the already established master facility list as a common list to be used by MOHSW as well as various vertical health programs.

This mechanism will continue to support MOHSW ICT efforts by providing technical assistance to existing regional sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	23,000	0

Narrative:
A strong workforce in the health sector is a critical component in carrying out various health related interventions. While the need for increasing the size of the health workforce is generally well recognized in the country due to alarming shortages, issues regarding health workers performances and productivities, and lack of skilled management currently is receiving attention as key issues in human resources for health (HRH). Thus, improvements in HRH require policies that are informed by evidence-based research about Tanzania's unique problems and issues. Therefore, capacity building in research for HRH and HIV/AIDS including evaluations is inevitable. The findings from research and evaluations provide key inputs in system improvements and policies related to HRH. National Institute of Medical Research (NIMR) has played a critical role in supporting MOHSW to address the human resource crisis through finding evidence by conducting operational research and evaluations related to HRH. The institute has also notable inputs in the improvement of health systems through CHMT trainings in basic skills for operations research that have been conducted for the past two years. Being part of the MOHSW under the Policy and Planning Department, NIMR is in a key position to advocate for major policy decisions based on the results of their evaluations. As a member of the HRH working group of the MOHSW, NIMR is strategically placed to give input, advocate, and advise MOHSW on changes in HRH policies and health systems. In FY 2012, NIMR will continue to carry out operational research with a greater emphasis on capacity building of the CHMTs at district levels to decentralize the research. NIMR will collaborate with TACAIDS, MUHAS, and Global Fund while benefiting from a technical support from Research Triangle Institute (RTI) to complete standardized materials for the training of CHMTs in operational research. NIMR will work closely with RTI to continue building capacity of its institution to be able to conduct quality research. Through this capacity building component, NIMR will have the necessary skills to sustain activities in the future. NIMR will also continue to develop HRH operations research and evaluation protocols in FY 2012, which will be submitted to the Tanzania Ethics Review Committee (NatREC) and CDC headquarters for IRB approvals and implementation in FY 2013. As a follow up to previous work, NIMR will disseminate findings of the task shifting study of health workers in health facilities. Results from this activity will be translated into policy changes for improving HRH in Tanzania. In addition, NIMR will continue to disseminate information and build health workers' capacity through production of the quarterly NIMR HRH newsletter and through membership of the MOHSW HRH working group.

Implementing Mechanism Details

Mechanism ID: 9597	Mechanism Name: Capacity Project
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,820,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	3,820,000

Sub Partner Name(s)

Aga Khan Foundation	Christian Social Services Commission	Interchurch Medical Assistance
Management Sciences for Health	Training Resources Group	University of Dar es Salaam, University Computing Center

Overview Narrative

The Tanzania Human Resource Capacity Project (THRP) is designed to address the current challenges that Tanzania faces in developing an adequate health and social welfare (SW) workforce within a complex system of public and private professional and paraprofessional cadres. Specific objectives are to assist the MOHSW and PMO-RALG to orchestrate the implementation of the HRH Strategy and the HR components of the HSSP III; strengthen the capacity of national and local government to predict, plan for, and recruit a workforce; improve its deployment, utilization, management, and retention; and increase its productivity.

Working through a local consortium, the THRP contributes to objectives two and three of the HRH goal of the PF; it also contributes to objective two of the first goal by developing a community-based para-social worker to provide essential psycho-social support and referral services for MVCs.

The program prioritizes capacity building of local partners, such as Mkapa Foundation and Christian Social Services Commission who co-lead the project, with particular focus on management systems and

leadership. It will support the University of Dar es Salaam/Computer Sciences Department in establishing an open source LGHRIS resource center to produce more graduates with the technical skills and systems to understanding how to best sustain the national HRIS.

The THRP will lead an assessment of the SW workforce to provide essential information for the development of a national SW workforce strategy. Continuous data quality audits will be conducted to test and validate data in the public and private national HRIS. BMAF will assess work climate/productivity, including a gender discrimination module, in select districts to determine interventions and best practices.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	BMAF	1000000	--Strengthen BMAF ability to plan and manage organizational growth meeting multiple donor expectations; strengthening leadership and systems for planning, program impementation and reporting to meet project goals and reporting expectations of both USAID

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	200,000
Human Resources for Health	3,500,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	9597		
Mechanism Name:	Capacity Project		
Prime Partner Name:	IntraHealth International, Inc		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	320,000	0

Narrative:

The MOHSW Department of Social Welfare (DSW) is mandated to oversee the OVC and other vulnerable populations in Tanzania. As in other countries, the social welfare workforce (SWW) is weakened by unclear or overlapping mandates, little resource allocation, unclear or conflicting policy and programmatic mandates, little availability of quality training, education, and supporting systems. The THRP MVC program will address the acute shortage of social welfare staff in two ways. At the central level, the program will coordinate across several ministries and developing partners (including UNICEF) to conduct an assessment of the SWW, providing detail of the gap between expectations as stated in numerous key national policies (such as the Law of the Child Act, 2009) and the reality of SW services on the ground. It will use the information to guide development of a national human resource strategy for social welfare, while advocate for increasing the professionalism and the quality of education and training of the SWW.

The THRP is working in partnership with the Institute of Social Welfare to provide a medium-term solution to the gap in SW services at community levels. It will expand the geographic coverage of para-social workers (PSW) to provide psychosocial support services, family support and early intervention, and links

to child protection services to address abuse, neglect, and increasingly documented violence against children. The THRP will train up to a 1,000 village-level para-social workers and PSW supervisors in Mtwara Region. The project will work with other USG-designated MVC implementing partners to roll out this training in select districts of Tabora, Mara, Singida, and Kilimanjaro regions. Updates of up to 900 PSWs and their supervisors in Iringa will follow the period of field practicum.

Concurrent with PSW training, the THRP aims to strengthen the existing local government infrastructure to connect village level need to ward and district level support for PSWs and MVCs, as evidenced by budget support in annual district plans, proactive supervision to the village, and routine collection and use of service data. The program is strengthening the government system to track SW services and referrals provided by PSWs and their supervisors, as well as increasing the commitment shown by local government authorities (LGAs) in the annual budget cycle and community initiatives in support of MVC. To further establish itself as a functioning civil society organization, the project will support the fledgling network of PSWs and PASONET. Understanding the challenges of motivating volunteer PSWs, the THRP will gauge commitment by selecting a number of LGAs to cost share bicycle distributions to PSWs in the district (most likely hard-to reach rural villages with enthusiastic PSWs).

Still considered a pilot program, the THRP/MVC program will disseminate findings, best practices, success stories, and lessons learned from routine monitoring and advocacy efforts by coordinating annual dissemination meetings to further enhance LGA ownership of the program and commitment to providing SW services to its vulnerable populations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	3,500,000	0

Narrative:

The THRP supports USG's efforts to address the human resource (HR) crisis of a 65% shortage in health positions across Tanzania. It also addresses the challenge of limited health worker data; data that is frequently out-of-date, inaccurate, and rarely used for health workforce planning or decisions. Program implementation is through a consortium of local partners that work through the existing government structures and systems to enhance country ownership and the potential for sustainability.

As program co-lead, the Mkapa Foundation (BMAF) leads advocacy and communications efforts with MOHSW. It will support the MOHSW in transforming the current HRH working group and strategic objective teams into a highly functioning Secretariat. BMAF will lead the planning for a technical review meeting dedicated to the national HRH agenda in conjunction with the JAHSR policy discussions. It will

also assist final revisions of the national staffing norms with international technical assistance.

USG focus continues to be the implementation of a revised HRM district strengthening program through an intense period of coaching and mentoring, extending coverage from 20 districts to 54. BMAF will enhance the knowledge and use of HRH evidence to improve district HRH interventions, build the capacity of district officials, and integrate HRH interventions into the existing district guidelines and plans. The expected outcome from the implementation of these activities is improved district and regional HRM practices, which will in turn reduce vacancy rates. The approach, tools, and materials provide the basis for Global Fund's health systems strengthening activities to cover the remainder of the districts. BMAF will bring central-level and district officials together to recommend policy change and highlight best practices in an effort to reduce the gap in HR planning, recruitment, deployment, and management between the two levels.

Good health worker data is essential for the effective planning, management, and retention of the health workforce, who are the most essential resource for health service delivery. This challenge can be addressed by effective deployment and use of a routinely updated human resource information system (HRIS). USG support will ensure that human resource information systems are in place in both the public and private sectors to manage and use HR data in the health sector effectively for recruitment, management, and retention of health workers, especially at the district level. Under the leadership of the Prime-Minister's Office for Regional Administration and Local Government, this program will implement a functional HRIS, linking at the central, regional, and district levels. The THRP will:

(1) Play a leadership role with inter-ministerial coordination to ensure interoperability across multiple information systems;
(2) Plan for district functionality and use of data to inform planning, policy, and routine management decisions;
(3) Provide the hardware and software to expand infrastructure; and
(4) Train program managers in the use of the system for data-driven decision making and effective deployment of health workers.

Sixty districts will receive hardware, software, and training this program year. It will leverage financial and technical support provided by the Local Government Reform Program, which is a multi-donor European funding.

Implementing Mechanism Details

Mechanism ID: 9614	Mechanism Name: Twinning

Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: American International Health Alliance Twinning Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,772,925	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,772,925

Sub Partner Name(s)

Boulder Community Hospital		

Overview Narrative

The overall goal of American International Health Alliance's (AIHA) programs is to strengthen human and organizational capacity to expand or scale up HIV/AIDS prevention and care and treatment services through volunteer-driven "Twinning" partnerships designed to enhance the HIV/AIDS skills of nurses, lab technologists, social workers, PSWs, and others to improve the lives of PLWHA and OVC in Tanzania.

In support of the national response to HIV/AIDS, AIHA's programs complement the five-year PF, particularly that of goal one of service maintenance and scale-up through the rollout of community focused PSW and palliative care programs; goal two of prevention through facilitating the implementation of a recovery system of care (ROSC)-substance abuse program for MARPs; goal three of leadership and management by strengthening the organizational capacity of national organizations and councils; and goal five of HRH through curricula development, skills labs, mobile libraries within the nursing program, and mentorship and supportive supervision opportunities within the laboratory program.

As AIHA is focused on capacity building of local institutions, investment will diminish over time as local partners gain the skills to support their own activities. AIHA partners develop work plans, which are approved by CDC, that outline deliverables and indicators that are measured over time. All activities are tracked at country level using AIHA's work plan and M&E plan.

In FY 2010, CDC approved the procurement of a vehicle for AIHA.   Currently, more cost-effective options are being determined to purchase a vehicle that will enable more frequent staff and partner site visits throughout all regions.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	25,000
Food and Nutrition: Commodities	15,000
Food and Nutrition: Policy, Tools, and Service Delivery	5,500
Human Resources for Health	2,700,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Safe Motherhood

Budget Code Information

Mechanism ID:	**9614**		
Mechanism Name:	**Twinning**		
Prime Partner Name:	**American International Health Alliance Twinning Center**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	242,875	0
Narrative:			

AIHA will continue to work with palliative care partners, Evangelical Lutheran Church in Tanzania (ELCT)-Pare Diocese, together with the U.S. partners, such as Empower Tanzania and Southeastern Synod of the Evangelical Lutheran Church in America, in conducting palliative care trainings to community health workers (CHW) and supervisors (clinicians serving within facilities). The trainings utilize standardized URT curricula to ensure service provision is strengthened and linkages with the national systems are improved.

Support of palliative care services is integral to the efforts of PEPFAR. To support clients, the program shall prioritize family strengthening approaches that reinforce families' long term caring capacities as the basis of a sustainable response to people affected by HIV/AIDS. Included under the rubric of family and economic strengthening are interventions that boost household food and economic capacity and improve family access to health care and support. Families in turn rely on safe and supportive communities to thrive. Therefore, AIHA palliative care program will continue to support capacity building to local community structures to respond to palliative care and support by mobilizing and integrating the palliative care services into Council Comprehensive Health Plans at the district levels, which will cascaded down to sub-district levels. In addition to the above activities, the program will invest in the monitoring and evaluation of the impact of the palliative care program and build on evidence based best practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	880,050	0

Narrative:

AIHA has been working with the OVC implementing partners, URT and USAID, for the past five years to design and pilot responses to the needs of the social welfare workforce, including the overall pre- and in-service social work curriculum and professional development at all levels. The overall goal of the OVC and social work twinning partnership is to strengthen the social welfare workforce in Tanzania. The project aims to strengthen the capacity in the provision of quality social work services to OVC by equipping social workers, and others, with the necessary knowledge and skills to ensure comprehensive social services are offered to children affected by HIV/AIDS throughout Tanzania, as per the guidelines set forth in the National OVC Costed Plan of Action.

AIHA and its OVC partners, specifically Tanzania Social Workers Association (TASWA) and U.S. based National Association of Social Workers (NASW), will continue to partner on strengthening TASWA's capacity to serve as the national 'voice' for social workers in Tanzania, enhancing the professional growth and development of its members, creating and maintaining professional standards, and advancing sound social policies within the Tanzania context. AIHA will also serve as a key stakeholder in the implementation of the National Social Welfare Workforce strategy, which seeks to set forth a

comprehensive plan to address HRH challenges faced by the social work profession in Tanzania.

AIHA will continue to work with its partners, ISW and Jane Addams College of Social Work, while collaborating closely with IntraHealth's Human Resource Capacity Project and other Pamoja Tuwalee partners, towards the further roll out of updated para social worker (PSW) trainings throughout the country. AIHA partners provide the lead training oversight with an end goal of producing more community-level PSW cadres and the ward level based social welfare assistant (SWA) cadre. This is a step towards decentralization of the system by bringing social welfare services to the local government authority levels.

AIHA will continue to build capacity of the Department of Social Welfare based on the previous assessment that was conducted. A key M&E component of ensuring PSW training is effective is to follow up PSWs during provision of service. Follow up activities will continue to be conducted by ISW, with JACSW, to provide technical assistance, as needed throughout the year, to inform training components and ensure materials and topics are relevant to meet the needs of the communities that PSWs serve. In addition, PSW and SWA curricula revisions will focus on comprehensive, family-centered care approaches that stress the overall well being of the child.

AIHA will also strengthen the 12 higher learning institutions under The Tanzania Education Social Work Program (TESWEP) to ensure standardized quality social work education. To ensure sustainability, AIHA will work directly with all local AIHA IOVC/social work partners, such as ISW, TASWA, and TESWEP schools to develop organizational capacity, financial and administrative capacity, and leadership and management skills.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	400,000	0

Narrative:

AIHA will continue to support the efforts initiated by MOHSW of strengthening capacity of all regional laboratories towards three star Strengthening Laboratory Management Toward Accreditation (SLMTA) accreditation standards. Through its partnerships, AHIA will focus on quality improvement principles and expand on mentorship and supervision using local and international mentors. Mentorship activities will be done using the mentorship training curriculum which has been developed by AIHA lab partners from MOHSW-Diagnostic Services, Boulder Community Hospital, and with input and guidance from CDC. Implementation of the curriculum, training, and roll out will be done in partnership with local and international experts using the TOT model which promotes sustainability.

AIHA partners will develop standardized tools that will help to keep information as well as monitor and evaluate progress of lab activities towards accreditation. The program will continue to support the Health Laboratory Professional Council (HLPC) through the provision of technical guidance in the development of the Council Comprehensive Strategic Plan, which will guide the council's overall goal and objectives. Partners will develop council documents, including job aid booklets and other manuals; this support will strengthen HLPC to complement the efforts set forth in the national HRH URT strategy.

Finally, AIHA will establish a learning exchange program to expose lab professionals to best practices concerning accreditation adherence and maintenance. Exposure of mentors and Tanzanian lab partners to other successful accreditation models will be supported, as this opportunity will enhance competence and efficient operations of lab activities as well as accreditation processes. The criteria for selection of the candidates will include a laboratory that is under the accreditation program and has a minimum of four technologists. The selected candidate should either be a lab manager, quality officer, or a mentor who is knowledgeable, highly motivated, and can train others.

In FY 2012, one visit will be sufficient to allow selected laboratory professionals to gain exposure and learn best practices pursuant to a three star accreditation. The overall lab accreditation process will be tracked continuously using PEPFAR NGI H1.2.D and will provide CDC with feedback on the progress regional labs are making over time. Intermediary SLMTA progress will be submitted through quarterly, semi-annual, and annual program review reports. In terms of transitioning from PEPFAR Track 1.0, the AIHA model specifically engages MOHSW and regional government lab staff. Since initial implementation of the program, AIHA has worked with local in-country partners who see accreditation as an important step towards provision of high-quality diagnostic services in Tanzania.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	600,000	0

Narrative:

Tanzania is currently facing an acute shortage of qualified healthcare workers that are able to provide comprehensive care and support for those with HIV/AIDS. Furthermore, the educational institutions that train Tanzania's nurses, social workers, and other health workers have not kept pace with the needs of emerging and existing professionals through the use of competency-based curricula, practical opportunities, and supportive supervision and mentorship. AIHA will provide support for lab skills development, mobile libraries, curriculum review with MOHSW, and pre- and in-service training as well as continued support to Tanzania National Nurses Association (TANNA) and Tanzania Nurses and

Midwives Council (TNMC).

In order to adequately support the revised competency-based national nursing curricula from a certificate to a Bachelors level, complimentary support for curricula will be scaled to reach all 87 nursing schools in Tanzania. With FY 2010 and FY 2011 funds, AIHA Tanzania Nursing Initiative (TNI) supported 25 schools with skills labs. Therefore in FY 2012, equipment and supplies will be purchased for the remaining 20 schools that are within AIHA-TNI zones.

Skills lab training of all faculty from the 20 schools will be conducted. In addition, continuous assessment of instruction on HIV/AIDS within skills labs for the 25 schools that received skills labs in previous years will be conducted. An additional 10-15 mobile libraries will be purchased and capacity building of faculty will be done.

On-going supervision, mentorship, and assessment of the mobile libraries that have already been provided will be conducted, along with curricula review of seven BSc programs (within universities). PMTCT components and modules similar to other TNI revised curricula will be integrated as necessary into the BSc program. A faculty development package will be developed with PMTCT components included. Practicum books and orientation of tutors and standardized training materials for this program will be developed. In order to ensure sustainability and country ownership, work will be done within the system to leverage existing structures; all in-country partners are the identified long-term stakeholders and own these activities as their own responsibility.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	150,000	0

Narrative:

Studies have revealed high HIV prevalence in people who use drugs (PWUD), particularly by injection, both in Mainland Tanzania, within the context of a generalized epidemic, and in Zanzibar where the epidemic is concentrated within identified most-at-risk populations. The HIV prevalence of the general population in Dar es Salaam City is 8.8% and 42% in people who inject drugs (PWID). In Unguja, Zanzibar HIV prevalence in the general population is 0.8%, however, it is 16% in PWID. Thus, substance abuse continues to be a main driver of HIV in Tanzania Mainland and Zanzibar.

AIHA Twinning Center will continue to support substance abuse programs (both Mainland and Zanzibar) by establishing partnerships among peers from AIHA substance abuse partners who provide technical support to the Drug Control Commission, Muhimbili University-Tanzania AIDS Prevention Program, the Mental Health and Substance Abuse Unit of MOHSW, and other stakeholders in Tanzania. With the aim

of complementing efforts by other stakeholders in providing the UN recommended comprehensive package of HIV services for PWUD and PWID, AIHA will coordinate (establish, guide, and support) the development and implementation of the recovery oriented system of care (ROSC) by improving substance abuse prevention and rehabilitation (recovery support) services and facilitate linkages to other HIV prevention, care and treatment services for PWUD and PWID. The program will expand the recovery system of care and support groups to families affected by substance abuse in Tanzania Mainland and Zanzibar. In collaboration with stakeholders, including community, political, and religious leaders and NGOs, the program will continue to solicit support in mainstreaming ROSC as part of the comprehensive services for HIV prevention, care and treatment for PWUD and PWID in response to substance abuse.

Although AIHA and its partners do not provide direct services for PWID, partners are in the process of creating monitoring systems for the national ROSC to ensure a functional referral system for comprehensive care. This includes national referral tracking to and from clinical and community services such as Medication Assisted Treatment (MAT), sober houses, drop-in centers, and ancillary health and legal services for PWID and people in recovery. Partners are also developing a framework that will allow for active monitoring of peer recovery group meeting attendance and other non-clinical recovery services. AIHA and its partners feel that this type of anonymous monitoring of peer group attendance is a meaningful proxy for the number of active recovering addicts utilizing community-based care. Tracking attendance levels also allows MOHSW, CDC, and other stakeholders to examine utilization trends over time and help inform MAT implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	500,000	0

Narrative:

The AIHA-Tanzania Nursing Initiative (TNI) will continue to integrate PMTCT in all facets of the TNI program to ensure that nurses are equipped with necessary skills and knowledge to decrease the incidence of MTCT. Thus, addressing the broader GHI goal of decreasing the prevalence of HIV/AIDS in Tanzania through improved nursing PMTCT education and further provision of technical assistance to national nursing bodies that are able to establish national frameworks to better facilitate the implementation of PMTCT services at the workplace.

In 2012,the capacity of Tanzania nursing faculty will be further strengthened to better instruct and evaluate nursing students on PMTCT. This will be accomplished through the provision of faculty development packages that address quality delivery of PMTCT education in the classroom and within skills labs. AIHA-TNI partners will continue to collaborate with MOHSW in the continuous development and evaluation of PMTCT resources, such as learning materials to accompany PMTCT curricula modules

that were integrated into all National Technical Award (NTA) Level 5 national curricula in 2010. Furthermore, intensive PMTCT modules, practicum books, and other learning guides will be developed and disseminated to accompany the national midwifery tract (BN specialization) curricula.

In terms of tangible support to the nursing schools, the fifteen new skills labs will include pelvic models and other necessary equipment for practical PMTCT instruction. In addition, AIHA-TNI will continue to procure and supply ICN mobile libraries to nursing schools. Mobile libraries will be equipped with several learning resources, including up to date PMTCT books, visual aides, such as PMTCT-specific CDs and DVD training materials, and PMTCT tool kits. These components will enable the AIHA-TNI program to prepare a nursing workforce that is competent in the provision of various PMTCT services.

Further, AIHA-TNI will support the Tanzania National Nurses Association to promote PMTCT adherence and skills development amongst its members through ICT campaigns as well as other forms of outreach. AIHA-TNI will also support the Tanzania Nurses and Midwifery Council to establish a regulatory framework that further supports the role of nurses in administering PMTCT services throughout all regions of Tanzania.

Implementing Mechanism Details

Mechanism ID: 9616	**Mechanism Name: IHI-MC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,000,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,000,000

Sub Partner Name(s)

ARUSHA MUNICIPAL COUNCIL		

Overview Narrative

The goal of the project is to support MOHSW and NACP to expand, strengthen, and sustain high quality HCT and MC services for HIV prevention. Specific objectives are to increase access to quality HCT services by strengthening HCT and MC services; support MOHSW and NACP to expand comprehensive MC services for HIV prevention; build district council capacity with grants and TA; and support MOHSW to develop and operationalize guidelines and tools for QA of HCT services. HCT will be implemented in Arusha, Kigoma, Musoma, Mwanza, and Shinyanga while targeting MARPs, persons attending health care facilities, and hard to reach populations. MC will be implemented in Shinyanga targeting men ages 10-49 years.

Implemented strategies will be aligned with national policies and guidelines. The primary framework for capacity building and sustainability will entail direct grants to four districts. HCT will focus on institutionalizing quality of care, building local capacity, orientation of the new guidelines, providing mobile HCT to MARPs and remote areas, and the roll out of HCT QA tools. Comprehensive MC services will be expanded through static and outreach campaigns, implementation of family-centered approach targeting older men, and incorporation of couples counseling and shared sexual decision-making.

Cost efficiency will be ensured through cost effective initiatives and training that minimizes disruption of services. Documentation and dissemination of best practices will be coordinated with partners at all levels.

Transition plans will focus on reinforcing efforts in two districts of Kigoma and rely on joint district planning in all districts. M&E will be done in collaboration with MOHSW at all levels with participation in service evaluation.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	26,762

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	9616		
Mechanism Name:	IHI-MC		
Prime Partner Name:	IntraHealth International, Inc		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	981,441	0

Narrative:

The comprehensive package of Voluntary medical Male Circumcision (VMMC) services includes MC counseling for HIV prevention, risk assessments and reduction, HCT, physical examination, sexually transmitted infection screening, syndromic diagnosis and treatment, MC surgical procedure, provision of condoms and referrals to other care and treatment services. In support of efforts to scale-up VMMC in PEPFAR programs, readily available data have been applied to estimate the potential cost and impact of scaling-up VMMC in Tanzania to reach 80% of adult (ages 15-49) and newborn males by 2015. The target for FY 2012 is 50,000 and FY 2013 is 70,000 men. Those testing positive with their partners will be referred to care and treatment clinics (CTC) for enrolment.

With this funding, Intrahealth will scale up VMMC services to 5 health facilities in Shinyanga region and conduct a phased MC Service provider training for 90 health care workers (HCWs).
The funding will also allow collaboration with the MC Technical Working Group to facilitate the development and dissemination of national VMMC related policies, guidelines, monitoring tools as well as standards operating procedures.

The funds provided will support district planning and whole site orientation meetings to HCWs on MC for HIV prevention in order to create awareness, ownership and increase participation. Capacity building of council health management teams (CHMTs) will take place on planning and facilitate and advocating for inclusion of VMMC activities and budgets in the districts Comprehensive Council Health Plans for

sustainability.

Funds will be used to strengthen MC services in four static clinics during normal working hours as well as Outreach services in hard to reach areas, mining settlements, ginneries, cotton plantations, during special events when need arise and through mass campaigns. Setting up these services requires space identification, site strengthening, minor renovation, procurement of MC supplies, community mobilization, orientation to key stakeholders and training of service providers.

For capacity building purposes, the funds will be used to support regional and district VMMC supportive supervision, mentoring, training and site strengthening. This will enhance mentoring, client follow up, data management and general quality of services.

Data management will be strengthened through on the job mentoring, Data Quality Assessment and capacity building for CHMTs on using data for decision making. Printing and distribution of MC registers, client appointment/identification cards, client files, theater registers, MC counseling and testing and follow up registers, monthly site report forms, carbon copy referral forms, adverse event record forms, posters/brochures and client booklets will also be done.

MC surgical procedures generate a lot of waste that need proper disposal. For waste management purposes, the funds will be used to purchase waste containers and support minor renovations of incinerators to improve waste management.

The support will be used for demand creation which is essential for continuity of service and will be strengthened in all sites. Awareness raising will be enhanced through printing of information and Education materials and other communication channels. In collaboration with MOHSW/NACP, JHU and EngenderHealth-Champion, messages targeting older men and women will be developed, pre-tested and distributed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,018,559	0

Narrative:

COP 2012 funding will assist in strengthening existing HTC services at 286 facilities with emphasis on HTC Quality Assurance (QA), expansion and maintenance of PITC services and prevention of Gender Based Violence. Funding will also focus on identifying HIV-infected patients in need of care and treatment. HTC services will target 250,000 clients in health facilities, MARPs, VMMC clients, couples, hard to reach and nomadic populations.

This funding will allow closer collaboration between Intrahealth, NACP and regions in delivering quality HTC services and providing technical support to the Counseling and Social Support Unit at NACP in developing a training roll out plan for HTC QI.

Funds received will be used to conduct refresher trainings for health care providers, to update them on new comprehensive HTC guidelines, revised HTC M&E tools, HTC QI and new HIV prevention initiatives, to increase knowledge and the quality of services. The content of refresher courses will also be based on gaps identified during supervision visits and emphasis on referral mechanisms. 35 health workers will be trained to screen for GBV and alcohol misuse within the context of HTC and MC services, safety planning, psychosocial support, referral and follow up to establish referral network among available GBV support services.

PITC services will be scaled up into 30 new facilities with basic training for 96 Health staff, site activation and trainee follow-up. Efforts will be made to integrate activities into the Council Comprehensive Health Plans for sustainability. Mobile community HTC and mobile PITC services will be organized in collaboration with regional and district teams in hard to reach areas.

With this funding, Intrahealth will support districts to conduct supportive supervision and trainee follow up for HTC service sites to ensure that there is improved program management, performance and quality of services at all levels. For coordination purposes, the funds obtained will be used to conduct regional partnership meetings in two regions aimed at strengthening coordination, collaboration and sustainability with other HTC and Treatment partners.

The funds will be used to set innovative ways to document best practices in M&E at all levels of implementation, support roll-out of new HTC monitoring tools, and data management for HTC. The anticipation of these initiatives is to create a culture in data use for implementers and decision makers, but it requires staff orientation

From the activities emanating from implementation of HTC, a number of reports will be produced; funds will be used to disseminate the reports locally and internationally for knowledge and experience sharing. Funding will also be used to support rolling out the implementation of the new comprehensive HTC guidelines, developing and pre-testing IEC messages to expand awareness and increase demand and up-take of HTC. Support received will as well be used in printing HTC national recording and reporting tools, new HTC guidelines, HCT QA tools and any other intervention when needs arise.

Lastly, COP 2012 funds will be used to maintain existing 22 staffs and an additional four positions to be filled. Support received will enable staff to strengthen their managerial skills through study tours, program management and other short courses available at Chapel Hill, supplemented by TA visits from Chapel

Hill.

Implementing Mechanism Details

Mechanism ID: 9618	**Mechanism Name: Touch Foundation- PPP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Touch Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,390,150	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,390,150

Sub Partner Name(s)

Baylor College of Medicine International Pediatric AIDS Initiative/Tanzania	Bugando Medical Centre	

Overview Narrative

The goal of this GDA is to strengthen the health system in Tanzania by increasing the available number of human resources for health (HRH), as well as to enhance the quality, deployment, and retention of available health workers. This goal aligns with the Global Health Initiative target of improving health systems to strengthen the delivery of health services.

The work is geographically focused in the Lake Zone, where Bugando serves as the tertiary care institution for the Zone's 15 million people. To date, the focus has been on strengthening Bugando's capacity to allow the organization to drive expansion into the greater Mwanza Region, with the ultimate program goal of expanding into the Lake Zone.

There are numerous cost efficiency changes that have been implemented, especially in respect to supporting Bugando, gradually transitioning funds from core operating support towards targeting

institutional growth and innovation. Faculty development at Bugando is a key element, giving the institution the tools it needs to continue to attract students and future research grants. In addition, plans to transition regional programs to URT are targeted for FY 2014. Robust monitoring and evaluation is being designed in anticipation of scaling up of programs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,390,150

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9618		
Mechanism Name:	Touch Foundation- PPP		
Prime Partner Name:	Touch Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	2,390,150	0
Narrative:			
All programs contribute directly to health systems strengthening initiatives and fall under two major objectives: increasing the number and quality of available human resources for health (HRH) in Tanzania and building national healthcare management capabilities. In Tanzania, there is a severe lack			

of HRH across all cadres, limiting access to health services for the majority of Tanzanians, including children and mothers. In addition, the low retention of healthcare workers further contributes to negative health outcomes. These issues are being addressed in all project areas. The broad activities for each major program areas are found below.

To increase the number and quality of available HRH, the project will:
(1) Provide a monthly grant for operational support to Bugando which will allow for approximately 1,400 students to be enrolled in pre-service training in FY 2012, with an almost equal number of female and male students;
(2) Enhance management capacity through support of academic and finance departments;
(3) Develop faculty through a fellowship program in South Africa to improve the quality of education and assist the institution to better position itself to attract research funds;
(4) Develop a regional treat and train program which will bring Bugando students to regional and district hospitals to perform their clinical rotations. This will not only relieve capacity constraints at Bugando Hospital, but also will enhance patient care at the regional and district facilities. Students will be accompanied and supervised by specialists from Bugando and from two U.S. academic institutions; and
(5) Strengthen emergency care training, including emergency obstetrics as part of medical and post-grad curriculum with U.S. academic partners.

There is a lack of formalized healthcare management training programs in Tanzania, and as a result, the system is sub-optimal and inefficient. A trained group of healthcare managers is urgently needed in order to maximize the efficiency of the health system and allow clinicians to perform their duties. In FY 2012, initial work with African and U.S. academic institutions will commence to create a healthcare management program. This will include conducting an initial assessment, understanding what curriculum currently exists and what gaps need to be addressed, which stakeholders should be involved, and how best to work with MOHSW to develop a program which suits their needs for training students from across Tanzania. Collaboration with leaders at academic institutions and stakeholders in the URT will help to determine the best approach to accomplishing these activities.

The agreement is a public private partnership, requiring a 1:1 match of private funds. Activities crucial to the work at Bugando, but not directly funded by USAID other than Touch program staff, include infrastructure enhancements of the library and MD hostel, as well as the support of a Weill Cornell Medical College specialist to work full-time at Bugando, and a resident rotation program.

Implementing Mechanism Details

Mechanism ID: 9627	**Mechanism Name: WHO**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: World Health Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 295,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	295,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

WHO-Tanzania receives PEPFAR support through WHO Headquarters under the CDC-PEPFAR-Multi-Center Program called 'Support Services for the HIV Pandemic.' It is a five year program which extends from October 2008 to September 2013. WHO has used this support to provide technical assistance to MOHSW and partners in the area of scaling up HIV/AIDS care and treatment services to primary health care facilities using the Integrated Management of Adolescent and Adulthood Illness (IMAI) approach. WHO has also provided technical support for improving ART patient monitoring systems.

During the initial first three years of the project, the foundation for introducing IMAI in Tanzania has been laid. Development of IMAI guidelines and training materials has been created. The operations manual to support implementation of IMAI at primary health care (PHC) facilities has been developed and printed. In addition, through partnership with other agencies, quality improvement and clinical mentoring guidelines and training materials for HIV prevention, care, and treatment have also been finalized. Tools for ART monitoring have been revised to enable cohort monitoring, analysis, and reporting. The main objective for the fourth year will be to ensure quality of services in care and treatment centers and to build sustainability mechanisms for inclusion of IMAI into the country's health care systems and pre-service training.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	280,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Safe Motherhood

TB

Workplace Programs

Budget Code Information

Mechanism ID:	9627		
Mechanism Name:	WHO		
Prime Partner Name:	World Health Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	95,000	0
Narrative:			
WHO will provide technical support to MOHSW in both Tanzania Mainland and Zanzibar to do a country adaptation of standardized minimum data set and illustrative tools for the three interlinked patient			

monitoring systems for HIV care, ART, MCH, PMTCT (including malaria prevention during pregnancy), and TB/HIV. External support will be available to train national and zonal trainers. Zonal trainers will in turn train and do follow-up supervision of health facility staff in their respective zone. WHO will also support the M&E Units of NACP and ZACP in using the EPP-Spectrum model for estimations and projections for national HIV/AIDS epidemic key indicators and their use for future planning. In collaboration with UNAIDS and UNICEF, WHO will coordinate data collection and preparation of the annual country universal access report. EPP Spectrum Estimations will be done through the training of a critical mass of staff at national and zonal levels in using the model. The MOH will process national data and provide national projected indicators by producing a national booklet. An annual country Universal Access report will be developed through meetings with MOH programme staff and national partners supporting HIV/AIDS in the country who contribute data for the HIV/AIDS response in the country.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	200,000	0
Narrative:			
Out of the 1,100 health facilities offering HIV/AIDS care and treatment services in Tanzania, over 800 are primary health facilities where health workers were trained using the IMAI approach. In FY 2012, the main objective for WHO in Tanzania will be to ensure the quality of HIV/AIDS care and treatment services and build sustainability mechanisms for the integration of IMAI into the country's health care delivery systems and pre-service training. To strengthen quality improvement of HIV/AIDS prevention, care and treatment services, technical assistance to the National AIDS Control Program (NACP) to conduct rapid assessment of quality of HIV/AIDS services, including client satisfaction levels, will be provided. The assessment will be conducted in HIV/AIDS care and treatment centers (CTCs) that are based at both hospitals and primary health care facilities. Support will be given to MOHSW to develop the format and tools for regional and district health management teams to include QI activities into the regular annual plans and budgets. To build sustainability mechanisms for IMAI in existing pre-service training and service delivery systems of the country, inclusion of IMAI in pre-service training programs for clinicians and nurses will be consolidated while orientation for tutors on how to use the IMAI training materials will be conducted.			

Implementing Mechanism Details

Mechanism ID: 9630	**Mechanism Name: SAVVY & DSS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Ifakara Health Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 490,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	490,000

Sub Partner Name(s)

National Institute for Medical Research		

Overview Narrative

The goal of this project is to strengthen the capacity of URT to collect and use mortality surveillance data to assist in the management of the national HIV/AIDS programs by expanding community based identification and reporting of AIDS deaths. This will be achieved through Sample Vital Registration with Verbal Autopsy (SAVVY).

The objectives of this project is to conduct formative investigations and activities to determine structures needed to produce reliable estimates at national and sub-national level; to develop a national infrastructure to coordinate, monitor, and report on SAVVY results; to provide logistical and technical support at district level to ensure data collection at this level is adequately supervised; to work with stakeholders in districts and with implementing partners to ensure that reports generated address their information needs; and to maximize the use of secondary data generated address issues of sustainability and further roll-out.

The geographic coverage of SAVVY is 23 districts of mainland Tanzania sampled to produce national level estimates, disaggregated by place of residence (i.e rural,urban), sex, and age. The target population is adults 18-59 years of age. For COP 12, ten new districts will be added to the four now implementing SAVVY.

Some of the strategies which are cost efficient over time is to use electronic data collection to cut down

the cost of paper and data entry, use mobile phones installed with a custom application to facilitate reporting and uploading of vital events directly to a central server, and to have periodic censuses to establish denominators.   M&E activities have been incorporated into the four SAVVY pilot disticts and will be included in the new districts.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	9630		
Mechanism Name:	SAVVY & DSS		
Prime Partner Name:	Ifakara Health Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	490,000	0
Narrative:			
Subsequent to ethical approvals from CDC and NIMR, sample vital registration with verbal autopsy (SAVVY) field activities began in Tanzania in four districts of Dar es Salaam (Kahama, Geita, Bagamoyo,			

and Kinondoni). Plans to expand SAVVY activities to an additional 10 districts has already begun and will continue into COP 2012. The recruitment of district SAVVY coordinators for each of the 10 districts has started, as well as training on SAVVY methodology and data collection. Additional activities for COP 2012 activities include: - sensitization of CHMTs and community leaders on SAVVY, including the roles and responsibilities, and support needed from the districts - identification and training of key informants to report vital events to district SAVVY coordinators - data analysis, which will be mainly be performed by Ifakara Health Institute HQ with inputs from the district coordinators compiling regular reports to feed into HQ reports - report writing - dissemination of data to appropriate fora and use. Data on deaths in Year One of the project from the four pilot districts was collected during the baseline census. Data collection of deaths is done through key informants, after which communication is sent to the district SAVVY coordinator using mobile phone technology. The coordinator, in turn, visits households where death has happened, to conduct the verbal autopsy. Coding for the deaths then takes place. Data entry, data analysis, and report writing on baseline data will be finalized in the first quarter of 2012. This activity will involve M&E officers from MOHSW, statisticians from the NBS, a demographer from NIMR, and epidemiologists from Ifakara Health Institute.

Implementing Mechanism Details

Mechanism ID: 9631	**Mechanism Name: UCC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Dar es Salaam, University Computing Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 310,000	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
GHP-State	310,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals for this mechanism are to support, train, and back-stop the use of databases and electronic systems for HIV data management. This also includes enhancing and developing software tools for HIV data management. The goals contribute to PF goal six, which relates to improving the use of timely and relevant evidence based information in HIV-related planning and decision making.

University Computing Center's (UCC) CTC2 database software is used in clinics located in all regions of Tanzania. Other software tools are used in a small number of clinics and districts.

UCC is a local training and software development organization, which works closely with NACP to impart skills on data management. HIV management software tools are developed in partnership with NACP. UCC is now coordinating joint trainings with NACP to ensure software trainings are fully integrated with general M&E trainings. Working with NACP on a day-to-day basis in the management of national level data, which is hosted and managed by NACP, UCC provides the technical assistance and support.

UCC monitors its work using intranet-based software where all support visits and communications are logged and categorized. UCC plans to monitor more closely how many clinics are not only using the software, but also submit timely reports using the software.

UCC uses a project vehicle to transport the mobile training unit closer to the locations of participants, thus reducing travel time and costs as it supports more trained people with the same budgeted amount. The PEPFAR-funded vehicle allows UCC to transport laptops to training events, thereby creating training venues even in regions with no dedicated computer training facilities, which allows UCC to visit clinics despite their location.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9631		
Mechanism Name:	UCC		
Prime Partner Name:	University of Dar es Salaam, University Computing Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	310,000	0

Narrative:

UCC will continue to enhance and improve HIV management software tools (CTC2, CTC3, HUWANYDATA) over time in line with user feedback and make any further changes to the NACP M&E systems, including the plan for an extensive overhaul of the CTC3 macro database. The growth in mobile communications will be harnessed and an SMS appointments reminder system for clinics using CTC2 database will be created. UCC will also examine the best available data transfer methods for reporting data between the CTC2 and CTC3 macro databases and will examine how the partnerships that the m-health project has with local mobile companies and other service providers could facilitate this.

Support for the integration of various software systems within the health sector will continue. UCC has enabled the CTC2 database to produce an export file compatible with MOHSW HMIS DHIS software. When details of the proposed MOHSW data warehouse are available, UCC will ensure that data can easily flow between health systems. UCC will continue to work on establishing the MOHSW online health facility registry, as a comprehensive and accurate health facilities list is a necessary foundation for

integrating data systems and enhancing reporting and data exchange. Support from other partners will help to expand the use of the CTC2 database. The database is currently used in 395 clinics. By June 2012, the number of clinics is planned to increase to 450; and by 2013 the number would be 560 or 75% of the existing number of CT clinics. UCC will continue to work with NACP, and partners working on home-based care, to expand the use of the HUWANYDATA system. Meeting these targets and continued expansion will depend not only on software availability and training, but also on hardware and human resources which are under the mandate of the government and other partners. UCC will work to improve reporting between clinics and district, regional, and national levels by making data transfer and reporting more user-friendly and will ensure inclusion on this during trainings. UCC will facilitate NACP to identify non-reporting clinics so that there can be follow up from NACP. MOHSW RCH department and PMTCT unit will be part of the development of patient level RCH and PMTCT database system. In view of the fact that there are several other initiatives underway in this area, UCC plans to organize a stakeholder meeting on this issue to discuss a future plan of action. Software tools developed by UCC under this mechanism are property of NACP. UCC has provided NACP with extensive technical documentation and will continue to do so. UCC will facilitate NACP to fully own the software and use formal software development cycle and management so they can independently choose an appropriate strategy for sustained software development post-project. One of the goals of this mechanism is to support, train, and back-stop the use of databases and electronic systems for HIV data management, helping to supportURT to collect HIV data from health facilities or districts, manage it, analyze, and use the information for HIV service delivery planning and decision making which contribute to PF goal six. The mechanism will help NACP to have readily available HIV data and, hence, support monitoring and evaluation activities. There are no other mechanisms that do what this mechanism is doing; which is supporting NACP on data management systems.

Implementing Mechanism Details

Mechanism ID: 9634	**Mechanism Name: UTAP UCSF-MARPS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: University of California at San Francisco	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 180,120	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	180,120

Sub Partner Name(s)

University of Washington		

Overview Narrative

University California San Francisco (UCSF) overall strategy is to work with GAP-Tanzania to provide training, TA, and long-term capacity building to improve HIV prevention and care programs, surveillance systems, and the ability to use results to guide program planning, program improvements, and allocation of resources. To help achieve this, UCSF works with GAP-Tanzania, the USG PEPFAR team, NACP, ZACP, TACAIDS, MOHSW, the National Institute for Medical Research (NIMR), Muhimbili University of Health and Allied Sciences (MUHAS), and other bilateral and multilateral donor agencies to help Tanzanian institutions sustainably reduce HIV transmission, improve HIV/AIDS care and treatment, collect and use data, and manage national programs.

UCSF provides TA to leaders and staff in mainland Tanzania and Zanzibar to conduct surveillance on populations most at risk for HIV. However, UCSF does not implement projects, but rather provides TA and support to projects. Due to the hiring and capacitating of in-country staff, the need for international travel has been reduced. Local agencies will require less support over time to conduct surveillance activities.

UCSF routinely tracks the number of people trained and assesses the quality of the training through evaluations, as well at the outcomes of the TA (e.g. reports and data use).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9634		
Mechanism Name:	UTAP UCSF-MARPS		
Prime Partner Name:	University of California at San Francisco		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	80,120	0

Narrative:

UCSF will continue to provide technical assistance in the area of HIV surveillance for MARPs. This will build the national capacity for MARPs surveillance and enable national programs to continue routine surveillance with less support in future rounds, whereby eventually surveillance activities will be conducted without support.

UCSF will continue to assist Zanzibar with their MARPs studies and size estimation in both Unguja and Pemba with MSM, IDUs, and sex workers. UCSF will work with ZACP and CDC/GAP Tanzania to train data collectors, provide oversight of the studies, and assist with data analysis and report writing for both Pemba and Unguja. A drug mapping exercise in Mainland, along with the Drug Control Commission (DCC), will be conducted in order to assess areas of the country where drug use is prevalent and help to

inform prioritization of drug prevention programming. UCSF will work with the DCC to write the protocol, collect data, analyze data, and disseminate results. Technical assistance to CDC-GAP Tanzania, and its partners, will be supported in the design and implementation of an assessment of PMTCT program data for national HIV surveillance. With in-country partners, UCSF will assist in developing study materials, including data abstraction tools, SOPs, and job aides. UCSF will also assist with the development of training curriculum and assist in training PMTCT assessment staff and study implementation.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	100,000	0
Narrative:			
UCSF will provide technical assistance to CDC/GAP Tanzania and the National AIDS Control Program in the development and implementation of a study to understand behavioral drivers of the HIV epidemic in three large cities in Tanzania. The scope and specifics of this project have not yet been determined. The populations will likely be high-risk populations within urban areas, though specific definitions of the populations to be studied have not been determined. UCSF will support the national program in this endeavor in order to build capacity for operational research in the area of HIV surveillance.			

Implementing Mechanism Details

Mechanism ID: 9639	**Mechanism Name: BMC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Bugando Medical Centre	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,059,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,059,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Bugando Medical Centre implements program interventions in the areas of HIV care and treatment, HIV counseling and testing, male circumcision (MC), and maternal mortality reduction interventions. These programs are linked, integrated, and coordinated to ensure synergy and efficient utilization of resources. The catchment areas are Mwanza, Shinyanga, Tabora, Kigoma, Kagera, and Mara with a combined population of 16 million people. These areas are considered to have some of the highest HIV burden in the country.

The main goal of HIV care and treatment is geared towards strengthening provision of quality ART Services. HIV counseling and testing seeks to increase access to HIV testing for health care seekers, TB patients, pregnant women and their spouses, and for the general population. The overarching goal of the MC program is to provide services to men 10-49 years and build capacity for delivery of MC services. The main goal of the maternal mortality reduction program is to reduce maternal mortality in the 36 hospitals in four regions. All the goals are linked to the National HIV/AIDS Strategic Plan, Partnership Framework, and Global Health Initiative, which will ultimately support URT to reach its targets. The program's activities will be implemented in a network model, linking district and regional stakeholders to capitalize on synergy, fostering cooperation, and leveraging resources from other partners. By strengthening district health systems, promoting program ownership, planning and budgeting for project activities, districts will be able to take over these programs.

M&E of program activities will use both national and PEPFAR indicators. Two 4WD vehicles are planned for extensive travel and for the transport of voluminous materials.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	891,787

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	9639		
Mechanism Name:	BMC		
Prime Partner Name:	Bugando Medical Centre		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	850,000	0

Narrative:

MC reduces female to male HIV transmissions by 50-60%. However, the HIV protective role of MC to female partners has not been established in Sub-Saharan Africa. Based on this evidence, WHO and UNAIDS recommend MC in areas where HIV prevalence is 15% or higher and MC prevalence is less than 20%. Where there is lower HIV prevalence and/or higher MC coverage, male circumcision should target higher risk male populations within these regions. The goal of the BMC MC program is to increase access to male circumcision interventions to contribute to the reduction of new HIV infections among male fishermen, and indirectly among their female sexual partners, in the fishing communities of Lake Victoria Islands in Mwanza region. The target will be to provide MC services to 7,000 men while linking them to other HIV prevention and care and treatment services. This will ensure provision of a comprehensive HIV prevention package and early access to HIV care and treatment services.
The BMC MC interventions will target hard to reach, high-risk HIV fishing communities in Lake Victoria Islands. Although the Tanzania Health Indicator Survey (THIS) 2007-2008 found that HIV prevalence in Mwanza is 5.5% and the MC rate is at 54%, fishing communities are quite a heterogeneous mixture of different tribes, cultures, and religions. Higher HIV prevalence and lower MC rates are anticipated to be lower than the regional average.
Mwanza Region has 12 big islands. In FY 2012, four islands will be targeted accounting for one third

(1/3) of the big islands. Providing access to MC to hard to reach high-risk fishing communities in the Lake Victoria Islands will augment other HIV interventions in these communities, such as early linkage to care and treatment for those found to be HIV positive. BMC MC programs on the Islands will provide a unique opportunity for males, specifically adolescents who are more vulnerable to HIV acquisition (10-24 age group), to access evidence-based HIV prevention interventions. MC will also provide opportunities for on-site testing according to national guidelines. MC will be integrated into and linked to other HIV prevention services, such as counseling and testing, to help ensure a comprehensive HIV prevention package is offered.
Supportive supervision and mentorship to MC static sites will be conducted to empower district health authorities to provide MC supportive supervision and mentorship to the health care workers in the MC intervention sites. Trainings will utilize the national curriculum along with a strategy to ensure post-program funding sustainability. Mass and mini campaigns will be conducted while mobilization of community and religious leaders will help perform mobile MC outreach services to selected islands. Increasing community awareness, acceptance, and demand for MC services will be communicated through mass media, posters, brochures, leaflets, and T-shirts. Education on the MC protective impact against HIV and other sexually transmitted infections will also be provided.

VMMC implementation takes place at 77 Islands in four Mwanza districts, involving extensive travel and transport of personnel and of bulky equipment. Two vehicles are required: one 4WD hard top and on 4WD large body pick-up. Monitoring and evaluation will be undertaken using national tools and National AIDS Control Program database. Monthly reports will be analyzed locally and shared with stakeholders for performance improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	325,000	0

Narrative:

Bugando Medical Centre (BMC) will use three testing modalities, namely voluntary counseling and testing (VCT), provider initiated testing and counseling (PITC), and mobile community outreach HIV testing and counseling. More emphasis will be put on PITC and mobile community outreach services, which have been found to be associated with increased early access to HIV testing and enrollment to care, treatment, and support services. The target population will be the hard to reach are of Lake Victoria Islands and fisher folks where HIV prevalence is relatively higher than the mainland. Areas with limited HIV testing services will also be targeted.

The program will use mobile community outreach HIV testing in collaboration with respective community health medical teams (CHMTs). Mobile community HIV testing will be conducted during special events,

such as AIDS Day, to maximize access to HIV testing. PITC will continue to be routinely provided at BMC for all health care seekers in both outpatient and inpatient departments, such as ANC, medical, surgical, cancer wards, out-patient, and TB clinics. The program will also support home-based HIV testing in collaboration with the home-based care program. Couples HIV testing and disclosure will also be promoted.

In order to strengthen successful referrals and linkages to care, treatment, and support services, the program will track HIV-positive individuals through referral and feedback forms. HIV infected clients who are identified as not showing up will be tracked through home-based care programs using their addresses. The program will conduct in-service trainings on PITC to health care providers with special emphasis on couples counseling and quality assurance. To ensure quality services, BMC will conduct quarterly supportive supervision and regular mentoring to the six Lake Zone regional hospitals in collaboration with USG regional partners. The regional teams will be trained in quality Improvement, supportive supervision, and mentorship using national curricula.

HIV testing, including couples testing and disclosure, will be promoted through mass media, posters, brochures, leaflets, and T-shirts. Monitoring and evaluation will be undertaken, while both paper based and electronic tools will be used to capture trainees' profiles and addresses using the electronic database, TrainSMART®. A national tool will be used to capture data on all who are tested. Data quality procedures will be followed and data will be used to improve quality of care. Quarterly reports will be analyzed locally and shared with stakeholders for performance improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	200,000	0

Narrative:

In 2009, the problem of high maternal mortality rate in the country was approximately 590/100,000 live births. In order to address this problem, Bugando Medical Centre (BMC) initiated a pilot maternal mortality reduction program in the two regions of Shinyanga and Mara, implementing targeted interventions aimed at reducing facility based maternal deaths. The baseline survey identified causes of maternal mortality and barriers to their reduction. The assessment also showed that in the two regions, over 75% of all maternal deaths occurred in hospitals. The major causes of hospital maternal deaths identified were obstetric hemorrhage, eclampsia, anemia, obstructed labor, and sepsis. Identified barriers to reduction of maternal deaths in the two regions were lack of appropriate skills, lack of essential basic supplies and equipment, inadequate proper supervision and mentoring of labor ward staff, and low morale.
All the factors identified as contributing to the high maternal deaths and the major causes of deaths

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

helped to inform the design of targeted interventions to reduce maternal mortality. These targeted interventions included training and retraining of key maternal ward staff on obstetric management skills, management of the identified major causes of maternal mortality, provision of adequate and proper supportive supervision and on site mentoring to ensure standards of obstetric care, and requirements that core competencies are maintained. Other measures included provision of basic supplies and equipment required for standard obstetric care provision and inexpensive incentive motivation for the labor ward staff.

These replicable, evidence-based interventions resulted in a phenomenal reduction of maternal deaths by 23% in these hospitals. After soliciting funding from CDC in FY 2010, these interventions were replicated in the 12 hospitals of two other regions of Mwanza and Kagera. Training, procurement of equipment, and supportive supervision were conducted during FY 2011. In FY 2012, supportive supervision and mentorship to build capacity of the targeted hospitals in the four regions will be continued. Supportive supervision and mentorship in 36 hospitals will ensure maintenance of quality maternity services, resulting in expected to reduce maternal mortality in targeted hospitals and increase survival of newborns, which is in line with the Global Health Initiative.
Supervision and mentorship will be conducted by a team of supervisors from BMC and from the regional mentors. There will be limited training for regional mentors to address the problem of attrition. Teams consisting of an obstetrician and a midwife will physically visit targeted hospitals. Labor monitoring and quality of care will be evaluated as well as providers' skills to manage pregnancy related complications and infection control in maternity wards. Availability of relevant essential drugs in labor rooms at all times will also be assessed. During supervision, identified gaps will be addressed by mentoring. Mentorship will be web-based so that health care workers can also post their management questions. Feedback will be given to health care providers and hospital administrators. Quality of obstetric services will be monitored using a quality assessment tool by both internal and external quality evaluations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	684,000	0

Narrative:

The HIV care and treatment program will train district Trainer of Trainers teams to help build the capacity of districts to conduct trainings using their district budgets as a sustainability strategy. In the previous years, capacity building through training has been a main focus. However, training will be scaled down for FY 2012.

Bugando Medical Centre (BMC) will focus on quality improvement of HIV/AIDS services delivery through supportive supervision, onsite and web-based mentorship, and clinical attachments. These funds will

help to build capacity of health care workers to deliver quality HIV/AIDS services, to develop the districts' capacity to train health care workers, and to conduct supportive supervision and mentorship in their catchment areas. BMC will provide Training of Trainers courses to district teams on in-service training on HIV/AIDS and pediatric HIV/AIDS care and treatment in order to decentralize training to the districts and meet training needs of regional USG partners and Regional Health Management Teams (RHMT). All trainings will be conducted in accordance with the national curriculum as well as provide onsite supportive supervision and mentoring to the six regional hospitals. BMC's target population for training is the entire Lake zone. BMC is one of the local partners receiving direct funding from CDC, although they are also a sub grantee to AIDSRelief on HIV/AIDS care and treatment, TB/HIV integration, and early infant diagnosis. It has scored the highest grades amongst AIDSRelief sub grantees in local partners capacity assessments. BMC uses TrainSMART database to track and archive trainees' information.

Implementing Mechanism Details

Mechanism ID: 9641	**Mechanism Name: APHL Lab**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 257,371	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	257,371

Sub Partner Name(s)

(No data provided.)

Overview Narrative

APHL goals in Tanzania are to strengthen the laboratory networks, infrastructure, and services in the country. APHL's major objectives for FY 2012 include strengthening national laboratory information

management systems (LIS)-paper and electronic, supporting the central laboratory database, and supporting the implementation, monitoring, and evaluation of the national health laboratory services strategic plan.

APHL will continue to support the following Phase I and II LIS regions: Bugando, Mbeya, Songea, Shinyanga, Dar es Salaam, KCMC, Tanga, Amana, Temeke, Dodoma, Morogoro, and Arusha. Within FY 2012, APHL will expand the eLIS system to six new sites to the following new regions: Kagera, Tabora, Mara, Mwananyamala, Lindi, and Rukwa.

Cost efficiency strategies will be obtained by building local capacity to manage the paper and electronic LIS system, reducing foreign technical assistance visits, and negotiating more competitive LIS contracts with the vendors selected by Tanzania.

APHL and MOHSW will co-develop and manage the LIS contracts and Tanzania LIS cost of ownership documents. This will build capacity for the MOHSW to plan and budget for the LIS in the coming years. APHL is also ensuring local MOHSW will get trained in the LIS software systems and central database, including troubleshooting, so that MOHSW can manage more of these responsibilities on their own.

APHL will evaluate the effectiveness of the LIS by examining indicators, such as turn-around-time, both pre and post the LIS systems. Key laboratory data will be shared with the MOHSW and CDC from the central database, per their data set specifications. APHL will provide M&E tools for assessing the national laboratory strategic plan implementation.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	9641		
Mechanism Name:	APHL Lab		
Prime Partner Name:	Association of Public Health Laboratories		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	257,371	0

Narrative:

In order to assist Tanzania in the implementation of a paper based laboratory information system (LIS) to support HIV/AIDS care and treatment, APHL will assist with reviewing the paper based tools with MOHSW and CDC on an annual basis. In addition, APHL will provide technical assistance to the MOHSW to update these tools. Continual support of the monitoring and evaluation component of a paper based training, which is being rolled out by MOHSW, will be supported by providing technical assistance to ensure improvement projects are being effectively implemented. Five laboratories implementing paper based improvement projects are being targeted with laboratory tools being reviewed and revised as necessary.

APHL will support data mining activities and deliver training on the LIS central database, which includes building MOHSW capacity to manage the central database. This database will be interfaced with the Health Management Information System database currently being developed in Tanzania. Training will be offered on the database, general data management, and data mining skills. This initiative will provide more timely data for surveillance and policy decision. The target will be to have two MOHSW designated data management administrators trained and 60 MOHSW representatives trained on data management and mining.

APHL will assist with the implementation of the LIS to support HIV/AIDS care and treatment in six of the phase III laboratory sites from Kagera, Tabora, Mara, Mwananyamala, Lindi, and Rukwa. APHL will expand the electronic LIS system to phase III sites as outlined in the Tanzania LIS strategic/operational plan. Laboratory assessments in these new sites will be completed to determine high-level system

requirements. Hardware procurement and minor renovations to prepare for the LIS will be completed. An open RFP process will be completed immediately thereafter to ensure the most appropriate LIS vendor is selected for the expansion sites. APHL will provide technical assistance throughout this process and ensure the LIS software selected is properly customized for Tanzania's needs. APHL will support software costs, oversee the implementation of the LIS at the sites, and ensure proper management and support structures are in place for the electronic LIS. APHL will work with the MOHSW to ensure capacity is built within the Ministry to sustain the ongoing initiatives. Super-user training, user training, and software customization will continue targeting key representatives from the new LIS sites. This will ensure knowledge transfer to the local laboratory community on LIS implementation. Scheduled re-fresher trainings will also be provided periodically to ensure the training is successful. APHL will continue these sustainability initiatives in the next phases of the LIS roll out training laboratory representatives from the newly selected sites. Six new sites are targeted to have LIS installation with at least 60 lab staff trained as super end users on the software. Technical assistance will be provided to review the national health laboratory strategic plan and to evaluate and document progress in this area. APHL will provide monitoring and evaluation tools to assess the effectiveness of the laboratory strategic plan implementation. The target will be to create and finalize the M&E tool for the national health laboratory strategic plan.

Implementing Mechanism Details

Mechanism ID: 9642	**Mechanism Name: ASCP Lab**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society of Clinical Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 300,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

For COP 2012, American Society of Clinical Pathology (ASCP) will maintain its laboratory strengthening initiatives in Tanzania by continuing to build in-country capacity. ASCP is revising the pre-service curricula for medical laboratory schools and mentoring the faculty through its implementation; this will continue during COP 2012 with further lesson plan creation and mentorship of faculty. ASCP will also support medical laboratory schools through the procurement of equipment in order to fully equip the teaching laboratories at one or two schools. Laboratory accreditation is aligned with Goal 1 of the Partnership Framework and with the GHI strategy of improving health status by promoting laboratory standards and accreditation.

ASCP is mentoring Tanzania's Medical Laboratory Scientists Association (MeLSAT). Through MeLSAT, NHLQATC, and the zonal training centers, ASCP will work to build Tanzania's ability to provide continuing medical education for medical laboratory science professionals. These efforts will be monitored by tracking the number of training programs offered to Tanzanian laboratory professionals, the pre- and post test scores at the training programs, and the number of new graduates from the medical technology schools

ASCP's activities in Tanzania will affect laboratory professionals throughout the country. Our activities will become more cost efficient over time as transition of primary responsibility for continuing medical education is made to indigenous organizations, such as MeLSAT, NHLQATC, and the zonal training centers.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	9642		
Mechanism Name:	ASCP Lab		
Prime Partner Name:	American Society of Clinical Pathology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	300,000	0

Narrative:

Strengthening Laboratory Management towards Accreditation (SLMTA) is focused on laboratory management and encouraging quality assurance of laboratory testing. The training program teaches, among other things, laboratory managers to better control for quality and accuracy in lab tests, to better organize stock rooms to prevent stock outs and unnecessary expenditures on reagents and other lab supplies, and to manage procurement processes for lab supplies in line with needs and budgetary constraints. In addition, laboratory managers will be trained to more accurately forecast, plan, and budget for laboratory operations. SLMTA affects laboratory testing throughout Tanzania as regional and district lab managers are currently being trained. In FY 2011 and FY 2012, SLMTA will be implemented at other labs throughout the country.

Through the revision and implementation of new curricula at medical technology schools, ASCP is helping to train future Tanzanian laboratorians. By improving the pre-service training of future Tanzanian lab workers, ASCP is assisting with the transition of lab services to in-country partners. A well-trained cadre of new graduates will ensure that Tanzanian labs can move forward along the path to sustainable accredited laboratory programs. This strategy is in alignment with PEPFAR goal of training 140,000 new health workers and PF goal of increasing trained health workers goal. ASCP will also contribute to the education of future Tanzanian laboratorians by procuring equipment for the teaching

laboratories at Namanyere Lab School. The type of equipment will be determined at a later date based upon a needs assessment. This equipment procurement builds sustainability by providing the school with the necessary means to educate its students. ASCP is assisting with the development and strengthening of continuing medical education opportunities in Tanzania through Medical Laboratory Scientists Association (MeLSAT), NHLQATC, and the zonal training centers. This builds in-country capacity and strengthens local in-country partners. Laboratory services throughout the country will be strengthened with a better educated work force. Creating education opportunities that laboratorians can attend at the beginning and middle of their careers in the laboratory makes it possible for lab workers to stay up-to-date on laboratory testing, thus giving them the knowledge to provide better laboratory services. In addition, a better educated work force will increase the ability for a lab to achieve accreditation.

Implementing Mechanism Details

Mechanism ID: 9643	**Mechanism Name: CLSI Lab**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Clinical and Laboratory Standards Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 500,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Clinical and Laboratory Standards Institute's (CLSI) objective is to provide laboratory capacity building assistance to NHL-QATC and five zonal hospital laboratories in Tanzania and enhance laboratory quality improvement skills through a quality systems approach. Utilizing accepted clinical and laboratory

standards and guidelines, CLSI will facilitate the development of quality management systems, quality improvement and management skills, and provide on-going advice to sustain and maintain the quality improvements. CLSI will implement these activities through conducting detailed assessments (gap analysis) of the laboratories, deliver customized training and educational workshops based on critical needs, provide on-going advisement, and deliver a mentor/twinning program designed to facilitate the implementation of best practices and improvement strategies. The measurable program outcomes will include the number of laboratories that attain or apply for accreditation, number of laboratories that have written quality manual and standard operating procedures, participation in EQA, and conducting corrective actions on failed EQA panels. As the laboratories move towards accreditation, CLSI mentors will support the laboratories throughout the accreditation process. This will be accomplished by mentors' presence at the laboratories two weeks prior to the accreditation inspection and two weeks after the inspection. This will help the laboratories in the final preparations as well as address any issues after the inspection. CLSI will also train local quality assessors and mentors who will be able to continue to carry out assessments and mentorship in the other laboratories countrywide. This will ensure the sustainability of the CLSI programs in the long term.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9643

Mechanism Name:	CLSI Lab		
Prime Partner Name:	Clinical and Laboratory Standards Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	500,000	0

Narrative:

CLSI will work closely with the six laboratories (NHL-QATC and five zonal hospital laboratories) to assist in the implementation of selected improvement plans and 'best practices.' Implementation of the mentor/twinning program will last up to a six week period. Within this period, expert volunteers will stay in country to work side-by-side local laboratory staff and managers to facilitate improvement strategies to prepare the laboratories for maintaining accreditation. The goal of this program is to not only facilitate the improvements for maintaining accreditation but to empower and build long-term working relationships with the laboratory staff and expand their network of laboratory professionals. Technical assistance and support to 10 local mentors will be provided. This will be achieved through a five-day workshop to build the local mentoring capacity. Two CLSI staff and two CLSI volunteers will travel to Tanzania to conduct the mentor training workshop. These mentors will be trained and assessed for competency in mentoring practices and skills. They will be assigned to regional or district laboratories where their main responsibility will be to mentor the laboratories in implementing quality management systems. The goal of this program will be to equip the local staff with adequate resources and skills to be effective mentors to other laboratories countrywide. CLSI staff and volunteers will travel to Tanzania to partner with the local quality assessor to conduct gap assessments of the six laboratories. The gap analysis will be based on the ISO15189 standard and checklists from the accrediting bodies, e.g. SADCAS/SANAS. The results of the assessments will highlight opportunities for improvement and each laboratory will be assisted in developing project plans that address the gaps that exist. CLSI has developed a certificate program in Laboratory Quality Management Systems that provides a robust and challenging curriculum designed to meet the needs of people who are responsible for laboratory policy and strategies at any level. CLSI will introduce this course through partnerships with local universities in order to strengthen local laboratory leadership in managing the laboratories. This program is part of an integrated approach to the delivery of high-quality patient results, which will support the achievement of a higher level of laboratory operations. Work with MOHSW laboratory leadership will be prioritized to develop national policies and guidelines for accreditation. This activity will involve the assembling of a Laboratory Working Group that will spearhead and play a leading role in the development and dissemination of the document. The Laboratory Working Group will conduct sensitization workshops and gather information from all relevant laboratory stakeholders before writing the final draft of the laboratory policy document.

Implementing Mechanism Details

Mechanism ID: 9644	Mechanism Name: ASM Lab
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society for Microbiology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the American Society for Microbiology (ASM) cooperative agreement is to increase the capacity of laboratories to perform quality testing for HIV/AIDS-related opportunistic infections and other infectious disease and to improve laboratory infrastructure nationwide, including implementation of necessary training and institutionalization of quality management systems procedures. In Tanzania, ASM's objectives are to work with MOHSW to strengthen clinical and public health microbiology services at the National Quality Assurance and Training Centre and the zonal and regional laboratories. ASM will improve the quality and skills of existing personnel and establish local mentors to strengthen staff retention. This directly supports Partnership Framework Goal 5, which is to ensure necessary human resource capacity is available for the achievement of quality health and social welfare services at all levels. Laboratory development activities also align with PF Goal 1 for service maintenance and scale-up.

ASM's coverage includes the national, zonal, and regional levels, targeting microbiology laboratory managers, technologists, and technicians at local Tanzanian laboratories. By increasing the number of quality local microbiology mentors and master trainers, ASM will decrease its external consultant costs over time. ASM will transition activities to URT by building leadership, training, and supervisory capacity

at the NHLQATC; and develop local mentors.

Activities in Tanzania will be conducted in alignment with ASM's monitoring and evaluation framework. Laboratory progress will be measured through a series of assessments and monthly quality indicators. Technical skill will be measured through tools, such as competency testing.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9644		
Mechanism Name:	ASM Lab		
Prime Partner Name:	American Society for Microbiology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	100,000	0
Narrative:			
Microbiology diagnostic services are important in the rapid and accurate identification of microbial diseases, in detection of antibiotic resistance and in assistance in the control of disease outbreaks and			

nosocomial infections. American Society for Microbiology (ASM) was brought in as a new partner in Tanzania in 2008 and has been working with the Ministry of Health and Social Welfare (MOHSW) and the Centers for Disease Control and Prevention (CDC-Tanzania) to strengthen clinical microbiology services at the National Health Laboratory Quality Assurance and Training Centre (NHLQATC), zonal, and regional laboratories. An assessment conducted by ASM in January 2009 found that the microbiology laboratories are highly underutilized despite their critical role in patient management and disease control. To achieve the goals identified in the MOHSW National Health Laboratory Strategic Plan (2009-2012) and better serve the health needs of the Tanzanian population, ASM is working to advance microbiology services to the same standard as the other clinical disciplines serving people living with HIV/AIDS. ASM support is in alignment with the objectives of the strategic plan and is addressing the multiple clinical laboratory tiers, that is, national, zonal, and regional. With COP12 funds, ASM will continue to work with MOHSW and CDC to strengthen the NHLQATC as a public health microbiology reference laboratory with capacity for confirmation and surveillance of communicable diseases including outbreaks. ASM will continue providing technical assistance for the improvement of the test menu, testing algorithm, specimen referral strategy, equipment maintenance, and supplies/reagents to support microbiology specialized diagnostic testing. Laboratorians will be trained on water and food diagnostic procedures and provide mentorship on quality management systems in microbiology laboratories. ASM will also strengthen microbiology services in zonal and regional laboratories by building local mentorship capacity.

Implementing Mechanism Details

Mechanism ID: 9645	**Mechanism Name: KIHUMBE**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Kikundi Huduma Majumbani	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 523,847	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	523,847

Sub Partner Name(s)

(No data provided.)

Overview Narrative

KIHUMBE's mission is to reduce the spread of HIV, reduce the social and economic impact of HIV/AIDS, strengthen the services and linkages to PLHIV, and address malaria morbidities and mortalities. The organization aims to prevent new HIV infections and provide care and support to people with HIV/AIDS and their families through strong community involvement and participation.

KIHUMBE serves Mbeya Region within the four districts of Mbeya City, Mbeya Rural, Rungwe and Chunya and targets marginalized populations that are disproportionately affected by HIV. KIHUMBE has vocational and secondary schools that are open to public and private students that generate income, as does KIHUMBE's small shop. KIHMBE established TAJIRIKA groups, which are supported through educational sessions rather than financial hand-outs. KIHUMBE works closely with LGAs and local communities and is seeking other partnerships to ensure comprehensive support for vulnerable populations.

KIHUMBE has an M&E plan and has been conducting M&E activities on quarterly basis, including conducting an end of term evaluation for project improvements. KIHUMBE has staff that supervises each program within each district.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	10,654
Economic Strengthening	144,901
Education	69,254
Food and Nutrition: Commodities	149,163
Food and Nutrition: Policy, Tools, and Service Delivery	74,581
Gender: Reducing Violence and Coercion	10,654
Human Resources for Health	42,618
Water	5,327

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Mobile Population

Budget Code Information

Mechanism ID:	9645		
Mechanism Name:	KIHUMBE		
Prime Partner Name:	Kikundi Huduma Majumbani		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	103,225	0
Narrative:			

KIHUMBE will provide physical, psychological, spiritual, social, and prevention services to HIV-infected adults, children, and their families in Mbeya region, in accordance with HBC guidelines. Other services will include adherence counseling, “care for carers,” and a strengthened referral system. A target of 6,300 clients (5,040 females and 1,260 males) is set under COP 2012. Planned activities include:

- Assessm of scope and needs for PHDP services in the catchment communities in Mbeya region;
- Strengthen the integration of nutrition counseling and support (NACS) components of PHDP services;
- Support economic strengthening activities to PLHAs through small scale IGAs and facilitate formation, collaboration and coordination of income generating projects. No cash will be given to clients;
- Strengthen provision of integrated HBC service that are linked to other HIV-related services such as OVC, ART, HTC, VMMC and PMTCT and other related programs;

- Integrate and strengthen linkages with other HIV-related services, including OVC, CTC, HTC, VMMC, and PMTCT and other related programs using focal persons, through KIHUMBE sub-partners;
- Conduct quarterly coordination meetings to discuss program performance ;
- Improve quality of M&E system through use of harmonized and standardized tools for data collection, analysis and reporting;
- Improve HBC provider skills through strategic in-service training, on-job mentorship and support supervision
- Improve local participation and demand for HBC services through community sensitization and support establishment of patient support groups and post-test clubs;
-Improve PLWHA participation in planning committees and program implementation on key issues such as treatment adherence and retention into care and support services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	156,131	0

Narrative:

KIHUMBE implements HVAB activities in four districts of Mbeya Region (Chunya, Rungwe, Mbeya Rural and Mbeya City). For COP 2012, activities will aim to promote abstinence, delay of sexual debut, fidelity, and reduction of multiple and concurrent sex partners, through individual, small groups and community health education sessions. KIHUMBE will conduct at least two sessions per week, to reach a target of with a target of 32,000 people.

The target population will be in-school youth, young adults, couples, PLHAs. Futhermore, activities will address key drivers of the epidemic (alcohol use, MCP, gender issues and transactional and inter-generational sex). KIHUMBE sub-partners will also work with schools and colleges in their catchment areas.

To strengthen the monitoring and evaluation system, and with support from URT facilitators, KIHUMBE will use harmonized and standardized tools to improve performance and ensure informed program implementation. Quarterly meetings with other stakeholders will be conducted to assess and share progress and discuss challenges at hand.

HVAB activities will also be integrated and linked to other HIV/AIDS services such as HTC, care, treatment and support, VMMC and PMTCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	148,439	0

Narrative:

KIHUMBE provides both static and mobile counseling and testing services in Mbeya region, covering the four districts of Mbeya Urban, Mbeya Rural, Rungwe and Chunya. These activities are client-initiated testing HTC targeting the general population through static and mobile VCT campaigns and activities. KIHUMBE serves the population which has a high HIV prevalence of 9.2%. In FY 2011, the organization reached 127% of the target of 13,340.

For COP 2012, the program will focus on:
i) couples counseling and testing
ii) MARPs (particularly long distance truck drivers)
iii) VMMC promotion through community sensitization
iv) counseling for PHDP through HBC
iv) identification of alcohol concerns through the brief motivational intervention (BMI) initiative.

HTC services will be linked to other services such as OVC, ART, TB/HIV and PMTCT to ensure continuum of care and timely referrals, linking clients who test positive to care, treatment and home-based care services. KIHUMBE will also work with LGAs, health facilities and community organizations to strengthen local ownership and program sustainability.

Community leaders and social service committees will be actively involved in planning and implementation of HTC services. In high transmission areas, community demand creation activities will be done through individual, small groups and community sensitization to ensure full participation. Patient support groups and post-test clubs will also be established and PLWHAs will be involved in steering committees so as to improve adherence and retention into care, treatment and support services.

Standardized M&E tools will be used to record report on quarterly basis to track and report on program performance, including PHDP services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	116,052	0

Narrative:

KIHUMBE will implement HVOP services in four districts of Mbeya region, addressing issues related to sexuality, gender issues and cultural practices that fuel the spread of HIV. The target populations will be at-risk youth, alcohol users, mobile populations (truck drivers, migrant workers especially in border areas, fishing communities and mining workers) and people involved in transactional sex, with 80% of the HVOP budget specifically focusing on mobile populations. The magnitude and size of these population are

currently not well known. Planned activities for COP 2012 include: - Distribute condoms and and promote regular and correct usage - Conduct sexual behavioral change communication (SBCC) messaging on MCPs, transactional and intergenerational sexual practices, age at sexual debut and alcohol use; - Integrate and link of HVOP activities into other service delivery platforms such as PHDP, HTC, care and support, treatment and PMTCT; - Strengthen and support utilization of PHDP services among PLWHAs, including income-generating activities; - Improve M&E framework through use of harmonized and standardized tools for data collection, analysis and quarterly reporting and ensure that all sub-partners have M&E focal persons. - Encourage sub-partners to participation in coordination meetings - Promote participation and coverage through individual, small groups and community sensitization messaging (peer education model) - Implement the Brief Motivational Intervention (BMI) to address alcohol use

Implementing Mechanism Details

Mechanism ID: 9655	**Mechanism Name: Conservation of Eco-Systems**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Rhode Island	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

UZIKWASA		

Overview Narrative

The University of Rhode Island (URI) funds HIV/AIDS activities that contribute to HIV prevention by promoting behavior change among fishing communities in Pangani and Bagamoyo; by improving the livelihoods of vulnerable groups, including widows and PLHIV; and by strengthening local leadership to address HIV/AIDS. URI's HIV/AIDS activities are integrated into USAID Natural Resource Management projects, following the integrated approach outlined in the GHI Strategy.

In Pangani, these activities are being implemented in all 33 villages within the district, although the focus is on the Mkwaja and Mkalamo wards. In Bagamoyo, activities will be implemented in 10 coastal villages. Target populations in both districts include fishermen, women involved in the fishing industry, village leaders, and young girls aged 10-24 (the age group most exposed to early/forced/transactional sex). All activities are implemented in coordination with local government ,as VMACs serve as the primary collaborator at the village level. Most activities are mainstreamed into village level HIV/AIDS action plans and integrated into district development plans. This intentional strategy of mainstreaming and integration enhances the cost effectiveness and sustainability of these activities.

URI has established an M&E system that includes quarterly data collection, with all data subjected to careful data quality assessment. All data files are stored in the TCMP office in Bagamoyo or with local partners.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	60,000
Gender: Reducing Violence and Coercion	40,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Mobile Population
Family Planning

Budget Code Information

Mechanism ID:	9655		
Mechanism Name:	Conservation of Eco-Systems		
Prime Partner Name:	University of Rhode Island		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	150,000	0

Narrative:

URI will continue to address harmful social and community norms, such as fish-for-sex, partner swapping, early/forced marriages, and gender-based violence. Activities will be geared toward the general population in 16 fishing villages in Pangani and Bagamoyo districts.

The project will strengthen the skills of VMACs and other village stakeholders (PLWA associations, women, and youth groups) to address local HIV and gender needs. The project will work with VMACs to update previously developed village HIV/AIDS Plans and will support implementation of those plans through quarterly technical support visits. Work with the VMACs in the three villages of Bagamoyo District will be focused on developing VMAC Action Plans and subsequently tracking the implementation of one of the plans. One hundred integrated population, health, and environment peer educators (PEs) living in coastal villages will conduct outreach activities to deliver AB messages to 3,000 individuals--primarily fishermen and women involved in the fishing industry. A second target group is youth, which will be reached by 30 specially trained youth peer educators. The adult PEs will refer clients to HTC services as well as other health-related services, such as those available at FP, SRH, and MCH clinics, whereas HIV-negative men will be encouraged to consider VMMC.

During visits to the VMACs and PEs, URI and local partners will monitor activities, provide support, and collect data to feed the project's M&E system. Community-level follow up visits will also monitor VMAC performance on implementing updated HIV/AIDS Plans. The project will develop indicators for the

gender responsiveness of village HIV/AIDS plans and semi-annually will analyze the village monitoring data. Work plan activities and monitoring data will be documented in tracking forms, field reports, and workshop proceedings. Meanwhile VMAC coaching reports, case studies, success stories, focus group discussions, and community diaries will capture more qualitative information about project activities. Pangani FM community radio will play a role in helping monitor community response to the interventions through direct feedback via SMS, call-ins to the station, and communications sent to the station via regular post.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	250,000	0

Narrative:

Target Population: Fishermen / Target: 360 / Estimated Cost: $10,000

URI's HVOP activities will focus on mass communication for the general population in the Pangani District and targeted interventions for high-risk adults involved in the fishing industry in the Pangani and Bagamoyo Districts. The project aims to reach 9% of adult fishermen (e.g. at least 160 fishermen out of a total of 1,750 fishermen active in the Bagamoyo District). In Bagamoyo, the work will be implemented in 10 villages, which together have over 52,000 inhabitants. In Pangani, the activities will target 200 individuals in the fishing industry will be primarily implemented in the Mkwaja and Mkalamo wards, which together have an approximate population of 6,000.

In Pangani, URI will continue its efforts in mass communication, including Theater for Development, video spots, IEC materials, and interactive radio programming to promote a reduction in high-risk behaviors. Mass communication events will reach at least 30,000 individuals in the Pangani District, which is 67% of the total population. The project will use educational sessions and peer education to reach at least 200 men and women involved in the fishing industry. By integrating fishermen-specific issues into the village HIV/AIDS and gender plans, the project expects to reduce high-risk behaviors and promote HIV prevention among migratory fishermen and women working in the fishing industry. As part of social marketing to encourage the use of condoms, the project will continue to support existing provider outlets and to monitor condom use. Furthermore, the project will continue working with savings and credit associations in the Pangani District to improve livelihoods and increase access to credit among PLWAs, CSWs, orphans, and widows. This activity will be expanded to Bagamoyo, where it will target the same audiences. Overall, the project will improve the livelihoods for at least 90 individuals in six villages (three villages in Bagamoyo and three in Pangani).

URI will scale its project activities in the Bagamoyo District where the project will focus on high-risk

groups involved in the fishing industry. Trainings will be conducted for VMAC leaders to increase their knowledge of the rights of vulnerable groups (women, girls, PLWAs) and of high-risk behaviors related to the fishing industry. The project will use training, peer counseling, IEC materials, and interactive theatre to help empower at-risk women and fishermen to end their high risk behaviors, improve their life skills (including teaching them skills in entrepreneurship), and to prevent HIV- and gender-based violence. Condom social marketing outlets will be established that will connect with trained peer educators, who in turn will refer fishermen and other high-risk groups to the condom outlets, as well as to other FP, SRH, and MCH clinics. HIV-negative fishermen will be encouraged to consider VMMC. To assure compliance with national and international standards, all training materials will follow MOHSW guidelines. Project staff will supervise and monitor monthly activities. In addition, information from these activities will be gathered and utilized during the quarterly and semi-annual self-assessment evaluations.

Implementing Mechanism Details

Mechanism ID: 9658	**Mechanism Name: AWF**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Wildlife Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

AFYABORA	LOOCIP	SUBIRA Women's Group

Overview Narrative

Africa Wildlife Foundation (AFW), a partner receiving funds through the Natural Resource Management (NRM) Office, targets hard-to-reach areas that have limited access to HIV/AIDS information and services.

To leverage NRM activities, PEPFAR funding is used to mainstream HIV/AIDS messages and activities into local partner programs in the Maasai Steppe. This activity aligns with GHI strategy in its attempt to integrate funding streams and technical areas. The objectives for the project include strengthening social mobilization campaigns and outreach activities in the Maasai Steppe to sensitize the communities on HIV/AIDS and provide referrals to appropriate clinical services; developing and supporting HIV/AIDS workplace policies and clarify internal and external models for HIV/AIDS mainstreaming; and supporting women's empowerment through an integrated development approach that links life skills, health, and economic empowerment.

Activities are conducted in the eight districts of Mbulu, Babati, Monduli, Kiteto, Kondoa, Simanjiro, Karatu, and Longido. These locales reach 54 villages with a total population of approximately 230,000 people.

Sub-contracts to three community-based organizations to work in six wildlife management areas (WMAs), as well as Kolo Hills and Karatu Highlands are provided. These partners also assist Mweka Wildlife College to mainstream HIV/AIDS into their core business. By integrating these messages into the foundation of these partners, there is an expectation that the interventions will continue after the cessation of funding. AFW utilizes a monitoring system that links with PEPFAR and national databases. Work with local partners to adopt best M&E practices will also be a main activity to ensure successful oversight of the project.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	30,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Workplace Programs

Budget Code Information

Mechanism ID:	9658		
Mechanism Name:	AWF		
Prime Partner Name:	African Wildlife Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	200,000	0

Narrative:

AWF is able to access hard-to-reach populations that are often unable to access HIV/AIDS messages and services. The target population includes wildlife managers, natural resource managers, pastoralists, and local farmer communities in schools and villages in the Maasai Steppe. Certain high-risk behaviors are prevalent in these isolated communities, including multiple partners (both in polygamous and non-polygamous unions), transactional sex among transient laborers who are separated from their families, alcohol abuse, and the sharing of unsterilized piercing and circumcision tools.

To address some of the key drivers of the local epidemic, AFW distributes condoms to local partners and institutions, including Tarangire and Lake Manyara National Parks, Manyara Ranch, to game scouts in the WMAs, and to local community-based organizations and villages supported through NRM funds. In addition to commodities, AFW ensures that those reached are informed of health services in the area that may serve the needs of their clients. AFW also supports Mweka Wildlife College to monitor its workplace policy and integrate HIV/AIDS messages into their curriculum.

The program intends to reach 2,850 individuals, of which 60% will be women aged >15 years, with HIV/AIDS educational information through community dialogues, peer education sessions, classroom teaching and radio programs. Additionally, all HIV education sessions will highlight the importance and opportunities for clinical services, including HTC, family planning, and ARV treatment for those already aware of their HIV-positive status. Approximately 8 women will be empowered from the conservation enterprise groups.

AWF will continue to work with its partners to strengthen internal and external HIV/AIDS mainstreaming approaches to maximize benefit and best leverage resources. To ensure that these activities and others are of a quality nature, AIDSTAR1 provides technical assistance, which includes periodic site visits and activity monitoring and evaluation tools.

Implementing Mechanism Details

Mechanism ID: 9665	**Mechanism Name: Pathfinder International**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Pathfinder International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,933,100	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	4,933,100

Sub Partner Name(s)

D-Tree International		

Overview Narrative

The goal of the project is to improve the health and well being of PLHA and their families in Tanzania with increased access to and quality of comprehensive community-level services through district coordination and community engagement. The objectives are to:

1) Facilitate quality CHBC/PHDP services for 45,000 PLHAs in 19 districts and five regions with emphasis on self-care/prevention and linkages to care and treatment clinics (CTC);
2) Offer an integrated package of family-centered services to 6,600 OVC in two councils in Shinyanga;
3) Provide home-based HIV counseling and testing, ensuring quality test results and supportive community-based follow-up for 94,800 persons;
4) Strengthen institutional capacity with 19 CHMTs and the Tanzania Red Cross Society (TRCS) in five

regions;
5) Increase national capacity for quality IEC and BCC programming through support to NACP, ZACP, and MUHAS;
6) Strengthen community-facility linkages for GBV survivors.

Implementation of cross-cutting M&E activities will go hand in hand with a gradual handover of HBC/HBCT program to TRCS, strengthening TRCS national capacity to manage and meet PEPFAR funding requirements while positioning TRCS to receive LGA funding for community-based HIV/AIDS activities. The program will strengthen links between care and treatment services and procure a vehicle for TRCS to reduce operating costs and ensure adequate coverage and effective monitoring and supervision in Shinyanga.

Transitioning management to TRCS will save costs due to reduction in Pathfinder staff time and increases in PLHAs self-managing. At the same time, development of graduation plans for districts and families through LGAs and self-help groups will ultimately increase in-district funding for community-based services.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	100,000
Human Resources for Health	750,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
TB
Family Planning

Budget Code Information

Mechanism ID:	9665		
Mechanism Name:	Pathfinder International		
Prime Partner Name:	Pathfinder International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	2,728,750	0

Narrative:

In FY 2012, Pathfinder will implement HBC programs in a total of 19 districts in five regions. In addition to increasing client enrollment in facility care, the Tutunzane II ("Let's take care of each other") program will continue to increase the number of clients enrolled to at least 45,000. Program sustainability will be emphasized by:
(1) Supporting HBC providers to offer a range of integrated services as per PHDP and GHI strategy, to strengthen self-management and care, palliative care, food security, home hygiene, improved prevention and treatment adherence, nutritional assessment, FP counseling and contraceptive provision, emphasizing dual protection, malaria prevention and management, support to pregnant women to access ANC and PMTCT, counseling and testing for household members, and identification of TB infections. Lessons from community-based GBV programming from Dar es Salaam and other regions will also be incorporated;
(2) Continuing to strengthen TRCS capacity to manage HBC and HBCT services. Pathfinder will continue to work with TRCS to implement a transition plan that allows for program shifting to TRCS. Transition of Pathfinder-led activities in Arusha to TRCS management will be explored. Milestones under the transition plan will be reviewed and revised regularly;
(3) Strengthening local government capacity to manage and provide technical direction to HBC programs. The program will engage existing community structures to develop and implement sustainability/graduation plans and play a supportive role with HBC providers in their community. Graduation plans will be developed with each district to carefully delineate roles and responsibilities;
(4) Gradually shifting model of care to reduce dependence on HBC providers by enhancing capacity of

families and clients to self-care and self-management of a chronic illness. With shifts in Tanzania's criteria for entry into treatment, more clients will be entering chronic care programs, thus support to self-care with fewer visits from HBC providers will be needed. Client role shifts to reliance on self and family resources to manage chronic illness moves HBC providers to become a resource to provide multiple community-based services. A well established process, such as "Pathways to Change" and "community action cycle" will be used to strengthen community action and responses to HIV. Eligible households will be linked to economic opportunity activities, while PLHA support group formation will be encouraged and a developed process to "graduate" households from the program will be created. Materials will be developed in collaboration with other organizations, such as PSI, IMARISHA project, and FANTA II, to support household decision making on issues, such as safer water, better home hygiene, complementary protein meals based on locally available grains and legumes supplemented by lower cost animal proteins; and
(5) Continuing expansion of the use of mobile phones for HBC data collection and adherence to home visit protocols through partnership with D-Tree International. Phone-based messaging systems may be developed to reinforce PLHA self-management at household level.
Pathfinder will continue to work with districts to assess the provision of HBC services through regular data review, DQA, and analysis. Pathfinder will provide monitoring and evaluation oversight to implementing partners in both activities and institutional capacity strengthening.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	874,350	0

Narrative:

Pathfinder, in collaboration with Save the Children, continues to work in two councils in Shinyanga Region to support OVC and MVC. In FY 2012, Tutunzane II (“Let’s take care of each other”) will focus on building a sustainable OVC program. In order to transition the program, the various activities will need to take place:
(1) Support 6,600 OVCs as identified by the district MVCCs. Services will focus on educational support for eligible OVCs, enrollment into community health funds, and support for vocational training for older OVCs, including job placements. In FY 2012, focus will shift away from only providing OVC households with supplies to strengthening family capacity as the primary means of supporting children. Families will receive economic strengthening support (with TA from Imarisha) through participation in Village Community Bank (VICOBA) savings and loans groups, as well as income generation activities (IGA), to improve both economic and food security;
(2) Work closely with Tanzania Red Cross Society (TRCS) and CHMTs to ensure that eligible families receive integrated HBC/OVC/HBCT/FP services that are linked closely with CTCs. Pathfinder will also ensure that TRCS supervised HBCT providers identify pediatric cases of HIV, offer testing to members of

caretaker families, and enroll eligible families for HBC/OVC programming support;
(3) Support at least 3,300 OVC households with nutrition interventions. MVCCs at the district, ward, and village level will receive refresher training and job aids to include nutritional information and actions to improve diets. Working in close collaboration with Department of Social Work (DSW), Tanzania Food and Nutrition Center (TFNC), and Food and Nutrition Technical Assistance 2 (FANTA 2) project, materials will be adapted to help household members focus on safer water, better home hygiene, and complementary protein meals based on traditional and common dishes using locally available grains and legumes supplemented by lower cost animal proteins. Based on 2010 WHO and National PMTCT guidelines of exclusive breastfeeding for the first six months, introduction of complementary foods and prolonged breastfeeding will be supported;
(4) From the DSW guidelines for MVCCs, Tutunzane II will continue supporting MVCCs at district, ward, and village levels to act as community-based advocates for vulnerable children and their families, mainly helping to access local government resources to keep MVCs in schools and increase access to health care. Advocacy activities with the district authorities will help to ensure selected care and treatment services reach OVC in rural communities and households that are unable to travel to distant CTCs. MVCCs will receive technical support from Tutunzane II and district governments to ensure their annual plan implementation is supported financially and technically;
(5) Based on the outcomes of the parasocial worker development program, Tutunzane II may support the enrollment of community-identified parasocial workers for training and placement back in their communities;
(6) Conduct monitoring visits with DSW to identify strengths and gaps in implementation of national standards for OVC support; and
(7) Develop a process of graduating OVC households and MVCCs from Tutunzane II support in collaboration with DSW and district MVCCs. Pathfinder will provide M&E oversight to Save the Children for activities and institutional capacity strengthening.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	630,000	0

Narrative:

The program will be implemented in Arusha, Dar es Salaam, Tanga, and Shinyanga. In Kilimanjaro, the costs of maintaining the current program is minimal, therefore the program will be maintained, but providers who leave the area because of transfer or retirement will not be replaced. Increases in the number of providers trained to provide HBCT will be primarily focused in high prevalence districts, such as Shinyanga.
The program will maintain its focus on index patients. All members of households with index clients will be encouraged to test. Testing of men, discordant couples, and children in PLHA households will be

encouraged. HBC providers will also provide focused attention to all pregnant women in the community to ensure they are tested in the home or at ANC clinics and supported to enter into PMTCT services. HBC providers will also continue to recruit door-to-door clients, especially in high-risk areas, such as Shinyanga. All clients, regardless of HIV status, will receive counseling on risk assessment.
Activities to support home-based couple counseling initiated in FY 2011 will be continued. In collaboration with NACP and other IPs, Pathfinder will develop materials and train existing home-based (HTC) counselors on couples counseling. A record will be kept of couples counseling sessions to ensure privacy is maintained, a safe environment is provided, and follow-up support is offered to ensure partner safety. A themed community-based promotion campaign may be developed to encourage couples to test jointly and disclose status with each other. Risk assessments will be carried out for all couples tested. In addition, counsel will be given regarding practicing safer sex and using dual protection. A total of 94,800 clients will receive their test results, counseling on risk assessments, safer sex, and dual protection through this program.
In collaboration with NACP, Pathfinder will support the development of tools and job aides to assist HTC counselors to provide follow-up services to all clients (including the development of phone-based reminder and confirmation systems). Referrals are already very strong and extensive through the HTC program, therefore simple systems will be developed to assess the number of confirmed referrals. Follow-up phone calls may be made to confirm clients who accessed available services.
In collaboration with NACP and local governments, Pathfinder and TRCS will implement QA standards outlined in the NACP HBCT guidelines. Pathfinder will provide monitoring and evaluation oversight to implementing partners in both implementation of activities and in institutional capacity strengthening.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	700,000	0

Narrative:

Pathfinder will continue providing TA and support to MOHSW Information Education and Communication (IEC) units and staff as well as pre-service training facilitators and teachers at Muhimbili University to design materials, trainings and interventions, create standards, ensure QI for IEC and sexual behavior change communication (SBCC) efforts to be in line with international and national guidance, such as the new PEPFAR Prevention Guidance, and support the most effective HIV prevention, care and treatment interventions.
Contents of the materials, interventions, and trainings will include IEC and SBCC support for (a) couples communications, couples HIV testing and counseling, disclosure and support for discordant couple; (b) promotion of voluntary male medical circumcision services; (c) support for adherence of ART, TB, and STI treatment, with particular attention to specific groups, such as HIV positive pregnant women and youth. Contents of messages and programs will be constantly adjusted to align with emerging evidence

and new guidance in areas such as early ART, pre-exposure prophylaxis, and other relevant effective prevention interventions as they emerge. In addition, the OP component of this activity will include support for development, review, and QI of materials and interventions to promote increased correct and consistent use of male condoms, promote female condom use among identified target groups, support Positive Health Dignity and Prevention (PHDP) and other interventions specifically designed to support PLHA. Creation of the relevant materials will give special attention to the needs of HIV positive girls and women and increase demand and up-take of comprehensive services among key populations such as sex workers and their clients, people who use and/or inject drugs, and men who have sex with men. Specific activities to be supported include: (1) Strengthening of the NACP and ZACP IEC units, such as reviewing reporting lines and clear job descriptions that differentiate unit members' roles and responsibilities; (2) Training for NACP and ZACP IEC and Muhimbili faculty staff; (3) Introduction and strengthening of IEC and BCC standards and QI tools that will enable NACP and ZACP IEC staff to review and assist with needed improvements, in particular for IEC and BCC programs developed and implemented by Tanzanian organizations; (4) Developing practical tools, job aides, and documented internal policies and procedures that will support the above described efforts and services; (5) Organizing quarterly or biannual prevention stakeholder meetings; (5) Supporting the design and technical contents of Muhimbili University's graduate degree course on HIV and health service promotion and social behavior change communications in line with emerging and existing evidence for most effective prevention interventions and services; (6) Mentoring Tanzanian faculty through international faculty advisors on teaching methodologies and interactive sessions; and (7) Supporting linkages for graduate students and faculty with relevant programs and partners for file level practice and pilots.

Implementing Mechanism Details

Mechanism ID: 9678	**Mechanism Name: Imarisha**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Development Alternatives, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,900,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,900,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The project aims to improve the overall effectiveness of existing and new economic strengthening (ES) activities undertaken by USG/T IPs in Tanzania by:

1. Increasing the capacity of partners and sub-partners in implementing ES interventions;
2. Building stronger linkages and alliances while piloting new innovations;
3. Improving coordination and implementation of URT's multi-sectoral response; and
4. Enhancing the evidence base of how ES and sustainable livelihoods programs can improve both economic resiliency of vulnerable households along with improving their health status.

The TA covers Dar es Salaam, Dodoma, Iringa, Mbeya, Morogoro, Mwanza and Shinyanga regions.

As IMARISHA's role is multi-faceted, the project builds capacity while sharing best practices and setting standards to help mentor Tanzanian organizations seeking to incorporate ES into HIV programming. IMARISHA works to demystify ES principles and concepts to forge a common language between health and ES communities of practice, contributing to more effective and comprehensive HIV programming. IMARISHA also supports smarter partnerships to improve and diversify ES activities, helping households move along the livelihoods pathway to improve their resiliency to economic shocks while helping to increase their incomes and assets. With USG/T prevention funding in FY 2012, the project adopts a core GHI principle of leveraging other efforts by working with USAID economic growth and natural resource management programs to mainstream HIV/AIDS programming and information. IMARISHA has an M&E plan and will report on PEPFAR indicators.

These funds will help procure two vehicles for daily logistics: one sedan for Dar es Salaam daily duties and one SUV for regional travel during field visits.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	1,600,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	9678		
Mechanism Name:	Imarisha		
Prime Partner Name:	Development Alternatives, Inc		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	600,000	0
Narrative:			
IMARISHA will continue to roll out its TA for economic strengthening and support package of services to USG/T HBC and OVC partners as well as LGAs. The support package of ES services includes a baseline assessment of households to better understand current ES activities, challenges, and barriers to economic improvements. The baseline information is essential in setting the implementation benchmarks, which are used to track progress on reduction of vulnerability and increases of resiliency. Other ES service components include customized and general training. Provided TA will be partner specific and addresses organizational needs. To leverage other USG/T funds, IMARISHA links with Economic Growth and Feed the Future (other USG/T initiatives) partners for those households that have the ability to participate in value chain activities. IMARISHA will grant between eight and 12 grants to sub-partners in an effort to pilot new technology and innovative models to improve household resiliency. Funding under HBHC will also go to complement the on-going work of developing national ES guidelines. The regions covered by this TA are Dar es Salaam, Morogoro, Dodoma, Iringa, Mbeya, and Shinyanga.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HKID	1,000,000	0

Narrative:

Economic strengthening (ES) is a key component of the OVC portfolio to ensure transition of USG/T OVC support from direct material provision to sustainable support. IMARISHA will work with various OVC partners and sub-partners to ensure ES activities are market driven, whether from a skills development perspective or from a business development perspective. Given limited experience among implementing partners in this arena, significant training will initially be required. One of the first four courses of training to be rolled out will focus on understanding the market, which aims at engaging IPs to undertake market analysis before planning different ES activities, particularly IGAs. IMARISHA will roll out training and TA related to agriculture, focused first at the household level, and then at more commercially-oriented ventures as beneficiaries demonstrate the ability to take on this type of activity. IMARISHA will also provide grants to sub-partners and other local organizations to pilot new innovations and activities in ES. Funded projects must demonstrate opportunities for scale and reproducibility. IMARISHA will also provide TA to IPs to determine appropriate exit strategies and ensure viable, long-term approaches are pursued. Finally, IMARISHA will provide best practices and develop an evidence-based model on different ES support packages to address the varying levels of vulnerability. This is a National TA with a special focus in Dar es Salaam, Mwanza, Morogoro, Dodoma, Iringa, Mbeya and Shinyanga regions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

(Please see HVOP above for further details on this activity.)

DAI will support EG/NRM partners to ensure that abstinence and delayed sexual debut are part of youth interventions and that faithfulness/partner reduction is a key component of all behavioral messages. These messages are accompanied by referrals to clinical services, includeing HTC, VMMC, ART, and PMTCT/RCH. Where possible, these partners will also link their clients to youth and women's groups. Technical assistance will cover Dar es Salaam, Dodoma, Iringa, Mbeya, Morogoro, Mwanza, and Shinyanga regions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	200,000	0
Narrative:			
IMARISHA will work with USAID's economic growth and natural resource management (EG/NRM) partners to incorporate and mainstream HIV/AIDS programming into their existing activities. This includes the integration of both behavioral interventions as well as linkages to clinical services. The technical assistance provided will help implement a baseline survey of clients/beneficiary groups before determining what particular issues should be addressed and identifying local HIV service providers who can appropriately serve the populations' needs. The target populations for these interventions include youth, mobile populations and women who engage in transactional sex -- all of whom live in wildlife protected areas and other national natural resource reserves. Approximately $30,000 will go toward Theater for Development, video spots, IEC materials, and interactive radio programming to promote a reduction in high-risk behaviors, and concurrently link individuals with existing health/HIV services. This will reach up to 30,000 (67%) of the population in Pangani. They activity will capitalise on the existing Pangani Radio and Theatre Group, to continue Theatre for Development and behavioral change work. Approximately $10,000 will be used for social marketing to encourage and monitor the use of condoms, by promoting and monitoring the use of existing condom outlets. The activity will also tap into development projects to improve the livelihoods for at least 90 individuals in six villages in Bagamoyo and Pangani. Fishermen are among the high-risk groups in Tanzania. $10,000 is being allocated to reach up to 360 (9%) migratory fishermen in Pangani and Bagamoyo districts. Partners will integrate fishermen-specific issues into the village HIV/AIDS and gender plans to reduce high-risk behaviors and promote HIV/AIDS prevention. Through a peer program, approximately $70,000 will be used to reach 5000 smallholder farmers with HIV/AIDS prevention interventions. The focus will be on partner reduction messaging, and referrals and linkages to health and HIV services. Development partners work with smallholders farmers. It is important that HIV/AIDS prevention is part of their training and mentoring agenda. 60 schools and 1500 hard to reach adolescents with limited access to HIV/AIDS information and interventions in the Maasai Steppe area of Tangarire Manyara Reserve will be reached with school class discussions awareness and peer reviews, and linking development and prevention work with other health services such as HIV/AIDS testing and counseling, PMTCT and ART.			

Given that these EG/NRM partners are not familiar with PEPFAR's reporting requirements, IMARISHA will work with each partner to ensure they adhere to specific deadlines as well as track and monitor appropriate outputs. In addition, partners will be expected to develop tailored indicators should the PEPFAR NGIs not adequately serve their projects. Seeing as IMARISHA will be working with several EG/NRM partners, they will be expected to document lessons learned and develop case studies on successful examples of HIV/AIDS mainstreaming. This will be critical as wraparound activities will continue to play a major role in the implementation of the GHI Strategy.

Implementing Mechanism Details

Mechanism ID: 9681	**Mechanism Name: Single eligibility FOA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Tuberculosis and Leprosy Control Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,762,430	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,762,430

Sub Partner Name(s)

Bukombe	Igunga District Council	Iringa Municipal Centre
Kahama District Council	Kyela District Council	Masasi District Council
Maswa District Council	Mbeya City Council	Mbozi District Council
Newala District Council	NJOMBE DISTRICT COUNCIL	Nzega District Council
Rungwe District Council	Songea Municipal Council	Urambo District Council
Uyui District Council		

Overview Narrative

The goal of this project is to contribute to the PEPFAR vision of providing treatment to 440,000 HIV/AIDS patients and HIV care to 2,500,000 individuals. To maintain agency operations, the various objectives will be achieved in FY 2012: expand access and maintain quality TB/HIV services; strengthen the capacity of managers and health care providers in both the public and private care sector to correctly manage TB/HIV co-infected patients; scale up management of childhood TB in 47 districts; provide expertise on scaling up implementation of intensified case finding, isoniazid preventive therapy (IPT), and infection control (3Is) in collaboration with NACP and other stakeholders; improve M&E systems, including surveillance of TB/HIV in the country; empower communities to participate in TB and TB/HIV control activities; and improve laboratory capacity to diagnose TB, including multi-drug resistant TB.

Activities will be implemented in 70 districts, which are located in 11 regions on the Tanzania Mainland; the remaining 86 districts will be supported by the Global Fund to Fight AIDS, TB, and Malaria (GFATM), PATH, and other partners. The targeted population are those with potential vulnerabilities to TB, TB and HIV/AIDS patients in both public and private health facilities, and community members. TB and TB/HIV modules will be incorporated into medical schools training curricula. Districts will be encouraged to include TB/HIV activities in their CCHP as part of the transition to local ownership. Progress of implementing project activities will be monitored through quarterly technical and financial reports following supervision visits, coordinating committee meetings, and annual audit.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,032,037

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Military Population
TB
Workplace Programs

Budget Code Information

Mechanism ID:	9681		
Mechanism Name:	Single eligibility FOA		
Prime Partner Name:	National Tuberculosis and Leprosy Control Program		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	1,762,430	0

Narrative:

This project is aligned with MOHSW's revised 2007 policy and Health Sector Strategic Plan III (July 2009-June 2015), Five-Year Partnership Framework that is in support of the Tanzania National Response to HIV/AIDS (2009-2013), National TB and Leprosy Program Strategic Plan (2009-2015), and National TB/HIV Policy Guidelines (2007). The National TB and Leprosy Program (NTLP) has taken a leading role in implementing and coordinating TB and TB/HIV control activities with great success. TB notification and treatment success rates are above the global target, currently at 70% and 88% respectively. Screening of HIV among TB patients is above 90%.
Given its technical capability, NTLP has taken a leading role in developing various TB/HIV guidelines and tools used by collaborating partners in the country. In the last five years, NTLP has established a human resource base to implement the proposed activities. The program, with CDC/PEPFAR and GFATM support, has recruited and trained 90 TB/HIV officers who have been deployed to 106 districts with two coordinators at the national level to monitor TB/HIV activities. In addition, over 4,500 health care workers have been trained in TB/HIV services. Annual audits of financial statements are conducted by the Office of Control and Audit General and predetermined USG approved auditors. The government

plans to absorb coordinators recruited through CDC/PEPFAR and GFATM support into regular services under the accelerated recruitment mechanism. The program has already adopted the revised Partnership Framework and PEPFAR II indicators, while M&E plans and tools have been updated to incorporate the revised indicators. The indicators will be reported on a quarterly basis at district, regional, and national levels. In the last COP, NTLP has made significant achievements in implementing TB/HIV activities in the country. TB/HIV services have been successfully scaled up throughout the country to all districts with support from CDC/PEPFAR, GFATM, and other partners. Over 90% of all TB patients are being screened for HIV and the co-infection rate is approximately 38%. Of these, nearly 92% were initiated on CPT, but only 35% were initiated on ART during the reporting period. Regarding 3Is, IPT was introduced successfully in 18 districts and plans are underway to expand to another 21 districts using experience gained from the early starters. The following guidelines and tools for implementing collaborative TB/HIV activities were produced: National Policy Guidelines for Collaborative TB/HIV Activities, collaborative TB/HIV activities training manual, 3I's training manual, 3I's M&E tools, TB infection control guidelines, pediatric TB/HIV guidelines, revised TB diagnostic algorithm, revised M&E tools to include TB/HIV variables, TB/HIV job aids, and strategic approach for 3I's phase implementation. The program took a lead in collaboration with NACP to pilot provision of HIV care and ART services in Temeke TB clinic in 2006. The aim was to increase early HIV care and uptake on ART to TB/HIV patients and ensure TB infection control. The pilot project was evaluated in 2009, which showed that about 81% of those eligible received ART. Following the pilot project, HIV care and treatment services have been introduced in approximately 62 TB clinics. In addition, 22 TB clinics have been renovated to provide HIV care and ART. The program has also updated the ETR.Net software to include TB/HIV indicators.

Implementing Mechanism Details

Mechanism ID: 9685	**Mechanism Name: PATH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,727,372	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	1,727,372

Sub Partner Name(s)

Management Sciences for Health		

Overview Narrative

The goal of Program for Appropriate Technology in Health (PATH) is to improve access to quality TB/HIV services, including TB diagnosis and treatment in Tanzania. The program works in close collaboration with MOHSW through the NTLP, NACP, and Association of Private Health Facilities in Tanzania, including LGAs.

The program is aligned with the Partnership Framework strategy under Goal One (Services). The main program activity is HIV screening of TB patients, which aims to have the HIV status of 95% of all TB patients recorded in TB registers; 95% of TB/HIV co-infected patients started on cotrimoxazole preventive therapy; and 60% of infected patients initiated on ART during TB treatment.

Cost efficiency strategies will include decentralization of trainings at district headquarters. Supportive supervision and mentorship will also be used.

Transitional strategies include negotiation with LGAs for possibility of gradual inclusion to the LGA payroll of PATH staff currently seconded to districts.

Programs will continue work in the six regions of Arusha, Dar es Salaam, Kilimanjaro, Mwanza, Pwani, Zanzibar, and scale up in two new regions of Geita and Simiyu. Continued TA to the NTLP will help maintain quality TB/HIV collaborative services. Program will continue to promote sustainability by working with Council Health Medical Teams to ensure that TB/HIV activities are included in Comprehensive Council Health Plan.

M&E is incorporated into the the NTLP M&E plan 2011 –2016.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Child Survival Activities
TB
Workplace Programs

Budget Code Information

Mechanism ID:	9685		
Mechanism Name:	PATH		
Prime Partner Name:	Program for Appropriate Technology in Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	1,727,372	0
Narrative:			
With the support of COP 2011 funding, PATH collaborated with the MOHSW through the National TB/Leprosy program (NTLP) and National AIDS control program (NACP) to implement TB/HIV interventions in 955 health facilities in six regions of Tanzania Mainland and Zanzibar. Main activities included HIV screening of TB patients and implementation of Intensified TB screening, Infection Control and Isoniazid Preventive Therapy (the three I's). With COP 2012 funding, PATH will continue to work in collaboration with ART implementing partners to ensure effective implementation of the "three I's". Through use of the national TB screening tool, the program will orient staff in different sections to perform intensified TB case finding among clients attending Reproductive and Maternal Child Health clinics,			

general and specialized clinics (i.e. CTC, Diabetic Clinic) in Out Patient Departments, and In-Patient Departments for admitted patients. This program targets screening for HIV of all TB patients and will strive to ensure that 95% of TB-registered patients have their HIV status recorded in the TB register. In collaboration with NTLP, PATH will also develop, print and distribute specific IEC material TB infection in children to enhance diagnosis of pediatric tuberculosis. The development of curriculum for TB management among children, currently in its final stage, began with funding from COP 2011. To increase the proportion of TB/HIV co-infected patients starting on ART from 32% to 60%, the program will support the training of TB clinic staff on HIV/AIDS clinical management. Health care workers who have no knowledge of TB/HIV will be trained on TB/HIV interventions using the National TB/HIV curriculum endorsed by MOHSW. This will result into easier access to HIV care at "Under One Roof" TB clinics. Through support for the formation and maintenance TB/HIV regional and district committees, the program will continue to advocate to RHMTs and CHMTs to incorporate and fund TB/HIV activities through their Comprehensive Council Health Plans (CCHP). In order to ensure quality interventions, the program staff comprises of TB/HIV officers and District TB/Leprosy Coordinators who will conduct supportive supervision visits and provide mentorship to peripheral facility staff on service delivery and program monitoring.

Implementing Mechanism Details

Mechanism ID: 9694	**Mechanism Name: Angaza Zaidi**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,800,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,800,000

Sub Partner Name(s)

African Inland Church Diocese of Mwanza	Aga Khan Foundation	Anglican Church Central Diocese
Anglican Church of Tanzania - Diocese of Mara	ARUSHA MUNICIPAL COUNCIL	

Overview Narrative

Angaza Zaidi's (AZ) goal is to mobilize innovative strategies to rapidly increase access and use of HIV/AIDS counseling and testing services (HTC) in Tanzania. AZ directly contributes to all three intermediate results within the GHI Strategy, including improved HIV/AIDS preventive behaviors and social norms, increased use of comprehensive HIV and AIDS services, and creating an enabling environment. The program is designed to prevent new HIV infections, identify and link HIV-positive individuals to care and treatment services, and provide care and support services to PLHIV.

The geographical coverage of the program is national, targeting the general population with specific emphasis on high-risk groups. The program expects to reach 440,000 individuals with counseling and testing services for FY 2012.

Since HTC is a service point for many other prevention activities, AZ will work closely with other implementing partners and district government authorities to ensure proper linkages. A capacity building approach that focuses on on-the-job training and mentoring will also be implemented as this is a more cost-effective approach and requires less time away from work for providers.

As a transition strategy, district engagement in partner budgeting and planning will be heightened and program activities will be integrated into Council Comprehensive Health Plans. Capacity building will include HTC, PMTCT, and HEID proposal writing to allow for opportunities of other funding streams.

AZ utilizes a robust M&E system to monitor its activities. In FY 2012, an additional emphasis will be placed on analyzing data and utilizing it for program improvement.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	20,000
Human Resources for Health	120,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	9694		
Mechanism Name:	Angaza Zaidi		
Prime Partner Name:	African Medical and Research Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	2,700,000	0
Narrative:			
AZ will continue to offer HTC services in both static and mobile settings using the national HIV testing algorithm. The program shall maintain support to all the current 42 partner sites. Empowered partner sites will provide onsite HTC services to the general population (HIV prevalence 5.7%) and conduct mobile HTC services targeting high-risk populations. Additional emphasis will be placed on couples			

counseling and testing and the development of risk reduction plans with clients. Discordant couples will be supported to prevent infection among negative couples while ensuring HIV positive couples are linked to care and treatment.

Counselors are trained to provide consistent messages on reducing multiple concurrent partnerships and breaking sexual networks during group and individual risk assessments, counseling sessions, and with developed IEC materials placed in client waiting rooms. Screening on alcohol and GBV will also be increased. Identified GBV victims will be linked to legal, social, or medical services. Being aligned with the GHI strategy, counselors will screen for family planning needs and refer, as appropriate. Condom demonstrations of correct and consistent use will be emphasized during sessions. Following patient visits, AZ will continue to track HIV-positive individuals through mobile technology and home visits to ensure a closed loop with HIV care and treatment services.

PHDP services and referrals to post-test clubs (PTCs) will be heighted. These clubs will be strengthened to ensure competency in addressing general health issues, nutrition, adherence, and referrals to spiritual and legal support. PTC members will also participate in community mobilization efforts and assist in building demand for HTC services.

A total of 440,000 individuals are expected to learn their HIV status, which is a 10% increase from last year. In FY 2012, at least 40 MSM and 100 SWs will be trained as peer educators. At least 5,626 individuals that test HIV-positive will receive the minimum PHDP package as set forth in the national guidelines. Twenty-five PTCs will be maintained and both be encouraged and empowered to register as local community-based organizations. Finally, the program will build capacity of 40 partner and district staff in counseling and M&E through on-the-job coaching and mentoring.

M&E system support will focus on data quality and use of information for decision-making. Quality of HTC services will be monitored through mystery clients, client exit interviews, health provider satisfaction surveys, and observations. End of project evaluation planned during the final year will focus on impact assessment and replication of the model and its sustainability.

AZ will support MOHSW in rolling out new national HTC priorities and guidelines. Partners and district authorities will jointly plan and budget to enhance transition and responsibilities of key project activities. Integration of program activities into CCHPs shall be championed and partners will receive coaching in proposal writing and fund solicitation as a sustainability strategy. Program results, lessons learned, and success stories will be documented and disseminated.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	100,000	0

Narrative:

In collaboration with MOHSW, RHMTs, CHMTs, and local USG/T implementing partners in targeted regions, AMREF will strengthen PMTCT/HEID linkages to enhance the impact of the PMTCT program in the country. SWAT teams will focus on identifying and assessing PMTCT/EID linkage gaps and bottlenecks, while proposing local solutions to implement. The identified gaps and solutions will be documented and shared in meetings that involve USG partners in the area, along with regional and district health management teams who will, in turn, take forward the implementation and scale-up of solutions.

To maximize effectiveness and buy-in, AMREF will work with partners to strengthen linkages between PMTCT and HEID in areas with low or problematic HEID/PMTC coverage, specifically in Ruvuma, Rukwa, Iringa, and Mbeya. All relevant stakeholders will be involved in the assessments and regional specific reports with proposed solutions. Both assessments and reports will be produced and shared with implementing partners, along with regional and district authorities. AMREF will also scale up the linkages between PMTCT/HEID to care and treatment in one region, while four additional regions are planned during FY 2012. AMREF will document program results in Ruvuma according to PEPFAR indicators, as well as findings of the PMTCT and HEID linkage assessment.

Community mobilization and awareness creation for increased uptake of PMTCT and HEID services will be heightened through use of Community Owned Resource Persons (CORPs) and mother support groups (volunteers) that already exist in the community. Promotion of male engagement in PMTCT services and couple HTC services will be heightened. These strategies, coupled with appropriate counseling, will result in increased PMTCT services uptake, retention, and adherence to care and treatment. Improved PMTCT uptake and efficiencies in services provision is expected to lower unit cost per patient reached with PMTCT.

To strengthen the community component of PMTCT and enhance access of mother-child pair follow up, the AMREF team, in collaboration with MOHSW, RHMT, and CHMT, will support PMTCT implementers in the region to organize on-the-job coaching and mentoring of district supervisors and/or managers in PMTCT and HEID linkages in order to create a pool of experts who can move this new initiative forward.

Job aids and guides for health care providers and community volunteers shall be developed and distributed to PMTCT sites in collaboration with MOHSW, districts, and other stakeholders. PMTCT implementing partners are responsible for producing and disseminating these materials to service delivery points. The AMREF team, along with government partners and PMTCT implementing partners, shall conduct a follow up site visit three months after implementation of the recommendations. The

status of PMTCT and HEID linkages will also be checked, while joint discussions and agreements will be made as to the way forward. Feedback meetings to share findings of the assessment shall be organized at district, region, and national levels. Integration of PMTCT activities into Council Comprehensive Health Plans (CCHP), as well as supervision and continued support to PMTCT sites, will be championed. Tools for PMTCT and HEID will be shared with MOHSW, regional, and district authorities for further use beyond Angaza Zaidi. Program results, lessons learned, and success stories will documented and disseminated.

Implementing Mechanism Details

Mechanism ID: 9695	**Mechanism Name: URC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,750,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the Health Care Improvement Project (HCI) is to support the Ministry of Health and Social Welfare (MOHSW) and implementing partners (IP) to achieve and sustain delivery of quality HIV/AIDS care through capacity building by applying and adapting modern quality improvement (QI) approaches to care delivery practices.

In FY 2011, six ART/PMTCT demonstration QI collaboratives were established in six regions, resulting in innovations that have been spread to six other regions. In addition to scaling up to new regions in FY 2012, the technical scope of the interventions will be enhanced to test applications of modern QI methods

to new program areas. These will include testing the application of QI approaches to enhance provider performance in Mtwara, adapt HBC Standard Operating Procedures in Tanga and Morogoro, test the feasibility of patient self-management in ART in Morogoro, and assess the modalities of improving management capacities of Council Health Management Teams (CHMTs). The program will also work to strengthen district health management performances. HCI will assist MOHSW with the roll out, benchmark, and improve the quality of OVC while assessing the impact of integrated PMTCT and RCH services in the Manyara region.

HCI's program approach encompasses many of the priorities within the PF and GHI strategy, mainly that of mainstreaming gender into activities, while partnering and leveraging resources from other stakeholders to harmonize work and maximize outcomes. Building capacity of MOHSW structures will help to ensure sustained practices. Strengthening MOHSW's knowledge management system will improve monitoring practices to track progress and outcomes of the work plan, thereby promoting learning and accountability as prioritized in GHI.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	100,000
Gender: Reducing Violence and Coercion	50,000
Human Resources for Health	500,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	9695		
Mechanism Name:	URC		
Prime Partner Name:	University Research Corporation, LLC		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	100,000	0

Narrative:

In collaboration with MOHSW and HBC IPs, HCI is currently in the process of developing Standard Operating Procedures (SOPs) for HBC services. As part of the SOP development, prototyping of the SOPs in Morogoro and Tanga regions aim to demonstrate and model how the application of HBC SOPs improve practice. Documentation of associated effectiveness using routine M&E tools, however, is an on-going process. The completion of this endeavor will be followed by introduction and application of the SOPs in the country's routine service delivery, thus helping to strengthen the quality of care within the HBC system.

Expanding on previous years' work, HCI will continue to support MOHSW and the IPs in FY 2012 to introduce SOPs in service delivery while documenting resultant care outcomes. This support will provide a formal, standardized mechanism for linking existing non-HIV community-based programs, such as family planning, community IMCI, immunization, and nutrition. Furthermore, to strengthen the M&E system, HCI will support the National AIDS Control Program (NACP), IPs, and council staff on using the HBC/UWANYU database, as well as provide training on how to link routine M&E indicators with client-level program performance measures. The SOP for HBC provides detailed descriptions of steps and procedures to be followed by providers in performing specific tasks, including referral management, adherence to treatment, linking clients to PLHIV support groups, IGA, family planning, and TB clinics. Implementation of the SOP is expected to result in harmonized HBC practices across councils and IPs, improved coordination among services, increased efficiencies in program monitoring and evaluation, and better health and social outcomes for PLHIV and their families.

Training on the HBC/UWANYU database will be coordinated through the NACP's M&E department, HBC IPs, and the UDSM computing centre. All 25 regional and 130 district HBC coordinators (totaling 155 staff) in Mainland Tanzania will be trained on how to use the database.

The SOP for HBC is based on eight priority programmatic areas, which are directly linked with HBC M&E indicators. Since adherence to standards of care delivery is associated with better care outcomes, HCI plans to build the capacity of MOHSW, IPs, and councils to be able to measure key HBC outcomes using routine M&E tools.

HCI and IPs will orient national, regional, and district HBC trainers to the SOPs as part of the formal roll out in FY 2012. The trainers will in turn orient HBC supervisors and providers. This intervention is planned to cover 10 out of 23 regions in which eight trainers from each region will be oriented on the SOPs (total of 80 trained); each region will then train 20 district trainers (total of 200 trained). In FY 2013, HCI intends to support SOP trainings to national and regional HBC coordinators and trainers from the government and IPs from the remaining 13 regions using a cascade model, allowing the national team to train regional teams which in turn will train district teams and, subsequently, HBC service providers and supervisors. This approach creates ownership and sustainability of the program across levels of care and allows for transition of responsibilities from the central government to local authorities. A total of 406 staff will be trained on SOP usage.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	200,000	0

Narrative:

HCI's goal in supporting OVCs in Tanzania is to strengthen the capacity of MOHSW, IPs, and local structures to provide quality of care, support, and protection to orphans and vulnerable children. In FY 2011, HCI will support scale up of OVC QI activities to Arusha, Tanga, Rukwa, and Shinyanga regions. Continuing activities in FY 2012, efforts will be directed to sharing lessons learned from Bagamoyo to the whole Pwani region while rolling out QI training activities to the rest of the country.

HCI will provide TA to the national level to support scaling up and utilization of QI job aides by local structures. As part of PEPFAR's OVC goals and priorities to address the severe human resource shortage, efforts will be directed to skills building for social welfare officers, para-social workers, and other key staff at local government authorities (LGAs) to facilitate effective implementation of national QI guidelines at the service delivery level. Furthering GHI's strategy of promoting learning and accountability through M&E, improvements to data collection and usage from MVC registers for planning and decision-making will be a prioritized capacity building activity.

Support to local multi-sectoral structures, such as the Most Vulnerable Children Coordinator (MVCC), child protection teams, and local CBOs, is key to sustainability to not only ensure mobilization of resources in providing direct social services, but also to identify and address various issues related to child protection, including violence, abuse, exploitation, and neglect. Through these interventions, HCI will support teams to identify, plan, and implement different changes in accordance to standards, norms, and structures that are in the best interest of the children.

National PEPFAR OVC goals of integration are addressed as HCI will support teams to enhance utilization of available resources in integration and linkages of OVC services with other HIV programs, such as PMTCT, care and treatment, and HBC to improve retention. This will help to explore opportunities in other sectors to strengthening the economic capacity of families in caring and supporting OVCs, creating an ability to meet other basic household needs.

HCI will support gathering evidence and documentation of QI processes focused on the impact, efficiency of QI models, and best practices through mentoring and coaching to local partners and LGA, leveraging of resources to avoid duplication of efforts, and scaling up in other areas applicable to the context. This will facilitate local structures' ability to harmonize and utilize tools in documentation of implementation of OVC standards at service delivery level. Exchange visits will be conducted across local stakeholders to facilitate in sharing best practices and challenges in implementing service standards.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	850,000	0

Narrative:

HCI will continue working with IPs, RHMTs, and CHMTs to facilitate regional scale up of PMTCT quality improvement to all regions in mainland Tanzania. At the national level, HCI will support the NACP to finalize updates to the infant feeding counseling training package, print copies for HCI QI supported sites, develop job aides, and continue to provide TA to infant feeding counseling trainings and refresher courses.

In all new regions, the sequence of events will include PMTCT quality gap analysis, consensus building on priorities, testing changes to close the gaps, and benchmarking outcomes using selected indicators. QI teams will be identified in all sites and go through modular cause of didactic training in QI, followed by coaching and mentoring. HCI will harmonize efforts with IPs and build capacities of RHMTs and CHMTs in quality improvement to ensure sustainable implementation. HCI is testing the role of on-site QI Preceptors in Iringa, which after positive evaluations has the potential for expansion. In general, COP

2012 will focus on scaling down regional trainings in favor of conducting district on-site trainings.

HCI will also work with MOHSW, local government structures, and IPs to support an assessment of the level, impact, and quality of integrated PMTCT/RCH services in Manyara region. The aim is to strengthen local government ownership of the programs, increase the coverage of quality PMTCT and RCH services, increase program sustainability, strengthen the health system, and improve MNCH's outcomes. Baseline assessments were conducted during FY 2011 and a synthesis of the findings will guide future development of PMTCT/RCH integration service packages, as well as help to identify current quality gaps. Integrated services will produce best results where functional management is optimal. HCI will apply QI methods to improve management performance of the Manyara RHMT and CHMTs through capacity building on strategic planning, program management, monitoring, and coordination. Learning from the experiences in Manyara, expansion efforts will be made to Shinyanga, Mwanza, Dodoma, and Mbeya for COP 2013.

Improvements to the district health information systems will provide quality data for monitoring PMTCT/RCH service integration and impact. RRCHCOs and RCHCOs will be trained.   Integration will also promote the scale up of more efficacious regimen for PMTCT by providing technical support to district supervisors and mentors. Additional benefits of PMTCT/RCH integration will address retention and adherence challenges of mother–infant pair, improve linkages and referrals to treatment, care and support services, and implement local strategies to promote male involvement in PMTCT/RCH services. Furthering a comprehensive approach, integration will also include detection and management of chronic illnesses, such as hypertension and diabetes.

Periodic review against the national policy and guidelines of the developed minimum package for PMTCT/RCH integration will take place over time. These will be done in QI learning sessions within the five regions. HCI will document and share with other partners best practices of the PMTCT/RCH integration.   HCI will also assist CHMTs to take responsibility for monitoring the quality of PMTCT services, through support of improved data recording, data verification and periodic analysis, and relevant responses to findings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	600,000	0

Narrative:

In FY 2011, HCI supported MOHSW to finalize the National QI Guideline for HIV/AIDS services and corresponding training curricula to harmonize training and practice procedures.   Currently, HCI is

working with MOHSW and other partners in training of National Trainers of Trainers (TOT) in QI with coverage in 12 regions. In FY 2012, HCI will support MOHSW and IPs to sustainably scale up ART services QI into six new regions of Shinyanga, Dodoma, Arusha, Kilimanjaro, Tabora, and Mbeya regions. Subsequently, HCI will cover the rest of the country in FY 2013. Within the new regions, baseline assessments of the quality of HIV services will be determined to provide initial learning on quality gaps to be addressed. This will be followed by identification of QI teams in each facility providing ART in all districts. The team will then prioritize initial challenges from the quality gap analysis they will like to address and agree on indicators to benchmark progress and outcomes in line with MOHSW and PF priorities. HCI will train the teams on the use of QI techniques that will provide optimal improvement of ART services. The guiding principle is that good ART services will ensure that all patients in need of ART receive the services, are retained in services, and experience good outcomes from the treatment. All teams will go through modular courses of three learning sessions that alternate with coaching and mentoring. During the learning sessions, there will be sharing of the experience observed in each facility in the QI efforts. RHMTs and CHMTs in each region will be trained to be program mentors and coaches as they facilitate some aspects of the learning sessions and coaching visits in preparation for the transition. It is envisaged that their involvement will increase QI program sustainability and some of the skills learned will also help improve other programs under each of the management teams' jurisdiction. In selected regions, HCI will apply implementation science to explore options of carrying the improvement agenda to other levels. Work started in FY 2011 of testing modalities of improving ART providers' engagement and productivity in Mtwara will be finalized and lessons learned will be applied in all on-going ART improvement collaboratives. Likewise, learning from the ongoing feasibility test of patient self-management as an additional option of improving ART in Morogoro will be applied to other ART programs countrywide. Since functionality of CHMTs is central to quality ART, HCI will support the RHMT in Lindi to apply QI techniques to improve management performance of the CHMTs and share the lessons learned with other improvement collaboratives.

Implementing Mechanism Details

Mechanism ID: 9702	**Mechanism Name: ACQUIRE Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Engender Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,997,254	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,997,254

Sub Partner Name(s)

Mothers 2 Mothers		

Overview Narrative

The Acquire Project aims to improve PMTCT services that are linked with HIV/AIDS care and treatment, family planning, and other RCH services. The goal is linked to a GHI core principle of focusing on provision of services by using an integrated approach. In addition, two of the Partnership Framework goals are addressed with PMTCT services contributing to the total reduction of the number of new infections in the country and capacity building for Council Health Management Teams (CHMT) to plan and use data for decision-making purposes.

Coverage of the Manyara and Iringa regions will provide PMTCT services to 90% of the total ANC clients and cover 100% of the RCH sites.

Providing PMTCT integrated services with other RCH services will offer improved access to more comprehensive services while decreasing duplication of activities. On-the-job trainings will be offered in lieu of central trainings to minimize costs.

Capacity building of the CHMTs to manage and raise funds will help to ensure the financial and operational sustainability of the project. The aim is to include the PMTCT services in the CCHPs and use the data for decision-making.

Monitoring of the project will rely primarily on routine data collected through the national health information system. Key indicators include those in the PMTCT Next Generation PEPFAR indicators, which is entered monthly into an electronic database. In-service training results will also be entered into the EventSMART database. Routine progress reports on all the NGI indicators will be provided and used to make programmatic improvements. In addition, the program will evaluate family planning and HIV

integration in 12 sites through the basic program evaluation initiative.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	70,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	9702		
Mechanism Name:	ACQUIRE Project		
Prime Partner Name:	Engender Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	1,997,254	0
Narrative:			
(1) Scaling up PMTCT services from 93% (Manyara) and 96% (Iringa) to reach 100% of RCH sites			

(2) To perform program costing analysis to relate cost of service provision and number of clients reached overtime. This will guide which cost elements need attention to reduce cost or increase coverage through changing our service delivery strategy (3)Training of service providers to provide comprehensive and integrated PMTCT services at all levels. Our strategy is to build on OJT to scale up EID services. (4) To decentralize EngenderHealth systems for tracking data collection completeness at regional/district level; data quality assessment; and service quality monitoring systems. This action will empower regions/districts to take lead and ownership of the program. (5) Conduct basic program evaluation of family planning and HIV services integration in selected sites. (6) Support supervison at national and district level. This include orientation of new PMTCT tools; build capacity of CHMTs on use of data for decision making; Training on COPE for quality improvement (7) Support refresher trainings in line with new WHO recommendations such as: Scale up PMTCT to all RCH sites; Provide psychosocial support and active follow up of mother - infant pair in the community by mentoring mothers and site coordinators through Mother to Mother program.; linkages to care and treatment and follow up mother-infant pair using HBC platform (8) Engage CBOs and local leaders to increase male involvement through: sensitization and planning meetings; using community action teams (CATs); facilitate community discussion to promote couple communication; design special packages to motivate males who escort their partnes at ANC. (9) Training of service providers on FP/PMTCT service integration to provide integrated services and hence impart skills to: Mothers to able prepare nutritional meals based on local food;

Implementing Mechanism Details

Mechanism ID: 9795	**Mechanism Name: African Palliative Care Association**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Palliative Care Association	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall goal of this agreement is to build the capacity of the Tanzania Palliative Care Association (TPCA) to become a viable national association and a key resource for palliative care development, along with becoming recognized as a leader within the field of palliative care in Tanzania. In keeping with the various PFIP goals, this agreement will have the following specific objectives: (1) strengthen the human and institutional capacity through organizational capacity development; (2) promote linkages and sharing of knowledge between palliative care providers within Tanzania; (3) develop capacity for training through training of trainer in palliative care; (4) promote availability of essential drugs required for provision of palliative care; and (5) implement monitoring and evaluation system for palliative care services.

Now in the third year of implementation, African Palliative Care Association (APCA) will continue to focus on systems strengthening, building on the work done in prior years. Drawing on previous experiences in coordinating and supporting palliative care activities in the African region, through training and mentoring efforts, APCA will continue to support and build the capacity of TPCA in organizing, managing, and supporting palliative care services in Tanzania, with eventual transition of all activities to TPCA.

TPCA activities will cover the entire country. AS TPCA increases their role in national level support, supervision, and mentorship for facilities integrating palliative care, there is a stronger need to purchase a vehicle that will be used to support district and region based work.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9795		
Mechanism Name:	African Palliative Care Association		
Prime Partner Name:	African Palliative Care Association		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0

Narrative:

APCA will continue to build management and organization capacity of TPCA to improve coordination of palliative care services in Tanzania. Year three activities will build upon work done in the second year, focusing on health system strengthening in terms of data monitoring and integration of palliative care services in the health delivery systems at the regional and district levels.

The planned activities will be implemented in collaboration with MOHSW, National Aids Control Program, and palliative care partners in Tanzania. APCA will provide technical support to TPCA and partners, while TPCA coordinates local implementation of activities. To strengthen the capacity of TPCA and support to the association, APCA will work with TPCA secretariat to finalize their strategic plan and incorporate comments from the board of directors. TPCA staff and board members will hold strategic meetings aimed at strengthening collaboration, including establishing and maintaining strategic partnerships for further growth of the association.

As a deliberate effort towards strengthening the human capacity for TPCA and supporting effective

coordination and implementation of project activities, a program manager will be recruited for TPCA. APCA and TPCA will continue to advocate for provision of better quality services by working in collaboration with MOHSW to review national palliative care/home-based care standards and guidelines. To enhance the ability of MOHSW and other policy bodies to prioritize and take forward the process of developing a national palliative care policy, a study visit will be undertaken to Uganda. The goal of the visit will be to support sharing of lessons in the areas of national level planning of palliative care service, the importance of national policy task shifting, and inclusion of morphine in national essential drug list. During FY 2012, APCA and TPCA will continue to promote the availability of essential drugs for pain relief, specifically the availability of morphine. The project will support the development of regional consultant hospitals as sites for the distribution of oral morphine for pain management. In the areas providing oral morphine, quarterly supportive supervision and mentorship will continue with support from TPCA, MOHSW, and Tanzania Food and Drug Administration (TFDA). To enhance local knowledge and skills in palliative care and sustained education for services providers, the project will support educational opportunities for trainings at various levels. The education and training programs will target both pre- service and in-service health professionals. APCA and TPCA will continue working with medical and nursing schools with support from the local stakeholders to strengthen their capacity to integrate and teach palliative care at the institutional level. Targeted institutions include HKMU, IMTU, MUHAS, UDOM, BUCHS, Ifakara St. Francis, and KCMC. Sixty hospital staff will be trained in palliative care, 517 communities with home-based care volunteers will be trained by ELCT in year one will receive refresher training. For M&E, this year’s focus will be to translate M&E tools in Kiswahili with roll out to all partners.

Implementing Mechanism Details

Mechanism ID: 9798	**Mechanism Name: Axios**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Axios Partnerships in Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 450,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

GHP-State	450,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Axios' goal is to improve access to comprehensive community based palliative care for HIV infected adults and children. This is in line with global health initiatives immediate results 3- Improved adaptation of health behavior including health care seeking behavior, and imediate result 2- Improved health systems to strengthen the delivery of health services . In response to the Tanzania Partnership Implementation Strategy goal 1, project activities will be coordinated with national, district and ward plans to incorporate existing structures for integrating palliative care services into local community systems. To ensure efficiency, Axios will continue to hold coordination meetings at the ward level which allows more cost savings and sustainability as well as is setting a stage for the eventual management of program activities by the local Ward Management commitees . The monitoring and evaluation of the project is integrated with the regular reporting expected through ward and district structures. Axios will continue to ensure quality of data.

Target population is children and adults living with HIV/AIDS in Lindi and Mtwara regions. Three districts are covered in Lindi (Kilwa, Lindi Urban and Nachingwe) along with two districts of Mtwara (Newala and Tandahimba). The project will expand to two additional districts in Mtwara in the coming year.

The use of existing government systems and human resources is Axios' cost-effective operational model; and coordination with Local Goverment Authority, other NGOs and communities harmonizes activities. Activities are integrated into council and community plans to support local resource mobilization and ownership.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	17,101

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Mobile Population

Budget Code Information

Mechanism ID:	9798		
Mechanism Name:	Axios		
Prime Partner Name:	Axios Partnerships in Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	450,000	0

Narrative:

Axios will continue to provide integrated HIV community care and support services to adults and children PLHIV in two regions of Mtwara and Lindi. In FY 2012, with the additional funds provided by USAID, Axios will expand HBC volunteer services to two more districts in the Mtwara region. In the new districts, Axios will work with government and community actors to identify existing trained HBC volunteers who are no longer engaged in other program. To ensure LGAs support and clear understanding of the project, Axios will organize sensitization and advocacy meetings at all level. Refresher course will be conducted with them with an emphasis on collecting and reporting quality data. Bicycles will be provided to the new volunteers, to ensure access to more hard-to-reach areas. Furthermore, the partner will provide economic strengthening support to vulnerable households through linkages with DAI and use of the VICOBA (Village Community Banking) model, the last of which would provide loans for small business operations through pooled capital.

Axios will continue to support quarterly coordination meetings and supportive supervision by District HBC team in collaboration with Axios team. Groups of PLHIV in old and new sites will be introduced to ideas and skills for self-reliance and sustainable income generating activities, through capacity building on

small scale business and marketing skills. In additional, work with the Ministry of Social Welfare through the National AIDS control Programme (NACP), other implementers to link all identified PLHIV to care and treatments clinics, and return default clients to the Care and Treatment Clinic (CTC). Furthermore, they will ensure that PLHIV are linked to other local Community Based Organization like PEMWA for food and legal support; to the department of council social welfare for psychosocial and counseling on importance of business coalition groups. Axios uses standard national collecting tools produced by NACP, including individual client forms, monthly client summary forms and supportive supervision tools. Volunteers and contact persons are trained to collect data, including storing and sending completed tools and reports to LGAs. Individual summary forms and reports are entered and stored. A database system exists for double entry. Summary forms are compared with individual client forms to ensure correctness of data quality and quantity. Quarterly feedback meetings are conducted with field partners. Analyzed data are used to monitor and evaluate project progress. Subgrantees are trained to use the data for their planning. Data is reported to USAID and MOHSW through NACP on a regularly basis, and shared with other stakeholders annually during stakeholders coordination meeting.

Implementing Mechanism Details

Mechanism ID: 10006	**Mechanism Name: ROADS II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,610,431	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,610,431

Sub Partner Name(s)

Adilisha Child and Youth Development	Anglican Church of Tanzania	Bokorani Upendo group

Bugogwa Amani Post Test Club	Chimaba Sanaa Group	Communication and Transport Workers' Union (COTWU)
Development Alternatives, Inc	Evangelical Lutheran Church of Tanzania Southern Diocese	Fishers Union Organization
Free Pentecostal Church of Tanzania, Ikwiriri Mission Clinic & Dispensary	Good Samaritan Mission	Howard University
Huruma Women Group	Iringa Development of Youth Disabled and Children Care	Jielimishe Epuka Ukimwi Makambako
Kayenze Beach Management Unit	Kilolo Development Foundation (KDF)	New Happy Development Foundation (NHDF)
Program for Appropriate Technology in Health	Resource Oriented Development Initiatives	Samba Development of Tanzania
SEREPTA Women group.	Shirika la Ushauri na Udhibiti wa Ukimwi Kahama (SHIUUUKA)	Shirika la Watu Wanaoishi kwa Uhakika Tunduma
Tanga Aids Working Group		

Overview Narrative

ROADS II is designed to reduce HIV transmission, improve care, and reduce the impact of HIV and AIDS along major transport corridors. The project achieves this goal by linking mobile populations and communities to prevention, care, treatment, and support services. In line with the GHI strategy, ROADS II recognizes the socio-cultural factors that place individuals at heightened risk for HIV infection and attempts to link households to economic strengthening opportunities that will create a stable and sustainable future.

ROADS II utilizes a community organizational model, which enhances the program's reach through the collective action of community clusters of small, sustainable, indigenous groups. These clusters are focused on reaching most at-risk populations (MARPs) in their respective communities, which often include truck drivers, fishermen, construction workers, mobile populations, food vendors, women engaged in transactional and commercial/transational sex work, in and out of school youths and OVC and their families.

In an effort to enhance country ownership and strengthen the indigenous response to the epidemic, capacity building and the transition of responsibilities represent essential components of the ROADS II cluster model. ROADS II works closely with local government authorities as well as provides sub-contracts to several local organizations.

The ROADS II monitoring system includes routine data collection and a tracking system with standardized recording and reporting protocols for services rendered. The evaluation component includes special studies to measure qualitative and tangible results.

Given the expansive areas that site coordinators and FHI staff serve, motorcycles will be purchased as a cost effective alternative to 4WD vehicles.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	300,000
Food and Nutrition: Commodities	50,000
Gender: Reducing Violence and Coercion	50,000
Human Resources for Health	250,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs

Family Planning

Budget Code Information

Mechanism ID:	10006		
Mechanism Name:	ROADS II		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

ROADS II will continue implementing community and home-based care (HBC) activities in Kahama, Makambako, Mwanza, Dar es Salaam, and Tunduma while initiating similar activities in Chalinze and Ilula. These areas are identified “hotspots” and, as such, the project will support adult care and support services in these areas. Activities will include strengthening provision of palliative care to adults and children and provision of the basic HBC/PHDP care package (condoms, water purification, reagents, insecticide-treated bed nets). Target audiences will be adolescents, key populations, and male and female adults.

To strengthen provision of palliative care, HBC providers will conduct monthly meetings to share experiences and challenges, as well as quarterly joint supportive supervision to ensure quality provision of HBC services. In the new sites of Ilula and Chalinze, the project will work closely with local governments and international and local partners to ensure project activities are complementary rather than duplicative of existing programming. The HBC program and team will be fully linked with district health facility HBC supervisors and adherence workers, where applicable.

HBC providers will be trained on the integrated HBC package. The project will organize and conduct in-service training on the HBC/PHDP core package for community para-social and health workers. In addition, project-supported field officers from PLHIV clusters will be oriented on the national recording and reporting tools to effectively and accurately compile and submit high-quality reports. As part of its family-centered approach to care, HBC volunteers will identify and refer family members for HTC (or facilitate home testing) and other needed services.

As part of the micronutrient component, ROADS II will build skills in home food production for PLHIV and their dependents. Training in business and entrepreneurial skills with a focus on group savings will

enhance the economic well-being of AIDS-affected households and caregivers. The project will also harness the reach and convenience provided by neighborhood pharmacies and drug shops, which are the first line of care for many community residents as well as truck drivers and their immediate networks. In between periodic trainings, HU/PACE will provide virtual coaching and mentoring to District MOH pharmaceutical care focal persons, clusters, and associations of local pharmacies and drug shop owners to continually strengthen this component.

For COP 2012, the project will integrate alcohol counseling and treatment options for PLHIV, particularly ART patients (see section on HVOP for additional information). Strengthening care for truck drivers will also be a particular area of emphasis through primary health care services (Wellness Centers) integrated into resource centers in Kahama, Dar es Salaam, Tunduma, and Mwanza sites. Recognizing the emotional and physical toll that HIV care and support can have on caregivers, ROADS II will implement programming specifically to address the needs of caregivers such as providing psychosocial support, education and training in nutrition, medical and social services, and access to economic strengthening through agriculture and other business development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

ROADS II will strengthen OVC programming at the three existing sites, Makambako, Dar es Salaam, and Tunduma, as well as initiate additional programming, as needed, in Ilula, Chalinze and Mwanza. As ROADS II expands into these areas, an emphasis will be placed on identifying opportunities for collaboration with partners already working in the area. ROADS II will adhere to recently released PEPFAR OVC guidance and will direct partner work plans on OVC/MVC programming for FY 2012, primarily focusing on building the capacity of governance structures and communities to lead OVC/MVC care and support to enhance sustainability of programs. The project's goals under this element are to improve access to safety nets for most vulnerable families.

ROADS II will work with and strengthen district and ward level social development and welfare units and local MVCC Committees in such areas as resource mobilization, collaboration among partners at site level, enhance community involvement in MVC/OVC care and support, and improve linkages with public private partnerships. Through local MVCC support, eligible OVC/MVCs will be provided with a minimum of one core care service, which includes food and nutrition support, shelter, protection, health care, education, economic strengthening, and psychosocial support. The project will provide technical assistance to the MVCCs to ensure evidenced-based OVC/MVC programming that truly benefits the target populations. The project will continually seek strategic collaborations and linkages with other

program elements including prevention, care and support, treatment, and gender. Further partnerships with other USG/T initiatives, such as Feed the Future, and other actors, including UN agencies and Global Fund programs, will also be sought after. Technical assistance will be provided to local MVCCs and local leaders to advocate and secure additional funding for OVC/MVC programming. The project will also look for strategic opportunities to work with local and national level government to ensure full engagement as the various government levels increase their efforts by taking on more technical, fiscal, and monitoring oversight for OVC/MVC programming.

To address the long-term needs of orphan-headed households, ROADS II will conduct vocational training and economic strengthening for MVC/OVC breadwinners. The project will also continue supporting HIV risk-reduction and care strategies, specifically for OVC who are the breadwinners within the households, linking them with HVOP and HVAB messaging, HTC services, and STI diagnosis and treatment. The project will introduce programming specifically to address the needs of MVC/OVC caregivers by providing education and training in nutrition, parenting, medical, and social services; access to economic strengthening through agriculture and other business development; and community sharing of child support. Health-related wrap-around services supported by the project will include, but not limited to, family planning and reproductive health services.

Reporting skills for cluster staff and volunteers will be enhanced and strengthened by providing training of the National Plan of Action (NPA) and national Data Management System (DMS), which are harmonized with the ROADS II regional M&E system. In existing and new sites, OVC/MVC identification or re-identification, will be conducted, per government guidelines, to ensure an updated and accurate list of OVC/MVCs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

While ROADS II sexual prevention programming primarily focuses on reaching MARPs, the project continues to have activities that target the general population, youth, and MVC/OVCs. ROADS II will continue to build capacity of peer educators and community mobilizers from indigenous volunteer groups to convey partner reduction messages while linking clients to services such as HTC and STI treatment. The project intends on reaching 40,000 individuals in FY 2013 with AB messages.

Rapid assessments of key behavioral drivers of the epidemic will be conducted at all project sites. This will ensure that activities are appropriately tailored to the context in which HIV transmission takes place. MCA-T sites will also implement similar behavioral interventions.

For COP 2012, ROADS II will examine barriers to partner reduction among certain populations, particularly transient workers who are young adult men and women aged 18-30. The project will also help facilitate and encourage dialogue among youth and OVC on transforming harmful sexual norms. The MCA-T program will extend AB programming to construction workers and at-risk community members near construction sites, including in- and out-of-school women and girls. The project will establish and strengthen health clubs in primary and secondary schools along road construction projects, drawn from best practices in Tanzania and the region. Additionally, the project will conduct regular in-school and inter-school debates, essays, and drama competitions addressing HIV/AIDS, gender, alcohol abuse, and sexual and reproductive health issues.

Recognizing opportunities for synergies with other interventions, the project will link its clients with clinical services, such as HTC, ART and PMTCT, as well as promote other community-based interventions. The project will continue to link and strengthen these services through the SafeTStop model, which mobilizes the community around HIV prevention, care, treatment, and mitigation services as well as addresses gender norms, alcohol use, stigma, and discrimination. The project will continue working with faith-based community organizations and youth groups to promote AB messages, specifically partner reduction, community men and women, and sexually active youth, while linking them to the appropriate services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	810,431	0

Narrative:

ROADS II will continue to implement facility and community based HTC programming in project sites. HTC programming will be implemented at all sites, including Dar es Salaam, Chalinze, Ilula, Makambako, Tunduma, Kahama, and Mwanza. MCA-T sites will implement HTC in Tanga, Ruvuma, and Tunduma -Sumbawanga sites. By generating interest and an appreciation for HIV services, an increase demand for HTC services has been noted at upgraded facilities and during special events and outreach activities.

ROADS II has and will continue to refresh counselors on URT guidelines. These trainings will cover counseling skills to serve discordant couples, including appropriate pre-test information and post -test risk reduction counseling; identify and counsel clients on alcohol use and abuse; and discuss family planning and reproductive health options while linking to services based on sero-status.

ROADS II will actively promote testing to all family members where the index patient is found to be HIV-positive. Testing all family members will be the entry point to referrals to a full menu of health

services, including child survival, family planning and reproductive health, malaria prevention and treatment, PMTCT, TB, and pediatric care and treatment.

For COP 2012, ROADS II will receive additional funds to support an increased number of HTC outlets in program sites with hours and locations appropriate for key populations, particularly truck drivers, construction workers, commercial sex workers and women and girls engaged in transactional sex. Sites will include HCT services in the SafeTStop Resource Centers, which serve as alcohol-free recreation sites as well as venues for a range of HIV and other health services. The MCA-T program will establish and implement strategic fixed outreach HTC sites at and near work places during special events and where construction workers frequent in the evening and weekend hours.

Additionally, the MCA-T program will offer HTC services after select monthly and bi-monthly HIV prevention sessions for construction workers. ROADS II will continue to work with community-based organizations to expand fixed outreach HTC during special events.

Importantly, the project will organize meetings between HTC staff, health providers, and community caregivers to ensure HTC clients and family members are referred to and from services. Clients who receive HTC services will receive relevant IEC materials. The project will also address gender barriers to uptake of HTC at health facilities, fixed outreach sites, and the home.

Through District DMO offices, quarterly joint supportive supervision will be conducted to ensure quality provision of HTC services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	800,000	0

Narrative:

Target Population / USD / Target Number / Type of Intervention
Truck drivers / $91,750 / 18,350 / Peer education
CSW / $300,000 / 4,900 / Peer education, economic strengthening, mobile HTC services
In and out-of-school youth / $700,000 / 136,000 / Prevention education, economic strengthening
Food vendors / $56,000 / 11,000 / Prevention education, economic strengthening, mobile HTC
Bar maids/Guest attendants / $32,000 / 6,000 / Prevention education, mobile HTC
Fishing populations / $320,000 / 60,000 / Peer education, mobile HTC
Construction workers / $150,000 / 4,050 / Workplace programming

ROADS II will provide targeted interventions for key populations while working with local district officials,

NACP, and TACAIDS at all levels to promote gains realized and sustainability. Peer educators and implementing partners will be trained to identify and reach key populations using strategic behavior change communication techniques and refer them to appropriate clinical services. A social mapping exercise will identify where key populations work, socialize, and live to determine what resources and health facilities are accessible to them. ROADS II will continue focusing on high-risk behaviors, such as multiple concurrent partnerships, alcohol abuse, and unprotected sexual intercourse, while linking clients to relevant health services . The project will also encourage biomedical interventions, including VMMC and ART, as well as adherence to ART for those already HIV infected. ROADS II will provide technical and program support to CBOs, peer educators, and drama troupes to sensitize key populations on alcohol and drug abuse. The MCA-T program will continue HIV prevention programming at the workplace, which includes monthly or bi-monthly HIV prevention sessions, workplace and community peer education training and outreach, and special events. The project will use local media, mainly radio, to channel various HIV and AIDS messages, discuss health services, and promote targeted condom distribution at key populations -frequented locations, such as shops, bars, guesthouses, truck stops, and construction sites.

Implementing Mechanism Details

Mechanism ID: 10044	**Mechanism Name: MUHAS-SPH**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Muhimbili University College of Health Sciences	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 850,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	850,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The focus of this cooperate agreement is to enhance Muhimbili University of Health and Allied Sciences (MUHAS) School of Public Health and Social Sciences's (SPHSS) ability to contribute to the development of the Tanzanian health care system through its trainings in the field of public health. Through the support, the SPHSS pre-service training programs will be able to admit and train an increased number of students to meet the increased demand in quantity, quality, and diversity of the human resources for health in Tanzania's health sector. By training the human resources for health, the University is producing the required personnel who shall work in the health sector to control the HIV/AIDS epidemic.

The Coag works in Dar es Salaam, Pwani, and Morogoro. However, students are drawn from all over Tanzania. This approach has three main objectives: public health curriculum development/enhancement, improvement of existing and the development of new masters programs, and in-service training courses and infrastructural development to support the ever increasing number of programs and students. Instead of starting afresh every year with new issues and objectives, existing achievements will be expanded upon and revised, if necessary, therefore available resources is utilized in a more effective and efficient manner.

All programs will be self-sustaining through the tuition fees paid by students when the project ends. M&E, through bi-weekly process evaluations and reports, are linked to the set targets as well as six-month and annual evaluations.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	850,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10044		
Mechanism Name:	MUHAS-SPH		
Prime Partner Name:	Muhimbili University College of Health Sciences		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	500,000	0

Narrative:

The system barriers that the program will address are of inadequate human resources for health, both in quality and quantity. This barrier is addressed through the development of the health care system, supporting trainings in the field of public health. Through the SPHSS pre-service training programs, an increased number of students will be admitted and trained to meet the demand in quantity, quality, and diversity of human resources for health in Tanzania's health care sector. These barriers will also be addressed through Public health curriculum development and enhancement, improvement of existing and the development of new masters programs, and in-service training courses and infrastructural development to support the ever-increasing number of programs and students. OHSS also supported the BCC program development strategies and activities by providing a broad foundation of strengthened capacity in the school of public health.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

Muhimbili University of Health and Allied Science (MUHAS) recently established a master's degree course in HIV and health services promotion and behavior change. Graduates from this program are expected to be able to design, plan, implement, and evaluate effective HIV and health promotion and behavioral interventions that promote the adoption of healthy options and health seeking behaviors. In line with current international and national guidance, along with existing and emerging evidence regarding most effective HIV/AIDS prevention, care, and treatment interventions and services, students will be trained to design, implement and evaluate IEC and BCC projects that support (a) couples

communications, couples HIV testing and counseling, disclosure, and support for discordant couple; (b) promotion of voluntary male medical circumcision services; and (c) support for adherence of ART, TB, and STI treatment, with specific attention to HIV positive pregnant women and youth.

MUHAS expects that the training, while specifically focusing on IEC and BCC for HIV interventions and services, will have a "positive spill-over" effect and inform improvements of broader health education efforts in the country. Special attention will be paid to other services promoted and prioritized under Tanzania's Global Health Initiative (GHI) Strategy. This program is expected to be the main Tanzanian "think tank" supporting the design and adaptation of evidence-based and effective interventions to prevent new HIV infections in Tanzania. This course will also include a strong focus on monitoring and evaluation of prevention programs.

The course will be of a two-year duration with five students per year being offered partial scholarships. Some of the ongoing activities include curriculum development, development of course materials, modules, case studies and other teaching materials. Both MUHAS academic and administrative staff are engaged in this activity. Students will be exposed to both competence based approaches and field attachments. They will be assessed according to the University examination regulations and guidelines.

HVAB as well as HVOP funds will go toward supporting this course. Through HVAB support in particular, this course will encourage the training of high quality graduates in implementing activities that target young girls and aim at reducing the age of sexual debut while also seeking to protect them from sexual violence. Emphasis will be given on case studies that focus on gender based violence and interventions that aim at changing social norms that facilitates violence against girls and women.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	250,000	0

Narrative:

Muhimbili University of Health and Allied Science (MUHAS) recently established a master’s degree course in HIV and health services promotion and behavior change. Graduates from this program are expected to be able to design, plan, implement, and evaluate effective HIV and health promotion and behavioral interventions that promote the adoption of healthy options and health seeking behaviors.

In line with current international and national guidance, along with existing and emerging evidence regarding most effective HIV/AIDS prevention, care, and treatment interventions and services, HVOP as well as HVAB funds will go toward training students to design, implement and evaluate IEC and BCC projects that support (a) couples communications, couples HIV testing and counseling, disclosure, and

support for discordant couple; (b) promotion of voluntary male medical circumcision services; (c) support for adherence of ART, TB, and STI treatment, with specific attention to HIV positive pregnant women and youth; (d) support for promotion of increased correct and consistent use of male condoms; (e) promotion of female condom use among identified target groups; (f) support for Positive Health Dignity and Prevention (PHDP) and other interventions, specifically designed to support People Living with HIV/AIDS and HIV positive girls and women; and (g) increased demand and up-take of comprehensive services among key populations such as sex workers and their clients, people who use and/or inject drugs and men who have sex with men. MUHAS expects that the training, while specifically focusing on IEC and BCC for HIV interventions and services, will have a "positive spill-over" effect and inform improvements of broader health education efforts in the country. Special attention will be paid to other services promoted and prioritized under Tanzania's Global Health Initiative (GHI) Strategy. This program is expected to be the main Tanzanian "think tank" supporting the design and adaptation of evidence-based and effective interventions to prevent new HIV infections in Tanzania. This course will also include a strong focus on monitoring and evaluation of prevention programs. The course will be of a two-year duration with five students per year being offered partial scholarships. Some of the ongoing activities include curriculum development, development of course materials, modules, case studies and other teaching materials. Both MUHAS academic and administrative staff are engaged in this activity. Students will be exposed to both competence based approaches and field attachments. They will be assessed according to the University examination regulations and guidelines.

Implementing Mechanism Details

Mechanism ID: 10067	**Mechanism Name: PASHA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Education and Training	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ministry of Education (MoEVT) developed policy guidelines in 2004 as a part of a multi-sectoral response from the education sector to HIV/AIDS prevention. In the guidelines, the MoEVT articulated four thematic areas: (1) prevention; (2) care and support; (3) impact mitigation; and (4) enabling environment. In this context, peer education and the establishment of psycho-social support though counseling services in schools have been identified as appropriate interventions. Through peer education, students learn comprehensive knowledge on sexual and reproductive health and rights, HIV/AIDS and STI prevention, and life skills in order to avoid risky behavior. They are also informed of relevant services that are available in the community.

The MoEVT has been pleased with the feedback it has received from implementing schools and has requested for project continuation. As such, funds will be used to support peer education, school counseling services, HIV/AIDS and other youth health-related IEC materials, and capacity building for education managers.

Cross-Cutting Budget Attribution(s)

Education	200,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Family Planning

Budget Code Information

Mechanism ID:	10067		
Mechanism Name:	PASHA		
Prime Partner Name:	Ministry of Education and Training		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	200,000	0

Narrative:

Funds will support the following activities:

(1) Peer education: Facilitate skills-based sexual reproductive health/HIV and AIDS/sexually-transmitted infections education to learners and education service providers in Mtwara and Iringa (five units per region for a total of ten units involving 600 peer educators at 100 schools)

(2) School counseling services: Strengthen and scale-up school counseling services in Mtwara and Iringa (five units per region for a total of ten units involving 200 school counselors at 100 schools)

(3) Education materials: Improve the utilization of multimedia educational materials for behavior change for learners and education service providers. Shangazi Stella materials, life skills booklets, Kinga booklets, and guideline booklets will be printed and provided to peer educators and school counselors at 100 schools in Mtwara and Iringa.

(4) Capacity building for education managers: Conduct stakeholder meetings to orient education managers about the importance of peer education and school counseling activities in Mtwara and Iringa; strengthen steering committee structures at all levels; strengthen monitoring and evaluation capacity at all levels; and disseminate guidelines, policies and circulars on SRH/HIV/AIDS/STIs to relevant stakeholders.

Implementing Mechanism Details

Mechanism ID: 10070	Mechanism Name: BIPAI-PPP

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Baylor College of Medicine International Pediatric AIDS Initiative/Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,000,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	3,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the Baylor-Tanzania program is to contribute to the reduction of HIV-related morbidity and mortality among infants, children and adolescents using a family-centered approach. Specific objectives supporting this goal include provision of comprehensive pediatric HIV care and treatment services; expanded pediatric HIV case finding; health systems and human resources capacity building; and community mobilization for pediatric HIV care and treatment services.

These objectives are aligned with goals one and five in the Tanzania Partnership Framework, which focus on service maintenance and addressing human resource challenges. The geographic coverage of the cooperative agreement is the Lake and Southern Highlands Zones.

Cost efficiency strategies will include using the training model of training regional and zonal level trainers and mentors to become master trainers in pediatric HIV care and treatment for cascaded capacity building. Coordination and collaboration with government health system leaders and implementing partners will be prioritized to achieve efficiencies in service delivery and capacity building.

Transitional strategies include close partnership with tertiary level host institutions to create pediatric HIV zonal leadership and ownership, which will incorporate program activities into zonal, regional, and council level health plans, e.g. Comprehensive Council Health Plans (CCHP). The M&E Plan incorporates the Balanced Score Card approach for holistic organizational health and efficient program implementation. Evidence-based programming will be implemented to ensure programs are improved and build upon

factual information.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	30,000
Food and Nutrition: Commodities	15,000
Food and Nutrition: Policy, Tools, and Service Delivery	5,000
Human Resources for Health	2,754,303

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10070**
Mechanism Name:	**BIPAI-PPP**
Prime Partner Name:	**Baylor College of Medicine International Pediatric AIDS**

	Initiative/Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	300,000	0

Narrative:

Linkages to pediatric HIV care and treatment services with orphan and vulnerable child (OVC) services will be a main activity, specifically with OVC service providers/implementing partners in operating regions that will establish meaningful OVC service and facility referrals, such as services to support family/household food security, child protection, education, and income generating activities.

Increased linkages with the social services system at the national, regional, district and ward/village levels will be enhanced in FY 2012 through engagement and sensitization of regional, district and community level stakeholders. Meetings and sensitization events focused on pediatric HIV testing, care, and treatment issues will be held periodically. Creation and adaptation of existing community and most vulnerable child community (MVCC) training curriculum to include pediatric HIV case identification and care and treatment issues will be supported.

Participating and supporting a multi-sectoral response will help to raise awareness of child care and protection issues, including post-exposure prophylaxis (PEP) care and treatment for victims of abuse. At the national level, integration of pediatric HIV care and treatment issues into the Early Childhood Development (ECD) social welfare guideline and annual action plan will also be supported through collaboration with the Department of Social Welfare. Community level events, media messages, and other culturally appropriate communication mediums supporting pediatric HIV case identification, testing, and stigma reduction will increase sensitization and help facilitate dialogue within the communities.

Efforts to measure the outputs and outcomes activities and build evidence-based programming in this area will include monitoring responses to radio programs, documentaries, and messages; participation in community sensitization events using a crowd estimation tool; and closely monitoring pediatric HIV testing and enrollment in care in the areas in which intervention activities are undertaken.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	500,000	0

Narrative:

In FY 2012, scale up of cotrimoxazole (CTX) prophylaxis for HIV-exposed and infected children will be a focus. As identified by PEPFAR, there is a lack of nutrition assessment tools and nutrition information in communities. To address this shortage, provision of nutrition assessment tools and counseling and

support services, including infant feeding and supportive breastfeeding in the context of HIV, will be offered. Assessment tools that identify household food insecurity will also be developed. Additionally, limited and targeted support for therapeutic food (Ready-to-Use Therapeutic Food), facility-based, and outpatient based food support will be provided. Pediatric-specific palliative care and psychosocial support, including adolescent and caregiver peer support groups, will be offered to promote healthier concepts in dealing with the various and complex health and livelihood issues.

Teen Clubs highlighting relevant issues, such as adolescent prevention with positives (PwP) concepts, self-esteem issues, life skills, sex and sexuality, treatment adherence and transitioning into adult care, will offer adolescent psychosocial support in a safe and caring environment.

Caregiver peer support groups will be organized to improve skills in supporting HIV positive children/adolescents. Plans for income generating activities will also be developed within the caregivers support group. Activities will be initiated through the Children's Clinical Centers of Excellence (COEs) at Bugando and Mbeya referral hospitals. Replication of services from COEs to lower level facilities are intended to be provided to allow for scale-up of activities and support groups. Additionally, improved linkages to community-based care, including under-five child survival interventions and community HIV support services, such as home-based care (HBC) for support of home visits, and lost-to-follow up patient tracking will ensure a more comprehensive approach to the health services. These activities will be achieved through training, on-site mentorship and COE clinical attachments, establishment of coordinating committees with local government and community-based organization, and advocacy combined with community mobilization.

Baylor-Tanzania will scale its COE clinical attachment activities will support capacity building for comprehensive pediatric HIV care and treatment. Expanded activities will include specific clinical attachments addressing pediatric HIV care and treatment counseling and nutrition/malnutrition management. National and local-government level, pediatric-focused technical support and input will also be provided on various technical groups addressing TB, nutrition, and maternal and child health issues, as appropriate.

The phased approach of both treatment partner and health professional capacity building for pediatric HIV care will take place in the Lake and Southern Highlands Zones.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	2,200,000	0

Narrative:

In FY 2012, funds will be used for the following activities:

(1) Implement updated pediatric-focused URT national HIV care and treatment guidelines, which incorporate a phased approach to the updated WHO treatment guidelines, including treatment of all HIV-infected children <24 months;
(2) Provide increased support to national level working groups and technical committees, including the Pediatric Technical Working Group, National HIV Care and Treatment Working Group, treatment partners, and quality improvement groups, to provide pediatric-focused advocacy and technical input to various national guidelines, curricula, and programs;
(3) Enhance the identification and diagnosis of HIV in infants and children through EID and exposed infant care, pediatric-focused provider-initiated testing and counseling (PITC) at all entry points, such as inpatient and outpatient settings, immunization, and TB/HIV clinics;
(4) Identify, diagnose, and link to care children and adolescents through "Know Your Child's Status" HIV testing events aimed at children of CTC clients and other high risk groups;
(5) Improve follow-up services for HIV exposed infants and children, including tracking and retention of children in care and on treatment;
(6) Monitor patient response and adherence to treatment; and
(7) Provide adolescent-friendly services, including reproductive health services.

These activities will be implemented through training, side-by-side mentorship, and expanded clinical attachments to the Children's Clinical Centers of Excellence (COEs) at Bugando and Mbeya referral hospitals. Clinical attachments will support all cadres of health professionals, including facilities throughout the Lake and Southern Highland Zones. Through the two COEs that were established in early 2011, direct provision of pediatric HIV care and treatment services and support for health professional capacity building will be provided.

The COEs will continue efforts to improve the quality of care and health professional capacity. In efforts to do so, the COEs will eventually serve as models of the highest level of pediatric HIV care and treatment services available in Tanzania, with attention paid to management of complicated referral cases. Additionally, specific efforts will be taken to support health facilities in pediatric focused data collection, monitoring and data use, supporting pediatric HIV diagnosis, and implementing care and treatment initiatives. Basic health evaluations will be conducted to review issues such as EID/exposed infant care cascade models, barriers to pediatric-specific PITC, and HIV disclosure issues in children are planned. National level participation and collaboration with UCC for pediatric updates to the care and treatment clinic (CTC) database and M&E/data collection initiatives will also continue.

Implementing Mechanism Details

Mechanism ID: 10087	Mechanism Name: FMP
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanzania Marketing and Communications Project	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 930,850	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	930,850

Sub Partner Name(s)

Women Development Association		

Overview Narrative

Tanzania Marketing and Communications Company (T-MARC) is a Tanzanian NGO implementing the Families Matter Program (FMP) with the goal to reduce sexual risk behavior among adolescents by giving parents of pre-teens (9-12 years of age) tools to support primary prevention among their children. FMP aims to enhance protective parenting practices, overcoming communication barriers, and promoting parent-child discussions about sexuality and sexual risk reduction. FMP provides training to parents to equip them with necessary skills and knowledge to be able to communicate confidently and freely with their pre-adolescents about sexuality issues and sexual risks behaviors in order to promote sexual abstinence and to reduce exposure to sexual risk activities among adolescents, thus delaying the onset of sexual debut among their children. The project objectives includes enhancing the knowledge and skills of parents/guardians to be effective primary sexuality educators for their children; increasing knowledge and skills of pre-adolescents aged 9-12 years to effectively practice abstinence and to reduce sexual risk behaviors; creating a supportive environment that increases adolescents' self efficacy to delay sexual debut and avoid risk; building local human and material capacity to roll-out and scale-up FMP. FMP is implemented in Ruvuma and Mtwara regions.

T-MARC also builds capacity and supports other local NGOs and CBOs to implement FMP. The project

has various monitoring tools for data collection and process monitoring. T-MARC is currently collaborating with CDC on protocols for a formative assessment to introduce and pilot a new module that focuses on prevention of violence against children as well as an outcome evaluation.

Cross-Cutting Budget Attribution(s)

Education	930,850

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10087**		
Mechanism Name:	**FMP**		
Prime Partner Name:	**Tanzania Marketing and Communications Project**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	300,000	0
Narrative:			
Tanzania Marketing and Communications Company (T-MARC) is a Tanzanian NGO implementing the Families Matter Program (FMP) with the goal to reduce sexual risk behavior among adolescents by giving parents of pre-teens (9-12 years of age) tools to support primary prevention among their children. FMP is implemented in Ruvuma and Mtwara regions and targets parents and guardians of pre-teens (aged 9-12 years old) and equips them with the necessary parental skills through trainings. The training			

is tailored to help parents overcome communication barriers between themselves and their children, especially on sexuality issues, with the aim of reducing risky sexual behaviors among youth, which will ultimately reduce HIV transmission and early pregnancy among children and youth. FMP is a curriculum-based intervention that comprises five modules.

The training sessions are conducted once a week for five consecutive weeks with each group having 18 parents. The FMP training modules aim to create awareness among parents on risks that their pre-adolescents face, enhance positive parenting skills, improve communication techniques to promote primary prevention of HIV among their children, and enhance delay in sexual debut. T-MARC also builds capacity and supports other local NGOs and CBOs to implement the FMP.

The project has various monitoring tools for data collection and process monitoring. T-MARC is currently collaborating with CDC on protocols for a formative assessment to introduce and pilot a new module that focuses on prevention of violence against children as well as an outcome evaluation. The T-MARC team provides supportive supervision and process monitoring of the FMP activities on quarterly basis. FMP coordinators are stationed in each region and help ensure quality delivery of the trainings as well as data collection, monitoring, and reporting. The FMP team continuously also provides refresher trainings for FMP facilitators and technical assistance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	630,850	0

Narrative:

Tanzania Marketing and Communications Company (T-MARC) is a Tanzanian NGO implementing the Families Matter Program (FMP) with the goal to reduce sexual risk behavior among adolescents. FMP is a curriculum-based intervention that comprises five modules. It is implemented in Ruvuma and Mtwara regions and targets parents and guardians of pre-teens (aged 9-12 years old), equipping them with the necessary parental skills through trainings. The training is tailored to help parents overcome communication barriers between themselves and their children, especially on issues of sexuality, with the aim of reducing risky sexual behaviors among youth, which will ultimately reduce HIV transmission and early pregnancy among children and youth. Sessions are conducted once a week for five consecutive weeks with each group having 18 parents. The FMP training modules aim to create awareness among parents on risks that their pre-adolescents face, enhance positive parenting skills, improve communication techniques to promote primary prevention of HIV among their children, and enhance delay in sexual debut. T-MARC also builds capacity and supports other local NGOs and CBOs to implement the FMP. The project has various monitoring tools for data collection and process monitoring. T-MARC is currently collaborating with CDC on protocols for a formative assessment to

introduce and pilot a new module that focuses on prevention of violence against children and an outcome evaluation. The T-MARC team provides supportive supervision and process monitoring of the FMP activities on quarterly basis. FMP coordinators are stationed in each region and help ensure quality delivery of the trainings as well as data collection, monitoring, and reporting. The FMP team continuously provides refresher trainings for FMP facilitators and technical assistance. The HVOP component focuses on enhancing the skills of parents to identify, understand, and prevent their children from engaging in higher risk behaviors, including transactional sex, and makes them aware of the need to communicate with children and youth about consistent and correct condom use at the appropriate age. FMP also intends to prevent adolescents from engaging in high risk behaviors by working with parents and providing them with accurate information to broaden their understanding and skills about factors and environments that may lead to child prostitution and other risky behaviors, such as excessive alcohol consumption. The program intends to provide parents with skills on how to identify when a child is being sexually, physically and/or emotionally abused as well as providing referrals (to health and social services, legal support, etc.) for further assistance when needed.

Implementing Mechanism Details

Mechanism ID: 10088	**Mechanism Name: DCC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Drug Control Commission	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 800,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	800,000

Sub Partner Name(s)

Ministry of Health and Social Welfare, Tanzania	Pangaea Global AIDS Foundation	

Overview Narrative

The goal of Drug Control Commission (DCC) project is to create a conducive environment to provide effective HIV prevention services among people who inject drugs (PWID) and people who use drugs (PWUD) in Tanzania. Specifically the program objectives are to sensitize the public, including decision makers at the government level on HIV prevention and care for PWUD; increase capacity of stakeholders participating in provision of HIV/AIDS and care for PWUD by 2013; and develop and maintain a system for monitoring and evaluating HIV/AIDS prevention services and care among PWUD.

The program is aligned with the PEPFAR goals, the MDG, UN declarations on HIV/AIDS, and various national documents, such as the National Strategic Framework on HIV/AIDS (2008-2012). The program coverage is Tanzania Mainland with initial coverage of needle-syringe programs (NSP), medically assisted treatment (MAT), and outreach services in Dar es Salaam, while M&E activities will be implemented in other urban locations with emerging services, including Mwanza, Mbeya, Arusha, and Tanga.

DCC is a government coordinating entity, though through this program, builds a sustainable response to the contribution of drug use in the HIV epidemic in Tanzania. The program advocates mainstreaming into existing services, encourages capacity building, and the involvement of communities and local government.

To ensure quality implementation of the program, a national M&E system is in the process of being developed that will enable systematic collection of data. Indicators for success are being developed and data collection systems established. The program also includes periodic planning and feedback meetings with stakeholders.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	40,000
Human Resources for Health	280,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	10088		
Mechanism Name:	DCC		
Prime Partner Name:	Drug Control Commission		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	800,000	0

Narrative:

HIV prevalence among people who inject drugs (PWID) remains at relatively high rate in Tanzania. A study in 2006 found that HIV prevalence among PWID in Dar es Salaam was 42% (William, et al., 2009). There are also indications that the number of PWID is rising in the country. This high HIV prevalence and growing number of PWID poses a significant threat for HIV spread not only among PWID (estimated at around 50,000 people) but also to the general population through existing sexual and injection networks with unsafe sexual and injection practices.

In 2010, URT responded to the problem by developing a draft National Strategic Framework on HIV Prevention for Injecting Drug Users (2011-2012) (NSF) under the guidance of The Second National Multi-sectoral Strategic Framework on HIV and AIDS (2008-2012) with the involvement and support of different stakeholders. A comprehensive package of scientifically proven and evidence based HIV interventions for PWID and human rights obligations to receive treatment were among the fundamental principles in developing the document. The NSF set forth multi-sector strategies to be adopted to reduce the HIV spread among PWID in the country.

Some of the interventions advocated for are those considered to be the most effective in reducing HIV among PWID, such as needle-syringe programming (NSP), medically assisted treatment (MAT), and access to antiretroviral treatment (ART). Currently, NSP and MAT remain the least understood.

Therefore, this program intends to provide the needed advocacy to establish these services in all of the three municipalities of Dar es Salaam City. In FY 2012, NSP and MAT programs will be established in two of the three municipalities and the program intends to sustain the services while expanding to the third municipality to complement ongoing initiatives providing comprehensive HIV prevention for PWID being undertaken by various stakeholders, including Muhimbili National Hospital. A Memorandum of Understanding between the DCC and MOHSW will guide the collaboration whereby the MOHSW will receive a sub-grant to expand MAT services and ensure access of sterile needles and syringes to PWID. Municipal councils where MAT services are expected to commence will be sub-granted to provide these services in collaboration with the MOHSW. PANGAEA Global AIDS Foundation will continue to provide the technical assistance for the initiatives. The DCC is currently developing a national system for monitoring and evaluation of HIV interventions for people who use drugs (PWUD). The draft national M&E framework and program level M&E guideline for comprehensive HIV prevention for PWUD has been developed. The system will be rolled out initially in Dar es Salaam before expanding to other urban centers of Mwanza, Arusha, Mbeya, Tanga, and eventually other parts of the country. Furthermore, supportive supervision of ongoing services and evaluation meetings will be conducted.

Implementing Mechanism Details

Mechanism ID: 10092	**Mechanism Name: Helpline & Youth**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanzania Youth Alliance	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 966,045	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	966,045

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Tanzania Youth Alliance (TAYOA) is implementing programs to support HIV prevention, care, and treatment efforts in Tanzania. TAYOA aims to contribute to the national goal of reduction of HIV prevalence among 15-24 years old from currently 2.4% to 1.2% by 2015. TAYOA engages young people and adults in the process of developing appropriate HIV interventions and communications for young people and the general public in accordance with the Health Sector HIV and AIDS Strategic Plan II (2008-2012) (HSHSP).

PEPFAR supports TAOYA for two programs, with additional complementary support being provided by URT as well as private sector telecommunications companies. Technical assistance (TA) and quality assurance is built into the project and provided by US-based behavioral scientists. The two programs are:

(1) A comprehensive HIV prevention outreach program for youth 14-24 years old, implemented in three regions (Dar es Salaam, Pwani, and Tanga) though a network of youth balozi (youth ambassadors) to reach youth in- and out-of-school with structured individual and small group level interventions. An outcome evaluation for this program is currently underway; and
(2) TAYOA operates a National AIDS Helpline and SMS service. The coverage of the helpline service is nationwide and over the past year the helpline received around 1 million calls. Aside from provision of information about HIV/AIDS, the helpline has a built in referral HIV service database. Aside from calls from the general public and youth, TAYOA has started to provide online counseling for key populations, such as people who use or inject drugs, men who have sex with men, as well as survivors of gender-based violence. the helplne will also be used for demand creation of VMMC and CHCT scale up

Cross-Cutting Budget Attribution(s)

Economic Strengthening	50,000
Education	200,000
Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	120,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Mobile Population
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	10092		
Mechanism Name:	Helpline & Youth		
Prime Partner Name:	Tanzania Youth Alliance		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	50,000	0
Narrative:			
In response to new prevention guidance, Tayoa is positioned itself to help create demand for MC services among adults in the target regions.. The main geographical coverage areas will be Kagera Mainland and the Lake Victoria Islands, with 55% estimated coverage of MC in Kagera Region, Shinyanga, Mwanza and the southern highlands. Since the main modality in reaching adult men for MC services is through campaigns, Tayoa plans to promote MC Services to adult male callers and send tailor made promotion sms to people in the target			

areas.
MC will be part and parcel of Tayoa's comprehensive package for HIV prevention which entails risk reduction counseling, referrals for STI screens and treatment, HIV counseling and testing, and MC counseling. Sexual partners of MC clients will be encourage to attend MC services for educational purposes and HIV testing and counseling. For MC client who are found to be HIV positive, Tayoa will assist them and directly link to an HIV care and treatment clinic through a formal referral process.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	200,000	0

Narrative:

The AB component of TAYOA's programs tartgets 14-24 years old, implemented in the three regions of Dar es Salaam, Pwani, and Tanga. The program is implemented though a network of youth balozi (youth ambassadors) to reach youth in- and out-of-school with structured individual and small group level interventions with greater focus on young girls. An outcome evaluation for this program is currently being implemented. The evaluation will be completed in FY 2012 where findings will be shared and disseminated with government and other HIV stakeholders. For COP 2012, TAYOA will continue to work with 1,327 existing youth balozi networks to promote behavioral interventions to reduce sexual risk behaviors and increase protective behaviors, such as abstinence, delayed sexual debut, partner reduction, and faithfulness among young people who are in- and out-of-school. Some of the activities include expansion of life skills, HIV prevention, and sexual reproductive health education and training. TAYOA also trains peer educators to provide adherence to ART counseling for youth who are HIV-infected and are on medication. The program also plans to establish 800 new youth balozi clubs with approximately 25 members within a group.

TAYOA also operates a National "117" AIDS Helpline and "15017" SMS service, of which a portion HVAB supports. The coverage of the helpline service is nationwide and over the past year the helpline received around one million calls. Aside from the provision of information about HIV and AIDS, the helpline has a built in referral database that allows helpline counselors to identify and refer callers to HIV services located nearest to the site of their call. The Helpline and SMS platform adresses gender norms and plans to increase linkages with the HIV care and treatment program by providing food and nutrition information; support treatment adherence for PLHIVs using SMS reminders for clients to take their medication as prescribed while reinforcing benefits of their medication in prolonging their lives; prevent their partners from getting infected (in the case of discordant couples); and help clients to identify side effects and adverse events that may require medical attention.

TAYOA will continue to capitalize on PPPs, leveraging strong linkages with the Tanzania Communication

Regulatory Authority and mobile operators' corporate responsibility commitments. On World AIDS Day 2010, TAYOA received an award from URT as an outstanding Tanzanian youth organization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	100,000	0

Narrative:

Using the National Helpline Services and free SMS services, TAYOA will play a vital role in supporting demand creation and promotion of HVCT services especially CHCT. Caller will be encouraged to test for HIV and AIDS together with their partners as well as users of free sms services. Tayoa plans to collaborate with direct providers of HIV testing and counseling (HTC) services in the respective regions to identify gaps that inhibit the optimal uptake of services. For FY 2012, the project's goal will be to scale up existing HTC services and reach about 100,000 people in the selected districts. Under the coordination of MOHSW, Tayoa will participate to accelerate the couples HTC services within eight high prevalence regions, including Dar es Salaam and Shinyanga regions.

Likewise Communities will be mobilized through trained faith outreach workers who will promote HTC services. Tayoa aims to strengthen outreach services with special emphasis on mobilization of couples, using nationally developed promotional materials. The following activities will be implemented:

(1) Publicity and Message Dissemination: Tayoa will utilize communication and promotional materials developed and designed for couples. If necessary, adaptation to the regional or local context can be made.
(2) Helpline services will be used for community mobilization and dissemination of information about general HTC services available as well as couples HTC;
(3) SMS will be developed to encourage couple to test for HIV and AIDS regularly
(4) Referral for Care and Positive Health Dignity and Prevention (PHDP): TAYOA will work on strengthening post-test follow up facilitated by institutions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	616,045	0

Narrative:

The Tanzania Youth Alliance (TAYOA) is implementing programs to support HIV prevention, care and treatment efforts in Tanzania. PEPFAR supports TAOYA for technical components of two programs, though additional complementary support is provided by URT as well as private sector telecommunications companies. Technical assistance (TA) and quality assurance (QA) is built into the project and provided by in-country CDC TA and US-based behavioral scientists supporting and visiting

the project approximately three times a year. The two programs are:

(1) A comprehensive HIV prevention outreach program for youth 14-24 years old, implemented in the three regions of Dar es Salaam, Pwani, and Tanga. . An outcome evaluation for this program is currently being implemented as baseline data collection and analysis has been completed and mid-term data collection is being prepared. The evaluation will be completed in FY 2012 where findings will be shared and disseminated with government and other HIV stakeholders. In FY 2012, the program plans to establish 800 new Youth Balozi Clubs with approximately 25 members within a group who will meet on a weekly basis. TAYOA supports availability and access to male and female condoms and promotes the correct and consistent utilization of condoms through youth friendly condom outlets in 100 hot spot neighborhoods.

(2) TAYOA operates a National “117” AIDS Helpline and “15017” SMS service, of which a portion HVOP supports. The coverage of the helpline service is nationwide and over the past year the helpline received around 1 million calls. Aside from provision of information about HIV and AIDS, the helpline has a built in referral database that allows helpline counselors to identify and refer callers to HIV services located nearest to the site of their call. Aside from calls from the general public and youth, TAYOA has trained helpline counselors and started to provide additional online counseling for particular groups and key populations, such as people who use or inject drugs (PWUD & PWID), men who have sex with men (MSM), as well as survivors of gender-based violence. The SMS service, which was established in FY 2011, aims to reach approximately 100,000 subscribers in Tanzania. The Helpline and SMS platform will increase linkages with the HIV care and treatment program by providing food and nutrition information; support treatment adherence for PLHIVs using SMS reminders for clients to take their medication as prescribed while reinforcing benefits of their medication in prolonging their lives; prevent their partners from getting infected (in the case of discordant couples); and help clients to identify side effects and adverse events that may require medical attention. The Helpline team presents and shares information about changes in information that occur over time with other HIV stakeholders to inform communications programs implemented by other partners.

TAYOA's budget and activities affect:
MSM: (1) $ 150,000 (2) coverage – approximately 10,000 MSM will be reached (3) activity - outreach activities using peer educators, sms services to subscribed MSM and helpline services
Other: (1) $466,045 (2) coverage – approximately 100,000 people to be reached and provide services to 200 condom outlets (3) activity - helpline counseling and sms services to clients of sex workers, survivor of gender based violence, people living with HIV, discordant couples

Implementing Mechanism Details

Mechanism ID: 10095	Mechanism Name: CHAMPION
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Engender Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,745,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	1,745,000

Sub Partner Name(s)

Chama cha Uzazi na Malezi Bora Tanzania (UMATI)	FHI 360	Huruma AIDS Concern and Care

Overview Narrative

The Channeling Men's Positive Involvement in the National HIV/AIDS Response (CHAMPION) project seeks to promote a national dialogue about gender roles, increase gender equitable beliefs and behaviors, and reduce the vulnerability of men, women, and families to HIV/AIDS. CHAMPION addresses key components of USG/T's GHI strategy, specifically the third Intermediate Result of adopting healthy behaviors, including healthcare seeking behaviors with a focus on women and girls.

The project focuses on comprehensive programming targeted at high-risk adult men and their partners. Activities are in the ten regions with highest HIV prevalence in the country. With workplace HIV prevention programs being conducted through MCC/MCA-T funds, the project will now extend to Unguja, Pemba, Dodoma, and Tanga. For the first time, the project will receive funding to improve referrals/linkages to VMMC and HTC services. Given the project's access to a population that has poor health-seeking behaviors, CHAMPION will play an increasingly important role in linking its clients to these critical clinical services.

CHAMPION's community action model engages district voluntary community action teams to plan and execute locally appropriate and cost-effective activities. CHAMPION builds capacity of local entities to

implement gender transformative HIV and RH programs. The project works with eight local NGOs to build their technical/programmatic capacity and financial/administrative systems. By working collaboratively with various entities within URT, CHAMPION is able to influence national policies.

For COP 2012, the project will emphasize documentation of the effectiveness of its "Men as Partners" curriculum as well as prepare for an evaluation of the overall CHAMPION approach.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	602,670
Human Resources for Health	712,900

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Mobile Population
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**10095**

Mechanism Name:	CHAMPION		
Prime Partner Name:	Engender Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	400,000	0

Narrative:

CHAMPION’s target population, men aged 25 years and above, mirrors the key population that VMMC activities are intending to reach in the coming year. Despite large numbers of circumcisions since the program began, a significant portion (40%) of the procedures have been done on men under 15 years of age and the vast majority (>85%) under 25 years of age. A USG/T partner conducted an assessment to better understand the barriers to VMMC among older men and will begin implementing new strategies to encourage greater clinic attendance.

CHAMPION’s access to older men makes it a well-placed partner to increase its focus on linking clients to VMMC services. Community action teams, lead NGOs, and workplace-based peer educators will strengthen their VMMC knowledge and will be expected to work closely with VMMC clinic staff to ensure coherent and consistent messaging and promotion of services. Community-level discussions and activities will be monitored for VMMC components and USG/T VMMC implementing partners will provide feedback and input on how to best utilize CHAMPION’s unique access to this key target population. Moving forward, CHAMPION will be both a norms changing behavioral intervention and health promotion project and a community-to-facility linkage/referral project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

(See CHAMPION's HVAB budget code narrative)

The CHAMPION project continues to promote reduction in risk behaviors for HIV, including transactional sex and unsafe sexual practices, with a focus on men ages 25 years and above. Secondary audiences include women and young men that are likely to be in the same sexual networks. Sexual prevention interventions are mainly focused on transport corridors for all CHAMPION regions and at particular workplace sites, including MCC/MCA-T projects (see below). Key behavioral messages for the target population include partner reduction, faithfulness, and condom promotion.

In an effort to leverage PEPFAR resources, CHAMPION’s MCC/MCA-T project funding ($1.5M over three years) will allow for program expansion into sites served with energy, water, and road projects

covering seven regions, namely Zanzibar (Unguja and Pemba), Dodoma, Mwanza, Coast (Mafia), Iringa, and Tanga. To ensure evidence-based programming, CHAMPION will conduct a community mapping/assessment in the MCC transport sites and a baseline mini-KAP for MCC project sites, and also implement the standards of performance in CHAMPION worksites and MCC energy, water, and transport sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	400,000	0

Narrative:

CHAMPION's target population, men aged 25 years and above, represents an under-represented group in HTC programming. CHAMPION's access to older men makes it a well-placed partner to increase its focus on linking clients to HTC services. Community action teams, lead NGOs, and workplace-based peer educators will strengthen their HTC knowledge and will be expected to work closely with HTC partners to ensure coherent and consistent messaging and promotion of services. Community-level discussions and activities will be monitored for HTC components and USG/T HTC implementing partners will provide feedback and input on how to best utilize CHAMPION's unique access to this key population. Moving forward, CHAMPION project will be both a norms changing behavioral intervention project and a community-to-facility linkage/referral project

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	945,000	0

Narrative:

In Year 4, CHAMPION will continue scaling up the "Men as Partners" curriculum that focuses on the reduction of multiple concurrent partners, correct/consistent condom use, referral to HIV and RH services, and GBV prevention. Harmful gender norms that drive these behaviors are a common theme throughout the curriculum and related community engagement work.

CHAMPION workplace programs operate in Dar es Salaam, Coast, Morogoro, Iringa, Mbeya, Dodoma, Tanga, Mwanza, Shinyanga, Mtwara, Tabora, Unguja, and Pemba. Their primary target audience is migrant laborers, although mobile populations and vulnerable groups (food venders, bar maids, guesthouse attendants, and CSWs) in selected hotspots in MCC/MCA-T sites and surrounding communities will also be reached.

The project will also introduce "CoupleConnect: A Gender-Transformative HIV Prevention Curriculum for Tanzanian Couples," a tool designed to prevent HIV among Tanzanian couples by addressing key sexual behaviors, including reduction of multiple concurrent partners, condom use, and referrals to VMMC and

HTC services.

In Year 4, CHAMPION will support existing community action teams and newly formed community change clubs to carry out community engagement activities on various thematic areas, including promotion of critical HIV services (VMMC and HCT), GBV prevention, male involvement in RH services, alcohol use, and multiple concurrent partnerships. The teams will receive training to enhance their capacity in carrying out effective interventions.

In promoting participation of men in health services, CHAMPION will continue improving the quality of male friendly services at the facility level. Besides capacity building and training of health workers, CHAMPION will develop a male engagement quality improvement tool. CHAMPION@Work programming will extend to individual worksites that will receive technical support on comprehensive workplace HIV programming. In an effort to integrate across sectors, CHAMPION received $1.5M for FY2011-2013 to carry out gender transformative HIV programming in MCC/MCA-T project sites and surrounding communities.

Through its policy and advocacy initiative, CHAMPION will continue working with MenEngage, a network of organizations that strengthens the accessibility of health services by promoting men as partners in gender equity, HIV prevention, and improved RH outcomes for men, couples, and families.

CHAMPION will use GBV funding to leverage its work through mapping of GBV services, training of clinical and non-clinical staff on GBV, strengthening of referral systems, strengthening the integration of GBV in existing prevention activities, expanding the reach of norm-changing interventions to couples (e.g., CoupleConnect curriculum, mass media campaign), and improving coordination of the national GBV response.

In Year 4 of implementation, the project plans to document more evidence for effectiveness of its approaches. Planned outcome evaluations for this year include: MAP curriculum/approach, CoupleConnect curriculum, and endline CHAMPION evaluation.

Implementing Mechanism Details

Mechanism ID: 10351	**Mechanism Name: UHAI-CT**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,700,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,700,000

Sub Partner Name(s)

Africare	Alpha Dancing Group	Capacity-Building and Network Associates

Overview Narrative

Jhpiego's UHAI program works with URT to scale up HTC for all Tanzanians, particularly those at high-risk for HIV infection. This is accomplished through the implementation of PITC in health facilities; HTC outreach activities through sub-grantees; training of providers in HTC and PITC; collaboration with district and regional authorities to ensure a whole district approach to training, quality assurance, and supervision; and strengthening links to prevention, care, and treatment services. The program aligns with the prevention and human resources goals in the Partnership Framework.

The program works in all districts of Iringa/Njombe, Tabora, Dodoma, Singida, Tanga, Mtwara, Kilimanjaro, and Manyara. For PITC, the general population is targeted. For outreach activities, MARPs (CSWs, MSM, IDUs, and mobile populations), couples, and under-served communities are targeted. UHAI's approach is to work with regional and district trainers and supervisors, particularly around M&E systems by strengthening the response capacity of local health authorities. As a result, many CHMTs in UHAI districts are incorporating PITC into their own budgets and plans. M&E systems for PITC and outreach HTC have been developed by URT and data reporting structures are followed and strengthened by UHAI.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	500,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Increasing women's legal rights and protection

Mobile Population

TB

Budget Code Information

Mechanism ID:	10351		
Mechanism Name:	UHAI-CT		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	2,700,000	0

Narrative:

UHAI's technical approach is guided by the principles of innovation, rapid expansion, appropriate diversity of strategies, quality, sustainability, strong links to HIV care and treatment, and cost effectiveness. UHAI uses a two-pronged approach. At the facility level, capacity in PITC, as per the national PITC guidelines, is enhanced. At the community level, a creative mix of community- based CITC outreach strategies focusing on key populations (MARPs) in high transmission areas and hot spots are utilized. These community-based interventions are also coupled with a gender approach and behavior change component.

The objectives of the project are: (1) To rapidly increase access to quality HTC for all Tanzanians,

particularly those at high risk, through PITC (general population) and outreach HTC (MARPs, including CSWs, IDU, MSM, and mobile populations); (2) Develop provider's skills for quality HTC services delivery by using a whole district approach for facility level services; (3) Strengthen links to prevention, care and treatment services, and establish community care and support for HIV-positive clients through close coordination with USG/T-supported care and treatment partners; and (4) Work with the NACP to strengthen supervision, quality, and data management systems. These objectives align with the GHI Strategy as well as nearly all the goals set forth in the USG/T Partnership Framework. Last year, UHAI trained health providers in PITC, developed a new cadre of regional trainers, provided HTC services following the national testing algorithm to those in need, and supported implementing partners. Ten district councils used their own funding and resources to train an additional 383 providers and conduct orientations and supervisions with limited support. Specific training in reaching MARPs, BCC, VMMC counseling, couples counseling, and supporting PLHIV were held for CSO counselors. In FY 2012, these activities will be enhanced, new sites will be added as district responses are strengthened, additional providers will be trained, and CSOs will receive additional mentoring, specifically in reaching MARPs, addressing GBV and couples counseling in PITC settings. Regional level small and mass media activities will take place to promote testing (and PITC specifically). To date, the majority of PITC activities have taken place in facilities with CTCs, and therefore, easy referrals and links to care and treatment are available and clients are often escorted to the CTC to initiate services, which is tracked by facility PITC focal persons. In the case of outreach HTC, clients are referred to specific health facilities in their catchment areas and the CSOs follow up to see if clients have attended, and in some cases follow-up in the community. UHAI works hand-in-hand with the districts to ensure that their supervisors are capable of overseeing PITC, mentoring them in supervision and quality assurance activities. These systems will continue to be enhanced in the coming year using URT's own tools. UHAI will also continue to strengthen data management and reporting systems at the district and regional levels and work with the national level, for example, through the STATUS PHE initiative.

Implementing Mechanism Details

Mechanism ID: 10807	**Mechanism Name: Futures Group**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement

Prime Partner Name: Futures Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 900,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	900,000

Sub Partner Name(s)

Association of Journalists against HIV/AIDS in Tanzania	Christian Council of Tanzania	Ministry of Community Development, Gender and Children, Tanzania
Ministry of Justice and Constitutional Affairs, Tanzania	National Council of People Living with HIV/AIDS	National Muslim Council of Tanzania
Pentecostal Church of Tanzania	Tanzania Commission for AIDS	Women Development Association

Overview Narrative

The project's main goal is to support URT and its civil society to build an enabling environment for the scale-up of HIV prevention, care, and treatment. The main objectives are to strengthen leadership and governance of HIV issues and programs; accelerate the development, adoption, and implementation of priority HIV/AIDS policies, plans, and regulations for scale-up; increase financial resources and accountability for HIV/AIDS programs; increase use of evidence-based information and data for decision-making and advocacy activities. Focus areas of the project include leadership and governance, policies, resources, and data use. The Health Policy Initiative (HPI) goals and objectives directly address the third and sixth goals of the PF. The goal and objectives also respond to GHI's strategy of strengthened leadership and governance.

Operationally, it will cover at the national, regional, and local levels. Iringa Region will be targeted for GBV guidelines implementation while targeting government, MPs, PLHIV, CSOs, FBOs, and media.

The main strategy will be to strengthen the council awareness to include HIV/AIDS and GBV programs into the integrated council health planning and budget process. To gain cost and time efficiencies,

partnering with other implementing CAs and NGOs will improve coordination and help avoid duplication of activities.

HPI will increase CSOs' participation as strategy to transition to the local organizations or other donors: Capacity building of Councils and integration of the work with councils and communities; capacity building for the target groups - both to enhance National and Local ownership. Avenues to share best practices will be created.HPI will use its Performance Monitoring Plan to monitor and evaluate its implementation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Family Planning

Budget Code Information

Mechanism ID:	10807		
Mechanism Name:	Futures Group		
Prime Partner Name:	Futures Group		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and	OHSS	900,000	0

Systems			
Narrative:			
The Futures Group will use COP 2012 funds for a range of activities that serve to enhance the policy environment for the HIV/AIDS response. In addition to advocacy for key change with opinion leaders, including MPs, PLHIVs groups, religious leaders, and the media. The Futures Group will also focus on specific technical areas. To address the significant shortfall in human resources for health, the project will provide policy support for task shifting. In addition, Futures Group will monitor policy reforms in the areas of gender equity to establish reforms needed for enhancing gender equity in economic issues. To contribute to reducing violence against women and children, which has proven to increase vulnerability to HIV acquisition, the project will work with GBV partners to develop a coordinated comprehensive response to GBV and document lessons learned to use during the latter phases of the graduated roll-out of GBV interventions. Futures Group will work with two Local Government Councils in Iringa to incorporate GBV activities in their comprehensive council development plans and budgets as a step towards sustainability of GBV programs . On the media front, funds will support a national women leader's conference to issue statement against GBV, train journalists to report accurately on GBV cases and issues, and promote coverage of GBV in media as a human right issue. In collaboration with other stakeholders, the Futures Group will work with TACAIDS and PLHIV to develop a Stigma and Discrimination (S&D) strategy, then develop user friedly maerials from the S&D reduction strategy for dissemination purposes. Another objective is to strengthen NACOPHA and the advocacy role of its constituent organizations in implementing S&D at the national and local level. Lastly, linkages will increase between Parliamentary AIDS Committee and national organs such as TACAIDS; this will include support for a policy forum to address and debate on HIV/AIDS policy reforms and their intersections with the GHI strategy and the PFIP.			

Implementing Mechanism Details

Mechanism ID: 10809	**Mechanism Name: AFENET**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Field Epidemiology Network	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 185,018	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	185,018

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the project is to strengthen the Laboratory Quality Management Systems and implement laboratory information systems through training of health workers in the areas of laboratory management and policy, laboratory information systems, quality management systems, biosafety, and certification of biological safety cabinets. The aim is to improve laboratory quality management stems through enhanced and expanded external quality assurance for HIV rapid testing, biosafety training, and other laboratory management strengthening activities. By improving laboratory management, African Field Epidemiology Network (AFENET) is contributing towards PEPFAR’s fundamental goal of providing integrated HIV/AIDS prevention, treatment, and care as HIV testing will be readily available and of improved quality. AFENET will also contribute to the strengthening of laboratory support for surveillance, diagnosis, treatment, HIV screening, and disease monitoring.

Coverage will be of HIV testing sites in all the regions up to the district level. AFENET is liaising with key personnel that are responsible with laboratory services to implement all of the laboratory strengthening activities. The monitoring and evaluation will largely comprise of the process, outputs, and outcomes of activities. Both internal and external audits will be used. Internally, program reviews will be carried out monthly to assess progress, identify delays, and potential causes and solutions. The external audit will be performed every three months.

Transitioning to a local organization is embedded within the planned activities. All activities are geared towards building capacity within MOHSW so that eventually the Ministry will be able to carry out all activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	36,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities

Safe Motherhood

Budget Code Information

Mechanism ID:	10809		
Mechanism Name:	AFENET		
Prime Partner Name:	African Field Epidemiology Network		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	185,018	0

Narrative:

AFENET will use COP 2012 funds for five distinct activities.

First, Tanzania currently has no trained and certified biomedical engineers for biosafety cabinet certification. The country relies on expertise hired from other countries (mainly South Africa and Europe) at a very high cost. To alleviate this shortage, with COP 2011 funds, a total of three biomedical engineers were trained to support biosafety cabinet and other equipment certification. With COP 2012 funds, three additional engineers will be trained to create a pull of six biomedical engineers to support biosafety certification in Tanzania. The funds will also support their travels to the regions to perform biosafety

cabinet certification activities.

Secondly, AFENET has been involved in phase 1 and 2 of evaluation of a new point of care CD4 enumerator (PIMA machine) which is expected to be registered in 2012. COP 2012 funds will be used to train a total of 30 trainers on the use of point of care CD4 diagnostic equipment. These trainers will go on to support on-site user traning of the PIMA CD4 diagnostic equiment at sites where the equipment is being deployed.

Furthermore, AFENET has been supporting 300 HIV testing sites, by proving proficiency testing panels and HIV logbooks for 2 years. For COP 2012, the partner will continue to support this activity at these 300 sites. AFENET has also been supporting three district labs under accreditation on Basic Laboratory Information System (BLIS). Depending on funding availability, AFENET will expand this support to six distirct laboratories under accreditation.

Lastly, Step-wise Laboratory Improvement Process towards Accreditation (SLIPTA) is one of the methods adopted at the MOHSW to improve the quality of laboratory services and achieving accrediation. AFENET will support the MOHSW on SLIPTA activities through facilitating SLIPTA trained auditors and mentors to travel and carry out montorship activities in the Country. A total of 19 laboratories are undergoing quality improvement processes towards accreditation, and more laboratories are being enrolled into the roadmap. The main challenge experienced by these laboratories is interrupted services due to frequent equipment breakdown and lack of necessary supplies and reagents. Depending on the availability of funds, AFENET will support provision of necessary supplies and parts that will ensure regular maintenance of the equipment.

Implementing Mechanism Details

Mechanism ID: 10811	**Mechanism Name: FXB**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Francois Xavier Bagnoud Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 831,500	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	831,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the Francois-Xavier Bagnoud Center (FXB) is to strengthen MoHSW capacity to standardize, monitor, and evaluate PMTCT services that reflect updated national strategies.

FXB will provide TA to improve institutional capacity of the MoHSW for coordinating PMTCT partners and stakeholders through use of inexpensive, effective strategies for communication, dissemination of information and enhanced use of data to improve service delivery and allocation of resources. FXB will develop systems for monitoring and evaluating training to effectively deliver training and manage training resources, support healthcare worker capacity development for PMTCT services with enhanced training and job aids. FXB will provide TA to the eMTCT workgroup to develop and implement improved systems for collecting, analyzing and reporting data. It will also support the eMTCT M&E workgroup to build capacity for new M&E systems at regional and district levels with support for training of trainers and site supervision visits.

These activities align with the Partnership Framework, as they build MoHSW capacity to sustainably monitor and evaluate its own PMTCT human resource activities; transition communication enhancing tools to MoHSW ownership by creating an advisory group; and maintain a woman-centered approach inherent in PMTCT.

FXB supports RCH healthcare workers in Mainland Tanzania and Zanzibar. The program will become more cost efficient as responsibilities transition from US-based staff to Tanzania-based staff and who, in turn, will actively ensure greater responsibility of outcomes by MoHSW. FXB will provide support to the in-country team to establish and secure funding for an independent NGO to sustain activities for the long term.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	531,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Safe Motherhood
Workplace Programs

Budget Code Information

Mechanism ID:	10811		
Mechanism Name:	FXB		
Prime Partner Name:	Francois Xavier Bagnoud Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	831,500	0
Narrative:			
FXB will support M&E, training and the development of tools and training materials. This will include TA and support for the eMTCT M&E workgroup to develop, disseminate and develop capacity to use PMTCT indicators and data collection tools. This project also aid MOHSW to streamline, monitor and evaluate PMTCT training and training materials.FXB will strengthen MOHSW M&E of PMTCT training activities by assessing quality of current data and data collection methods and by developing a universal training workplan for implementing partners. In collaboration with MOHSW, the partner will develop an effective, standardized, sustainable system for M&E of PMTCT training that allows facility, district and regional planning and tracking of trained PMTCT healthcare workers as well as evaluating effectiveness of curricula. FXB will develop data collection tools to properly measure PMTCT training outcomes to ensure			

comprehensiveness and quality of data, and usability for sustained M&E activities, creating a standardized tool for recording and tracking trainings and evaluations. This will help the MOHSW and implementing partners to address training gaps and to eliminate training redundancies.FXB will provide technical support to the MOHSW's eMTCT Strategic Plan to strengthen, coordinate, analyze and report on PMTCT services. FXB will provide TA and support to improve M&E of eMTCT and Pediatric HIV care and treatment, including surveillance and research. Activities include dissemination of indicators; quarterly and semi-annual reviews of targets and achievements; distribution of updated M&E tools; TOTs related to M&E; and supportive supervision visits to regions, districts and health facilities. FXB will revise, edit, format and disseminate the updated PMTCT Refresher Course, and also update the PMTCT site supervision tool to reflect changes to PMTCT strategies and PMTCT guidelines, as requested by Zanzibar MOH. FXBC will also continue to provide support to MOHSW for standardized PMTCT services by enhancing communications and dissemination of materials among and between implementing partners. This will include TA and admin support to the MOHSW for the annual meeting with implementing partners and other key collaborators. The annual partner meeting will provide an opportunity for communication and input with implementing partners regarding the PMTCT website, catalogue and listserv; M&E of training and the development of evaluation tools to measure the efficacy and impact of training; and M&E of the eMTCT strategic plan initiatives. FXB will support ongoing follow-up with implementing partners to monitor agreed plans of action, and report findings to MOHSW. The PMTCT partner catalogue will be updated quarterly on the PMTCT website. A print edition will be distributed annually to a minimum of 150 stakeholders. The PMTCT listserv will be distributed quarterly to subscribers and posted to the PMTCT website. The PMTCT website will also be updated with news, information and materials on a monthly and as-needed basis. An MOHSW-PMTCT newsletter will be added to the site, in collaboration with the MOHSW. Other activities related to the website include: - Hold quarterly meetings with the PMTCT Website Advisory Group - Host "roll-out" meeting to walk through the website - Market website via postcards - Use Google Analytics to monitor and evaluate website usage and impact - Conduct user survey to obtain feedback on site usability and usefulness.

Implementing Mechanism Details

Mechanism ID: 10970	**Mechanism Name: Grants**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Grant
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ambassador's HIV/AIDS Relief Fund (AHRF) projects that provide care and support to assist individuals and communities affected by HIV/AIDS, especially orphans and vulnerable children, and people living with HIV/AIDS. As such, the AHRF makes immediate contributions to Goal 1 of the Partnership Framework of improving the quality of life for PLHIV and those affected by HIV and AIDS. The longer term effects of these projects go toward GHI IR 2.4 for improved health support systems and IR 3.3 for strengthened social norms and structural environment for the empowerment of women and girls.

To support all these goals, grants can fund the gamut of projects, from the procurement of materials and goods to infrastructural development to start-up capital for income generating activities. Project details are not available at this time, since review and approval of projects takes place during the following fiscal year .

The Small Grants Coordinator convenes a selection committee twice a year, made up of members from throughout the USG mission. The committee assesses applications based on their relevance to the overall objectives of the AHRF but also on budget reasonableness and price efficiencies, applicant references, and project location in regions of Tanzania that are underserved by other USG foreign assistance programs. Grantees, all of whom are local organizations, are required to submit regular progress reports to the Small Grants Coordinator. In addition, the Small Grants Coordinator as well as other members of the USG Mission such as the Front Office and PEPFAR make site visits to evaluate project completion.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	10970		
Mechanism Name:	Grants		
Prime Partner Name:	U.S. Department of State		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0

Narrative:

The objective of the AHRF is to fund activities that support communities affected by HIV and AIDS. One of its two target audiences is orphans and vulnerable children. The local organizations who are the AHRF grantees use the funds for a variety of interventions that improve OVC access to quality care and education, from direct support for school fees and school materials to infrastructural devleopment such as classrooms, playgrounds, and homes. The income generating projects described under budget code OHSS also contribute to increasing the capacity of local structures to respond to children, families, and communities in need. The AHRF has positioned itself as a source of assistance for organizations that have few other such opportunities . This mechanism consequently prioritizes grantees in areas where USG implementing partners are not very active, but also supports interventions that have immediate

impact as well as more sustainable effects.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0
Narrative:			
The AHRF often provides grants that serve as start up capital for income generating activities. This initial contribution can procure inputs such as lifestock and fish which in turn produce goods that the grantee uses as a source of revenue to fund its core activities of care and support. The beneficiairies not only receive additional financial support but often gain management, business, and other technical skills These funds have also often paid for the construction or renovation of classrooms and related spaces to enhance the learning environment for OVC and for women and girls. The overall effect of these grants lends toward capacity and skills building both of the implementing organization itself and of its beneficiaries.			

Implementing Mechanism Details

Mechanism ID: 10973	**Mechanism Name: JGI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Jane Goodall Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

Kigoma Vijana Development Association - KIVIDEA		

Overview Narrative

The Jane Goodall Institute (JGI) advances the power of individuals to take informed and compassionate action to improve the environment of all living things. The Natural Resources Management (NRM) Office at USAID/T identified JGI as an important partner in conservation of primate habitat and PEPFAR has decided to leverage this relationship and provide critical HIV/AIDS services to the Institute's beneficiaries. Through PEPFAR funding, JGI attempts to reduce youth vulnerabilities to HIV infection as well as provide home-based care services to the isolated populations where JGI operates. The project covers Kigoma and Mpanda districts while targeting 300,000 people in 52 villages.

Given JGI's presence and influence in these hard-to-reach communities, the organization is well-positioned to empower community volunteers as home-based care service providers as well as train youth peer educators to promote life skills education. In addition, JGI has mainstreamed HIV/AIDS programming into its own organization to ensure sustainability after the cessation of PEPFAR funds. JGI acknowledges the role that local government and community-based organizations can play and thus collaborates closely with district government officials as well as sub-contracts with a local CBO to implement its youth HIV prevention interventions.

To ensure highly quality programming, JGI has developed a performance monitoring plan (PMP) and employed an M&E officer. There are also monthly review meetings and planned mid-term and end-of-project evaluations.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	10973		
Mechanism Name:	JGI		
Prime Partner Name:	Jane Goodall Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	100,000	0
Narrative:			
JGI will provide home based care services in Kigoma and Mpanda districts and will ensure that PLHIV and their families participate in JGI natural resource and development activities for HIV/AIDS impact mitigation. In addition, JGI refers its clients to critical HIV clinical services, some of which are provided by USG/T partners. JGI appreciates the financial toll of caring for HIV-infected individuals and builds key skills for economic strengthening opportunities, including beekeeping, tree planting, and access to micro-credit services (SACCOS), to improve household income that can be used to provide such care for HIV-affected families. JGI intends to economically empower these households to meet their health needs.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	100,000	0
Narrative:			
JGI will promote AB activities through the already existing Roots and Shoots clubs, which are school-based youth environmental clubs. This will be accomplished through a sub-contract with the local organization known as Kigoma Vijana Development Association (KIVIDEA). The program will offer an opportunity for in-school youth to learn through training sessions and youth summits. Patron and matron teachers will be involved during the trainings to ensure that the messages are reinforced in the school setting. There will also be teacher training workshops focusing on HIV/AIDS and natural resource management mainstreaming. This integrated approach of addressing HIV within the context in			

which these youth (and teachers) live allows for a more holistic development approach. All dialogues and interventions will discuss referrals to relevant clinical services. The target population for this intervention is youth and OVC as well as their households.

Implementing Mechanism Details

Mechanism ID: 11528	**Mechanism Name: U.S. Peace Corps**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 120,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	120,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Peace Corps (PC) Tanzania is active 15 Regions, including Zanzibar, in the sectors of Education, Health, and Environment. PC Tanzania will use COP 2012 to support prevention and care activities implemented through Peace Corps Volunteers (PCVs), living and working primarily in rural communities.

The first goal of this activity is to reduce the number of new HIV infections through evidence-based interventions addressing the key drivers of the epidemic, including sexual and behavioral risks, vertical transmission, and harmful gender/cultural norms and practices. The second goal is to support evidence-based care interventions for PLHA, OVC and their caretakers, based on prioritized needs to mitigate HIV and AIDS impact, and improve health outcomes through interventions in education, psychosocial support, nutrition and economic strengthening/ livelihood support.

These activities contribute to GHI IR 3 and PF Goals 1 (Services) and 2 (Prevention). The approach of PC also works in the spirit of GHI as it encourages collaboration with other partners and integration with

other USG-funded programs, while capitalising on existing synergy to bring the response to scale.

PC Tanzania will maintain current cost saving measures such as combined supervisions and training activities. Activities will also find efficiencies as PCVs work through existing PEPFAR partners. M&E will be in sync with existing guidelines for reported indicators. The organization intends to use COP 2012 funds for the purchase of a vehicle to replace the existing one bought in Dec 2008 which is about to reach 100,000 km covered. Monitoring visits and PCV site support require reliable transport, with a majority of sites having challenging terrain throughout the year.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	90,800
Education	15,100

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Mobile Population
Workplace Programs

Budget Code Information

Mechanism ID:	11528		
Mechanism Name:	U.S. Peace Corps		
Prime Partner Name:	U.S. Peace Corps		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	120,000	0

Narrative:

More than 140 PCVs located in 15 Regions will undertake HIV prevention activities as both primary and secondary activities in their respective communities. The target population for these interventionsincludes groups at high risk of infection such as MARPS, PLWHA, as well as youth in school and out of school , both girls, young women aged 15-24, and boys who are reported to practice high risk behaviors.

The eventual interventions undertaken by PCVs are contingent upon their own village situation analyses using the VSA tool once they reach site. Most interventions include a range of behavior change and risk reduction activities, HIV/AIDS communication campaigns, life skills and peer education, and condom programming. Other activities include advocacy/education and mobilization for PMTCT, VCT and MC jointly conducted with other implementing partners at their sites, to complement ongoing interventions and provide a more comprehensive service package to the beneficiaries.

Implementing Mechanism Details

Mechanism ID: 12192	**Mechanism Name: MCHIP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 5,961,696	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	5,961,696

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Voluntary medical male circumcision (VMMC) for HIV prevention is a key element of URT's HIV prevention strategy and supported by the USG/T Partnership Framework. The goal of the MCHIP program is to assist URT in the scale-up of VMMC for HIV prevention services, which targets 2.8 million circumcisions in eight regions. The specific objectives of MCHIP include:
(1) Work with the regional health authorities to scale-up VMMC for HIV prevention services (adult and early infants) in Iringa/Njombe region;
(2) Work in partnership with the regional health authorities to scale up adult MC services in Tabora region;
(3) Provide on-going technical support to USG/T VMMC partner agencies in Tanzania; and
(4) Provide technical assistance to MOHSW both at the central and regional level.

With FY 2012 funding, MCHIP will collaborate with regional officials in Iringa/Njombe and Tabora to provide 80,000 safe voluntary adult circumcisions and 10,000 early infant circumcisions. MCHIP's program will continue to look for ways to improve supply and demand driven efficiencies. MCHIP will continue to provide M&E technical assistance to URT and partners, and continue to use web-based data to capture and ensure accurate reporting of targets.

The purchase of four vehicles will be required in order to scale up these activities, which will take place across vast distances over difficult to reach terrain during campaigns and outreach activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,000,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	12192		
Mechanism Name:	MCHIP		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	5,961,696	0

Narrative:

Voluntary medical male circumcision (VMMC) services will be provided per WHO guidelines, endorsed by URT, using training tools developed by MCHIP and partners. MCHIP will continue to refer all HIV-positive and STI clients to appropriate services within health facilities. Quality assurance, supportive supervision, and M&E tools will continue as per the pilot phases, pending the development of national tools by URT. Formative assessments and other informative research activities will take place, as needed, to inform improved service delivery.

Objective 1: Scale up VMMC services for 60,000 adolescents and adults and 10,000 neonates in Iringa/Njombe region in partnership with regional and district authorities. MCHIP will continue to improve existing adult VMMC service delivery sites and add additional sites in underserved areas. During FY 2012, VMMC services will be provided in campaign waves—targeting specific districts and providing outreach services down to the level of very rural communities using a mix of permanent and temporary structures. One or two region-wide campaigns will be held to take advantage of seasonal preference. MCHIP will work with USAID-funded prevention partners to create demand for VMMC and supplement these activities with community advocacy, an advertising campaign, experiential media, radio and print media, and grants to community-based organizations to reach adult males and their partners. The primary target audience will be males aged 10-49, with a specific emphasis on men aged 20 and above. The secondary audiences are female partners, guardians of adolescents, and community opinion

leaders. FY 2012 will also see the scale-up of early infant male circumcision (EIMC) in Iringa with services rolled out to every district. The service delivery structure for the scale-up will be determined based upon the results of the EIMC pilot to be held in the prior year. In order to achieve VMMC and EIMC objectives, 100 providers will be trained in Iringa/Njombe region.

Objective 2: Scale-up VMMC services for 20,000 adolescent and adult clients in Tabora in partnership with regional and district authorities. MCHIP will maintain the four existing VMMC static service delivery sites and add up to six more. Outreach VMMC will be held on a monthly basis to reach rural communities and campaigns will be held twice a year. MCHIP will work in collaboration with other HIV prevention partners in Tabora to create demand for VMMC as stated above in Iringa/Njombe. Two hundred providers will be trained.

Objective 3: Provide technical assistance to USG/T VMMC partner agencies in Tanzania, as requested. MCHIP will continue to provide partners with technical assistance to scale up VMMC programs in their regions, including the provision of training to 100 providers, trainings of trainers, implementation of campaigns, and the launch of any EIMC activities. As needed, MCHIP will continue to support USG/T with data collection and synthesis.

Objective 4: Provide support for URT health authorities to scale up VMMC. MCHIP will continue to provide support to URT to scale up the national VMMC program. MCHIP has been asked by URT to help develop guidelines for the implementation of campaigns using efficiency models, participate in the national MC Technical Working Group, continue to support government training of trainers, and support government coordination and implementation activities as needed.

Implementing Mechanism Details

Mechanism ID: 12193	**Mechanism Name: Africare**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Africare	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,649,607	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	1,649,607

Sub Partner Name(s)

Evangelical Lutheran Church of Tanzania		

Overview Narrative

KAYA Community Care Initiative's goal is to link PLHIV with continuum of care services through HBC supervisors (CHBCSs) and providers (CHBCPs). Adherence support is central to the program, ensuring patients are linked to HCT, enrolled at CTCs, and maintained on treatment. The project's strategic objectives are: (1) Strengthen capacity of regional and district authorities to coordinate, plan, and fund HBC activities; (2) Strengthen the capacity of CSOs, FBOs, and PLHIV support groups to coordinate, plan, and fund HBC activities in collaboration with R/CHMTs; (3) Support HBC program quality improvement and data management through technical assistance to District Councils and CSOs; and (4) Strengthen dual referral networks between households and health units to decrease barriers to accessing health services.

Under the PF, KAYA CCI furthers the goals by expanding prioritized care, treatment, and support services to 35% more patients reaching 9,064 PLHIV and chronically ill clients; ensuring existing and additional care, treatment, and support services adhere to a minimum quality standard and package of services by working with 14 District Councils; and ensuring HBC services are offered per MoHSW guidelines and documented using HBC RRS.

KAYA CCI works within the three regions of Mara, Manyara, and Kagera, targeting PLHIV and chronically ill patients in 103 wards. Increased cost efficiencies will be leveraged through funding from CHMT budgets and providing HBC RRS training to providers trained by district councils. Direct service scale up by district councils will facilitate transition of the project to URT. Monitoring and evaluation of project activities will be done using the four national HBC RRS tools and HBC database (to be initiated in FY 2012).

Cross-Cutting Budget Attribution(s)

Economic Strengthening	25,800
Food and Nutrition: Policy, Tools, and Service Delivery	16,200
Human Resources for Health	248,443

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	12193		
Mechanism Name:	Africare		
Prime Partner Name:	Africare		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,649,607	0
Narrative:			
KAYA CCI’s network of community HBC providers and supervisors (509 HBC providers; 103 health			

facility-based HBC supervisors) implement the MOHSW HBC service package, which includes nursing care, psychological support, nutrition education, socioeconomic support by establishing VSL groups, and legal support. Prevention services are included within the Positive Health Dignity and Prevention package, including water purification and sanitation interventions whereby KAYA CCI has established household hand-washing stations for diarrheal disease prevention. Targeted beneficiaries include PLHIV and other chronically ill patients. Special focus has been given to HBC enrollment and retention for HIV positive pregnant women since this group has been documented with high lost to follow up (LTFU) rates. HBC services are focused on home-based service delivery. Community-based interventions support recruitment and retention of HBC clients, PHDP services, and economic strengthening activities, by linking clients and caregivers to PLHIV support groups.

Under the USG Tanzania country strategy, HBC coverage is regionalized to limit duplication while focusing priority to areas of high HIV prevalence and incidence. Africare's KAYA CCI works in 103 wards in the three regions of Mara, Manyara, and Kagera. In FY 2012, KAYA CCI will serve 9,064 clients in six districts of Manyara Region, 6 districts of Mara region, and 2 districts of Kagera region. Within the fourteen districts, a total of 103 wards have been covered by the project in FY 2011.

The program addresses various HHS/CDC program areas including the expansion of confidential counseling and testing; building programs to reduce mother-to-child transmission by decreasing PMTCT lost-to-follow ups; and improving the care and treatment of HIV/AIDS and related opportunistic infections. The project initiated the provider linkage and referral strategy to ensure HIV continuum of care services, linking HBC providers to 73 health facilities. This work has been central in addressing the high rates of missed appointments and lost to follow up patients at CTCs. Patients are tracked monthly by HBC volunteers, which has accounted for a 60-70% return rate for those that are located. Referrals to health facilities are captured using the national HBC Recording and Reporting System. Africare facilitates joint annual review meetings with HBC cluster leaders and health facility staff to identify gaps in the dual referral system and proposes measures to address these gaps.

Africare's program is linked to care, treatment, and prevention facilities in its regions of operation focusing on the CTC as the primary point of service delivery for PLHIV. AIDS Relief (Mara and Manyara), ICAP (Kagera), and EngenderHealth are included in planning sessions related to HBC strategy development, per region, covering continuum of care and PMTCT services, respectively.

In the upcoming year, Africare is proposing to undertake joint planning with the Kagera RHMT and ICAP to ensure newly trained HBC providers are linked to 13 health facilities and mobilized to increase CTC coverage and increase ART retention rates, which are now as low as 50%. Supportive supervision and mentoring are the primary means for program quality improvement. In FY 2012, district action plans will

be developed to ensure joint targets are established with local government authorities to improve HBC services and coordination mechanisms.

Implementing Mechanism Details

Mechanism ID: 12196	**Mechanism Name: UNICEF**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 700,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	700,000

Sub Partner Name(s)

African Medical and Research Foundation	Mothers 2 Mothers	National Council of People Living with HIV/AIDS

Overview Narrative

The goal is to improve utilization of PMTCT and MNH services to contribute to the elimination of mother to child transmission of HIV. The objectives are to: (1) Increase access to PMTCT, nutrition, and SRH information to HIV infected women and their partners, as well as provide access to PMTCT continuum of care; and (2) support innovative models to reach women and children with PMTCT/MNCH services and reduce loss to follow up.

The project will be implemented in Iringa, Ruvuma, and Dar es Salaam. The primary targets are HIV infected pregnant women identified in PMTCT sites, their babies, and partners, while the other target groups are community members and key informants. The project will focus on establishing mother support groups, comprised of HIV infected women, who will be trained to provide psychosocial support and follow up with their fellow women to ensure that they all get the PMTCT services and EID, as

required. CORPS will also be oriented to support and supervise mother groups. The groups will be linked to the PMTCT sites where regular communications will be made using mobile phones. This will allow the support group members to follow up when there are missed appointments. In addition, mother mentors will be deployed at PMTCT sites where all HIV infected pregnant women will be referred for follow up and support.

The CHMT and W/VHC will be involved in planning, training, monitoring, and follow up to ensure that once the project ends, there is ownership and continuity of activities. The mother groups will also conduct awareness to the communities and promote male participation in the PMTCT program. Reported indicators will be aligned with the national PMTCT program. In addition, evaluations of the support group models will be conducted.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	550,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	12196		
Mechanism Name:	UNICEF		
Prime Partner Name:	United Nations Children's Fund		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	700,000	0

Narrative:

UNICEF works as a prime PMTCT partner of CDC to increase the uptake of HIV counselling and testing, antiretroviral prophylaxis, ART among pregnant women, early infant diagnosis, and prophylaxis or treatment of eligible HIV exposed infants through the MNC health service platform.

The sub-partners under UNICEF are Mother 2 Mothers (M2M) and AMREF Tanzania. The current geographic coverage is the five districts in Iringa region, namely Kilolo, Ludewa and Njombe (for M2M), and Makete and Iringa rural (for AMREF). These have the highest HIV transmission rates in the region and high loss to follow up. The project aims to reach at reaching at least 35,000 people per year, translating to USD20 per person per year.

COP 2012 and 2013 will see the scale up of current activities including training for mentor mothers, establishment of mother support groups, distribution of BCC materials on PMTCT, and the empowerment of reproductive and child health coordinators in advocacy. The program will continue to strengthen linkages and referrals of HIV positive mothers and exposed children to care, treatment and other reproductive health services in the health facility and the community.

This program will also use COP 2012 funds towards expanding peer education support services started in the first two years of the project, from 60 sites in two regions to a cumulative total of 130 sites in three regions. HIV positive women who will be recruited and trained in the programme and trained CORPs will take the lead in conducting active client follow up of HIV infected mothers and HEI. This will be complemented by the development of messages for interpersonal communication, community support and couples dialogue. The efforts of HIV positive women will be supported by community health workers and supervisors in fifteen wards who will be trained to provide integrated education on PMTCT, MNCH and nutrition. To facilitate ownership and sustainability of the project, village health committees will be trained and facilitated to conduct bottom-up planning that addresses bottlenecks for utilization of MNCH

services, including engaging men in PMTCT and MNCH services. In addition, CHMTs will be trainined in results-oriented planning to assist in developing district action plans in line with the eMTCT targets. For COP 2012, at least 120 health workers will be oriented on the PMTCT program, and 150 others for 2013. The number of community health workers who will complete M&E and active client follow up training on peer support is 350 for COP 2012 and 340 for COP 2013. The target number of facility sites is 150 for COP 2012 and 180 for COP 2013. This project will support monitoring and supervision to ensure quality service delivery and achievement of results. During the process of implementation, best practices will be document and disseminate experiences for wider scale up. In addition, new innovations like use of mobile phone to reach majority of women and children with PMTCT and MNCH will be used.

Implementing Mechanism Details

Mechanism ID: 12197	**Mechanism Name: Fintrac**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Fintrac Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 730,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	730,000

Sub Partner Name(s)

AIDS Business Coalition	Chama cha Uzazi na Malezi Bora Tanzania (UMATI)	Huruma AIDS Concern and Care

Overview Narrative

Fintrac aims to increase agricultural productivity for smallholder farmers through improved horticultural production and access to markets. With regards to HIV/AIDS, vulnerable households are engaged in

prevention and impact mitigation activities, which are aligned with the PF prevention goal of reducing the number of new HIV infections. As a mainstreaming strategy, Fintrac will help vulnerable households increase the productivity of their farms, which will provide income generating opportunities. Coupled with increased HIV awareness and referrals to clinical services, this approach will provide vulnerable populations with the resources to combat the threat of HIV/AIDS. Fintrac will, also, adapt some of the integrated approaches utilized by Tanzania Agriculture Productivity Program's (TAPP) that centers around four key intervention areas of HIV/AIDS: prevention, food security, HIV/AIDS workplace policies, and OVC care services.

Work is currently being done in Arusha, Kilimanjaro, Tanga, Morogoro, Pwani, Dar es Salaam, and Zanzibar. The target population is comprised of smallholder horticulture farmers, their families, and their communities. Fintrac will be working with local NGOs involved in HIV/AIDS and OVC interventions to ensure community efforts are maximized.

Cost efficiency and a transition strategy are centered on capacitating local organizations and horticultural workers to create their own HIV/AIDS prevention and mitigation strategies, mainly through developing workplace policies to combat HIV/AIDS at the organizational level. Monitoring and evaluation efforts will be done through progress review meetings that are based on implementation and results monitoring plans, which have been developed with partners and peer educators.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12197		
Mechanism Name:	Fintrac		
Prime Partner Name:	Fintrac Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	300,000	0

Narrative:

Fintrac will complement the on-going sustainable approach of the OVC program, which will include activities to support linking caregiver groups to value-chains. Younger OVC will be targeted through their caregivers who will facilitate establishing nutritional gardens that will serve as a source of nutritious vegetables for the families, offer income opportunities, and provide food security. Junior horticulture clubs will be created to increase interest and knowledge of the importance of horticulture to younger OVC. The clubs will also provide training and information on the value of good nutrition. This activity will be conducted while the caregivers are undertaking production activities.

Older OVC, aged 13 years and above, will be directly involved in horticultural production through the establishment of garden groups. The groups will be trained on various horticultural production techniques, which will develop the skills needed to establish successful horticultural activities, specifically in the areas of income generation and improved nutrition.

To ensure the project continues to build upon previous activities, Fintrac will provide TA to USG and URT sub grantees, CSOs, and ward officials. In order to strengthen the capacity of sub grantees to plan and implement HIV/AIDS interventions, best practices will be shared among sub grantees through conducting support visits and experience sharing workshops. Fintrac agronomists will deliver the technical support for the visits and workshops. Through consultations, the capacities of HIV/AIDS sub grantees will be assessed. Any gaps that arise from the assessments will be addressed by Fintrac's Health and Nutrition Manager. It is expected that with this intervention, 500 OVC and 300 vulnerable households, which includes at least one OVC, will be reached.

Among the challenges is the caregivers' unwillingness to participate in production activities as a result of overdependence on direct support from donors. Targeted areas will hold community awareness meetings in order to address this challenge. The meetings will focus on the importance of effective involvement, commitment, and participation from the community with development activities. It is

expected that with this intervention, 500 OVC and 300 vulnerable households, which includes at least one OVC, will be reached.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

Fintrac implements its AB intervention through peer-to-peer and farmers group discussion programs. These interventions target youth smallholder famers working in agricultural plantation or farm plots. Through this peer-to-peer and farmers discussion program, a number of other health issues such as prevention of early pregnancies and STIs are discussed. Discussions also address barriers to remaining abstinent and being faithful.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	330,000	0

Narrative:

Given that farmers, particularly migrant farmers, are considered a hard-to-reach population, there is great utility in integrating HIV/AIDS information and services into an existing activity to allow for a more holistic approach to reaching this population. With these funds, Fintrac will continue its peer education program, which in addition to providing predominately partner reduction messaging, also collaborates with other service providers to refer its clients to HTC, VMMC, and reproductive health services. Peer educators come from within the targeted communities and are trained to specifically address key drivers of the epidemic with their clients. Fintrac also ensures that partners are distributing condoms where appropriate. This intervention will take place in all of the regions in which Fintrac's Tanzania Agriculture Productivity Program (TAPP) operates.

Fintrac will work with sub-partners to reduce transactional sex among smallholder farmers and farmers working in big agricultural plantations. About $50,000 will be used for prevention of transactional sex and it is expected up to 1,000 individuals will be reached. Fintrac will also ensure availability and use of condoms among smallholder farmers while economically empower farmers' group through their value chain interventions. Fintrac will link and refer individuals as necessary to other health/HIV services such as ART, PMTCT and reproductive health. Approximately $50,000 will be used to reach 1,000 individuals. Finally, through a peer education program, approximately $80,000 will be used to reach 2,000 smallholder farmers with HIV/AIDS prevention. The focus will be on partner reduction messaging and referrals and linkages to health/HIV services.

Implementing Mechanism Details

Mechanism ID: 12200	Mechanism Name: UNAIDS-M&E TA
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: UNAIDS - Joint United Nations Programme on HIV/AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 95,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	95,000

Sub Partner Name(s)

Tanzania Commission for AIDS	Zanzibar AIDS Commission	

Overview Narrative

Tanzania UNAIDs Country Office will continue to support multi-sectoral HIV/AIDS monitoring and evaluation system to meet data requirements at the regional, council and district levels for Mainland and Zanzibar. UNAIDs is commited to work with TACAIDS for mainland and ZAC in Zanzibar by streamlining roles for stakeholders with regards to a multi-sectoral HIV/AIDS monitoring and evaluation system.

UNAIDS also will facilitate the “knowing your epidemic (KYE)” and “know your response (KYR)” studies so that the country have a better understanding of the dynamics influencing HIV epidemic in Tanzania. Available evidence shows that in Tanzaina;the HIV epidemic is stabilizing and treatment programs are in place. The importance of KYE and KYR study results will thus provide a better understanding of the HIV epidemic and thus be able to have targetted responses.

UNAIDS will working with TACAIDS, ZAC, and other stakeholders to prepare annual progress report for the multi-sectoral response. This is an important undertaking to monitor the level of performance towards controlling the HIV/AIDS epidemic in the country.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	12200		
Mechanism Name:	UNAIDS-M&E TA		
Prime Partner Name:	UNAIDS - Joint United Nations Programme on HIV/AIDS		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	95,000	0
Narrative:			
COP 2012 funding will be used to further support monitoring and evaluation activities which UNAIDS is providing to TACAIDS, ZAC, councils and districts. UNAIDS will also conduct "Know Your Epidemic and Know Your Response" (KYE and KYR) studies in both Tanzania Mainland and Zanzibar. COP 2012 funds will be supplemental prior year funding to hire local consultants to finalize these activities as well as to disseminate results to stakeholders.			

Through these activities, UNAIDS will be enhancing local capacity building efforts with in-service training on M&E and on KYE and KYR.

Implementing Mechanism Details

Mechanism ID: 12204	Mechanism Name: PPP
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: CDC Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

Voxiva		

Overview Narrative

The mHealth Tanzania Partnership, an innovative public-private-partnership (PPP), works closely with MOHSW TZ, USG CDC, and numerous Tanzanian and international public and private sector partners. The Partnership implements 'mhealth' solutions on a national scale. Target populations are health care workers, community members, community health care workers, and senior MOHSW management. Program mHealth priorities include: education and awareness building, remote data collection, remote monitoring, communication and training for healthcare workers, disease and epidemic outbreak tracking, and diagnostic and treatment support.

The Partnership convenes multiple sectors and resources, implementing sustainable and scalable public health programs with increasing cost-efficiency. The Foundation charges an administration fee and includes specific direct costs covering management of the project (personnel, supplies, travel, & equipment); however, PPP relationships with sub-partners/contractors will be transitioned directly to the

MOHSW (via the MOHSW PPP Unit) as part of the sustainability plan. M&E plans are incorporated within program plans.

The Partnership supports the PF goals relating to prevention, such as 'Mama messaging' which educates pregnant women in ANC, PMT-CT, malaria, birth planning, nutrition, and danger signs, with emphasis on prevention for HIV/AIDS positive women. Human resources is supported as part of the Integrated Disease Surveillance & Response (IDSR) system scale-up, including informative messaging and quizzes related to materials learned during the health care worker training. IDSR also supports evidence-based strategic decision making by making disease surveillance information available.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVSI	MOHSW (a partner but not receiving funds as a sub partner)	250000	MOHSW has budgeted GF resources to help sustain and expand M-Health activities

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)

Safe Motherhood

Budget Code Information

Mechanism ID:	12204		
Mechanism Name:	PPP		
Prime Partner Name:	CDC Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0

Narrative:

The mHealth Tanzania Partnership (Partnership) supports key programs under SI that back the national SI strategy in building institutional capacity at the MOHSW, supporting health information and surveillance systems, and strengthening existing national systems. The Partnership specifically aims to leverage the rapid expansion of mobile networks and technologies in Tanzania to improve the flow of information across and between different levels of the health system, reduce the response time of providing critical services, and increase evidence-based planning and decision-making within the sector. The Partnership will continue supporting efforts to develop national mHealth guidelines and PPP relationships with the MOHSW and private sector partners.

Following an in-depth Ministry-lead project evaluation, MOHSW HMIS and Epidemiology departments advocated for scaling the Partnership's pilot integrated disease surveillance and response (IDSR) system. The joint team is leading the scale-up with the Partnership and additional partners from the HMIS Technical Working Group (TWG). A national scale system is the ultimate objective; however, in the next year, with support from partners, the IDSR system will roll-out to an additional 35 districts, focusing on high-disease threat/surveillance priority areas.

The scaling of the IDSR system directly supports the Ministry's M&E Strengthening Initiative 'Combined Plan' (Oct 2010) in providing a consistent, scalable, and sustainable data collection tool to facilitate

evidence-based policy formulation, priority setting, and budget allocation. Disease surveillance is a key component of HMIS reporting and the scale up of the IDSR system fits within the long term vision of the M&E Strengthening Initiative. The Initiative includes direct contributions from several international funding sources and MOHSW to fund a combined plan.

The IDSR system provides health facilities with tools to transmit real-time notifications of infectious disease cases, as well as broader disease trends via a weekly IDSR report, following WHO standards (Diseases of Public Health Importance, Epidemic-prone Diseases, and Diseases Targeted for Eradication / Elimination). The system helps facilitate real-time analysis and use of the submitted data by making it immediately available to public health officials at the district, regional, and national offices via the internet.

The Partnership will continue support of the core indicator data collection tool, district health information system (DHIS), which integrates directly with the existing HMIS being rolled out by MOHSW. The core indicator reporting (CIR) system is utilized to consistently collect key indicators across vertical health programs in a timely and cost effective manner. The continued support of this CIR system will support the PF priorities in improving evidence-based and strategic decision-making related to HIV-related planning (see HTXS section), as well as across vertical health programs. The CIR data collected integrates directly with the Ministry HMIS system (DHIS) and thus promotes use of data concurrent with the national roll-out of the broad data collection of DHIS. The CIR supports the PF by capturing key data related to drug and commodity supplies, thus strengthening the procurement and management of drug supplies by making information regularly available.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	0	0

Narrative:

The Partnership will continue to support blood donor recruitment and retention activities to assist in addressing the critical blood shortages in Tanzania. Support will be through the further development and utilization of the blood donor SMS messaging system (BDM) launched two years prior. In partnership with the National Blood Transfusion Services (NBTS), the mHealth Tanzania Partnership launched the BDM system, which the NBTS team will be completely trained to administer and operate independently. The BDM system allows the NBTS team to send text messages to existing blood donors in order to retain existing donors and mobilize assistance.

The Partnership will continue support of the NBTS' approach to blood donor recruitment and retention through the further utilization of the SMS-driven Blood Donor Messaging System. The current objectives of the BDMS are to help the NBTS maintain contact with its pool of active donors over time and

disseminate targeted messages to blood donors in a timely and cost-efficient manner.

SMS messages will continue to be sent one-way to existing blood donors, focusing on the following content areas: Post-donation thank you messages; notification of test result availability; general public service messages as reminders and shortage notifications; notification of specific donation drive sites; specific events and holiday messages; lapse donor reminders; and replacement donors. In addition, the message content will link-in with testing and counseling as the messages will notify donors of counseling and test result availability (with no disclosure of confidential or sensitive data) in order to address issues of low return rates by donors to collect test results and receive counseling.

In addition to supporting the NBTS in leveraging SMS technology to communicate with existing donors in the manner mentioned above, the Partnership will continue providing Technical Assistance to the NBTS in developing an SMS strategic plan for expanded donor and community engagement. The Partnership will support NBTS goals of increasing levels of safe blood donations by exploring the various activities that NBTS currently engages in, such as new donor recruitment and M&E, which could be supported and even enhanced by introducing SMS technology. The Partnership will support community sensitization, education (for populations to 'opt in' to receive SMS messages with facts about blood donation), and community members' involvement, whereby they can take quizzes about blood donors/donations, to the extent the NBTS program is interested in such use of the technology platform.

In addition, the Partnership will assist the NBTS team in exploring and utilizing SMS technology in order to conduct routine M&E activities using the mobile phone. For example, sending SMS messages following donors' visits and asking them, through a free 'ping pong' (back and forth) SMS function, a series of questions related to their experience. The Partnership will assist the NBTS team in establishing workplace SMS enrollment programs, whereby members of an organization can receive messages related to blood donation activities for their institution specifically.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	400,000	0

Narrative:

Building on the 'Mama Nipende' campaign from the prior year, the Partnership will continue providing messaging platform support to the Ministry PMTCT SMS programs and related implementing partner programs supporting PMTCT. As the Partnership secured a dedicated SMS 'short-code' for the Mama Nipende campaign, the Partnership will continue to promote use of the system and growth of the content included.

The service will remain free of charge for pregnant women and families to register for the SMS service. The SMS campaign will be expanded to include quizzes and two-way messaging (such as keyword information look-up function), in addition to the one-way information messages and appointment reminder messages that were sent the year prior (based on the woman's expected delivery date).

Continued outreach to private sector partners will seek additional funding to off-set the cost of the SMS messages and support expansion of the program. In addition, as enrollment rates increase, the telecommunications sector is committed to reducing per unit SMS costs.

While the outreach efforts will continue to be for all pregnant women across Tanzania, the Partnership will continue to focus on developing additional partnerships with PEPFAR PMTCT implementing partners in order to increase health facility and community health worker engagement. Partners will assist in registering and following-up with pregnant women in communities and at health facilities (ANC and PMTCT) and messages can be sent to CHWs and facility workers with educational or reminder messages, as desired by the partner.

In addition to continuing support of the SMS platform, the Mama Nipende, and related activities, the Partnership will also continue support for the Java or SMS core indicator reporting platform. The PMTCT key indicators will continue to support evidence-based and strategic decision-making. PMTCT partners will continue to provide in-service training of health facility workers where they operate programs. The Partnership will continue follow-up with implementers on data use and quality.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

The Partnership will support increased evidence-based and strategic decision-making within NACP by continuing to develop an SMS or Java based mobile-phone reporting tool that will assist with the collection of care and treatment core indicators. Support for the system will assist in promoting its scalability and sustainability by leveraging existing implementation efforts.

The core indicator program captures critical, key indicators, as identified by the NACP, to ensure timely decision-making and reporting to partner organizations. The Partnership provides basic support of a core indicator care and treatment tool to support NACP's quarterly reporting to help promote improved timeliness, accuracy, and completeness in reporting. NACP will be responsible for working with care and treatment partners to follow-up on data quality, analyze timeliness and completeness of reporting, and update training materials and performance metrics in order to improve reporting performance over

time.

Implementing Mechanism Details

Mechanism ID: 12208	**Mechanism Name: donor mobilization**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Regents of the University of Minnesota	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this program is to increase the safety and availability of Tanzania's blood supply through the recruitment and retention of eligible blood donors. To achieve this, the University of Minnesota will focus on four strategic objectives: establishing national policies and guidelines for all blood donor recruitment and collection practices throughout Tanzania and Zanzibar, with a focus on promotion of voluntary, non-remunerated blood donation; reinforcing and building capacity of blood donor mobilization leadership, staff, and volunteers through training and mentorship to establish a sustainable cadre of capable blood donor recruiters; compiling and analyzing donor and non-donor demographic and epidemiologic statistics to define population groups to target the safest potential blood donors; and establishing strong public-private partnerships with organizations to host blood drives, as well as linkages for counseling and delivery of test results.

The project covers eight zones in Tanzania and Zanzibar. The target population is limited to eligible Tanzanian adults between the ages of 18-64. The purpose of the initial trainings and guidance preparation highlighted in the objectives is to create practices and policies that will facilitate greater

effectiveness and efficiency in the area of blood donation. Cost-reduction is built into this program since there will be an increasingly reduced need for external technical expertise, as policy changes occur and donor recruitment processes become successful, which is also a central component of the transition strategy. Monitoring and evaluation plans include measuring the number of activities planned, individuals trained and competencies gained, as well as units of blood collected and voluntary donors recruited.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	90,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12208**		
Mechanism Name:	**donor mobilization**		
Prime Partner Name:	**Regents of the University of Minnesota**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	100,000	0
Narrative:			
Specific program objectives and approaches currently being applied in the areas of policy development and blood collection include the preparation and implementation of a donor recruitment production			

planning process. This item is being collaboratively developed by the University of Minnesota (UMN) and NBTS, and seeks to streamline the process of blood collection in the interest of promoting donor retention, production planning based on achievable goals, and increased transparency and communication between key stakeholders. The second objective is to develop and support a program to increase blood donations from new donor groups not associated with schools or universities. Thirdly, UMN plans to help update and implement NBTS' public relations and communications program in an effort to improve marketing strategies and heighten the organization's name recognition throughout Tanzania. The fourth objective is to conduct a knowledge, attitudes, and behavior survey on motivational factors affecting blood donation, in which the results will then be analyzed and presented to NBTS and CDC leadership to determine if and how existing recruitment and retention methods may be altered to better address donor concerns. The fifth objective is to conduct an assessment of current transmissible disease testing data to support/reject the concept that family replacement donors are less safe than voluntary blood donors. Additionally, UMN will compile and analyze key data/statistics to assist the NBTS in operational decision-making. The sixth objective is to assist NBTS in implementing a donor recruitment texting program in collaboration with Phones for Health. Finally, UMN plans to support the establishment of blood donor clubs for youth and blood donor community groups for adults, including Club 25 which is an international youth-oriented global social club for young people committed to saving lives by regularly donating blood.

UMN will monitor and evaluate the progress of its objectives by measuring the number of proposed activities that are conducted in each of the programs' eight zones. Specifically, success of the production planning process will be measured by comparing projected statistics to the number of actual units collected during each of the scheduled blood drives. UMN will measure the effect of the program to expand donor sites beyond schools and universities by conducting an assessment of potential blood donation sponsors, including community groups, religious organizations, businesses, etc. in each zone. The sites will then be compiled into a list to be used in zonal outreach and recruitment efforts.

Success of the program will be determined by the number of new non-school and university sponsors acquired in each zone. Outcomes of the new communication program will be measured by the number of media activities conducted. The measure of the KAP survey will involve the production of a comprehensive report including key findings and recommendations. Similarly, the assessment of infectious disease transmission in family replacement donors as well as the evaluation of key operational data/statistics will also conclude in the production of two final reports and recommendations. Effectiveness of the Phones for Health programming will be measured by the number of donors that are recruited via text messaging. Finally, donor club activities will be evaluated based on the number of members and repeat donors.

Implementing Mechanism Details

Mechanism ID: 12217	**Mechanism Name: BOCAR**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Deloitte Consulting Limited	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,331	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	400,331

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Building Organizational Capacity for Results (BOCAR) is mobilizing greater civil society participation in the HIV/AIDS response by strengthening the capacity of CSOs and CSO networks. More specifically, the activity will strengthen four to six large CSOs working in the area of HIV/AIDS, develop six to nine durable HIV/AIDS CSO networks, and build the capacity of 50-75 small CSOs through the multi-donor Rapid Fund Envelope (RFE). The RFE component supports small CSOs in all regions of Tanzania Mainland and Zanzibar. Large CSOs that have the potential to play a national leadership role in the HIV/AIDS response and CSO networks that can impact on high HIV prevalence regions are being prioritized for BOCAR capacity building support.

BOCAR supports GHI IR.2 (Systems Strengthening) and contributes to PF Goal 3 (Leadership) by enabling civil society to take greater leadership in the response to HIV/AIDS. The multi-donor funded Rapid Funding Envlope (RFE) component of BOCAR has been an innovative approach that has mobilized significant donor funds that are granted to small CSOs to implement HIV/AIDS activities. PEPFAR funds are used to provide these CSOs technical assistance to ensure that these funds are used properly and to build their leadership, financial and human resource capacity. Several of the RFE graduates have become primary implementing partners.

To increase cost efficiencies and improve effectiveness, this activity involves capacity building interventions working with the leadership and technical staff through coaching and training at their place of work. BOCAR has developed tools for monitoring the work of CSOs on a quarterly basis. In FY 2012, one vehicle will be purchased for the project term in order to reach CSOs based in remote areas of the country.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12217		
Mechanism Name:	BOCAR		
Prime Partner Name:	Deloitte Consulting Limited		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	300,000	0
Narrative:			
Building Organizational Capacity for Results (BOCAR) is mobilizing civil society to participate more fully in the response to the HIV/AIDS epidemic. More specifically, this activity is building the capacity of CSOs and CSO networks involved in the response to HIV and AIDS. The Tanzania Commission for AIDS			

(TACAIDS) and the Zanzibar AIDS Commission (ZAC) are the key partners in this activity, along with other donors contributing grants to small CSOs to conduct HIV/AIDS activities under the Rapid Funding Envelop (RFE) component.

BOCAR conducts organizational assessment/surveys to identify the capacity needs for technical assistance to CSOs involved in providing support to OVCs. Upon identification of these needs, BOCAR develops an implementation plan focused on capacity building interventions to the CSOs. One of the objectives of the activity is to improve the integration and effectiveness of monitoring and evaluation systems by building the capacity of CSOs to provide data through the TOMSHA (for TACAIDS) and ZAPMOS (for ZAC) reporting systems. Increased attention is being given to monitoring and documenting the types of HIV care and support services provided by the CSO and documenting the referrals made to facilities in their geographic areas. The target groups of these CSOs vary, depending upon the nature of the grant awarded through the multi-donor RFE mechanism.

Through Implementing Partner's monitoring and evaluation unit, tools have been developed to capture success stories and best practices. These stories and best practices are shared widely among different key stakeholders for the purpose of increasing awareness about the significant role that civil society can play in addressing the needs of PLWHA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

Building Organizational Capacity for Results (BOCAR) is mobilizing civil society to participate more fully in the response to the HIV/AIDS epidemic. More specifically, this activity is building the capacity of CSOs and CSO networks involved in the response to HIV and AIDS. The Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) are the key partners in this activity, along with other donors contributing grants to small CSOs to conduct HIV/AIDS activities under the Rapid Funding Envelop Component.

BOCAR conducts organizational assessment/surveys to identify the capacity needs for technical assistance to CSOs involved in providing support to OVCs. Upon identification of these needs, BOCAR develops an implementation plan focused on capacity building interventions for the CSOs. One of the objectives of the activity is to improve the integration and effectiveness of monitoring and evaluation systems by building the capacity of CSOs to provide data through the TOMSHA (for TACAIDS) and ZAPMOS (for ZAC) reporting systems.

With COP 2012 funds, BOCAR will provide specialized support to at least three local organizations that directly serve vulnerable children. In addition, BOCAR will provide technical assistance to the Tanzania Social Work Association to develop the Tanzania Emerging Social Work Education Program, a nationwide program that will set up and implement locally accredited social work programs in up to 12 schools in the country. BOCAR's support in developing the social work profession in Tanzania is critical to improving the lives of vulnerable children in a country where there is only one social worker per 200,000 children.

Through Implementing Partner's monitoring and evaluation unit, tools have been developed to capture success stories and best practices. These stories and best practices are shared widely among different key stakeholders for the purpose of increasing awareness about the significant role that civil society can play in addressing the HIV/AIDS epidemic.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	100,331	0

Narrative:

The Rapid Funding Envelope (RFE) is a multi-donor basket fund component of BOCAR. PEPFAR funds provide technical assistance to the RFE for grants management and for building the capacity of CSOs receiving grants from other donors under the RFE. Adverts are placed in English and Swahili soliciting concept letters from CSOs involved in a range of HIV/AIDS activities. A multi-donor RFE committee, which is co-chaired by TACAIDS and ZAC, selects the best proposals from a short list developed by the PEPFAR-funded implementing partner, which then provides assistance in financial and project management, monitors performance, accounts for grant expenditures, and builds organizational capacity. The CSOs have one to two years to implement PLWHA activities using the RFE grant, and the best performing CSOs become candidates for additional capacity building support under BOCAR.

COP 2012 will go toward critical technical assistance specifically to build the capacity of CSOs by establishing stronger financial management, project management, and M&E systems, and by addressing other aspects of longer term organizational sustainability such as strengthening the CSO executive team and Board of Directors, improving client and beneficiary relations, enhancing resource mobilization efforts, developing better public relations with local and national government and networking with other CSOs working in the response to HIV and AIDS.

With COP 2012 funds, BOCAR will support 17 small CSOs with different capacity building interventions and will identify and additional 35 new small CSOs for capacity building activities. Two large CSOs in

Zanzibar will also be recipients of capacity building support, as well as three CSO networks, two in Tanzania Mainland and one in Zanzibar. The type and nature of these capacity building interventions depend on the unique capacity needs identified in the pre-intervention organizational assessment. Depending upon the CSO or CSO network organizational development needs, activities may include leadership development, advocacy and communication skills development, fundraising strategies and campaign planning, governance restructuring, monitoring and evaluation training, or enactments of human resources functions in the organization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

Building Organizational Capacity for Results (BOCAR) is mobilizing civil society to participate more fully in the response to the HIV/AIDS epidemic. More specifically, this activity is building the capacity of CSOs and CSO networks involved in the response to HIV and AIDS. The Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) are the key partners in this activity, along with other donors contributing grants to small CSOs to conduct HIV/AIDS activities under the Rapid Funding Envelop (RFE) component.

BOCAR conducts organizational assessment/surveys to identify the capacity needs for technical assistance to CSOs involved in the HIV/AIDS response. Upon identification of these needs, BOCAR develops an implementation plan focused on capacity building interventions to the CSOs. One of the objectives of the activity is to improve the integration and effectiveness of monitoring and evaluation systems by building the capacity of CSOs to provide data through the TOMSHA (for TACAIDS) and ZAPMOS (for ZAC) reporting systems. Because TACAIDS considers behavior prevention to be an important area of intervention, the RFE funds often are awarded to CSOs that work with young adults in promoting fidelity, using small peer groups and mentors to reinforce safe and respectful relationships. Although the approaches vary among the various CSOs who receive RFE grants, many use standard life-skills curricula such as Stepping Stones. Monitoring and documenting the results of these activities have been prioritized by TACAIDS and ZAC.

Through Implementing Partner’s monitoring and evaluation unit, tools have been developed to capture success stories and best practices. These stories and best practices are shared widely among different key stakeholders for the purpose of increasing awareness about the significant role that civil society can play in promoting safe sexual behavior and healthier lives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	0	0
Narrative:			
Building Organizational Capacity for Results (BOCAR) is mobilizing civil society to participate more fully in the response to the HIV/AIDS epidemic. More specifically, this activity is building the capacity of CSOs and CSO networks involved in the response to HIV and AIDS. The Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) are the key partners in this activity, along with other donors contributing grants to small CSOs to conduct HIV/AIDS activities under the Rapid Funding Envelop (RFE) component. BOCAR conducts organizational assessment/surveys to identify the capacity needs for technical assistance to CSOs involved in the HIV/AIDS response. Upon identification of these needs, BOCAR develops an implementation plan focused on capacity building interventions to the CSOs. One of the objectives of the activity is to improve the integration and effectiveness of monitoring and evaluation systems by building the capacity of CSOs to provide data through the TOMSHA (for TACAIDS) and ZAPMOS (for ZAC) reporting systems. Because TACAIDS considers behavior prevention to be an important area of intervention, the RFE funds often are awarded to CSOs that work with mobile populations, especially migrant workers and truck drivers or specialize in working with older youth or sex workers to promote the use of condoms. Monitoring and documenting the results of these activities have been prioritized by TACAIDS and ZAC. Through Implementing Partner's monitoring and evaluation unit, tools have been developed to capture success stories and best practices. These stories and best practices are shared widely among different key stakeholders for the purpose of increasing awareness about the significant role that civil society can play in promoting safe sexual behavior and healthier lives.			

Implementing Mechanism Details

Mechanism ID: 12227	**Mechanism Name: Tanzania Social Marketing Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,260,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	4,260,000

Sub Partner Name(s)

Tanzania Marketing & Communications Company, LTD		

Overview Narrative

PSI's Tanzania Social Marketing Project's (TSMP) intermediate results include aggressively expanding impact of targeted social marketing initiatives that are aligned to measurable behavioral outcomes in HIV/AIDS and strengthened local capacity to sustain social marketing activities to achieve public health outcomes. The project links with the USG/T's PFIP and GHI Strategy by increasing uptake of preventive health services and product use. TSMP products include use of condoms and household water treatment among young males, PLHIV, and other project target groups. The project works nationally to leverage the total market to correct market inequalities and develop sustainable solutions, providing customers with effective choices. TSMP provides technical support to one Tanzanian organization, T-MARC, and key stakeholders from the public, non-profit, and private sectors to improve market segmentation, subsidy strategies, and distribution systems. TSMP maximizes cost efficiencies through cost share and collaboration with activities under the GF Round 4 HIV RCC. M&E activities include baseline/endline target group surveys, retail outlet surveys, and other formative research; and regular MIS of communication and other key programmatic activities.

Six vehicles will be procured in the second year. PSI has investigated both US and foreign made vehicles and has selected foreign made based on the fact that spare parts are easily available and repair services are significantly better for Toyota vehicles than any other vehicle throughout Tanzania. TSMP also compared rental costs with purchase costs and found significant cost savings over the life of the project through procurement.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**

3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Economic Strengthening	1,000,000
Education	1,000,000
Human Resources for Health	220,000
Water	600,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	12227

Mechanism Name: Prime Partner Name:	Tanzania Social Marketing Program Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	500,000	0

Narrative:

TSMP will procure and distribute household water treatment commodities and condoms (condoms procured through co-financing support from the Global Fund) to support 165,000 vulnerable households supported by 19 PEPFAR implementing partners of home-based care services for PLHIV.

The household water treatment component aims to reduce morbidity and mortality related to opportunistic infections, in particular diarrheal diseases, among PLHIV by integrating household water treatment product promotion and distribution with hygiene awareness into existing community-based activities led by USG/T HBC implementing partners. The integration of safe water into palliative care and support increases the acceptability of the product and the targeted communication messages. Product distribution will be accompanied by behavior change communications to promote correct and consistent household water treatment and good hygiene practices among the vulnerable and affected households, as coordinated by individual partner organizations. TSMP has identified a range of appropriate household water treatment products, including WaterGuard, Safe Water Solution (SWS), WaterGuard Tablets; PUR water filtration system; and Lifestraw instant microbiological purifier. All of the products have been approved by the Tanzania Bureau of Standards.

A total of 14.4 million condoms will also be procured, using co-financing through the GF. TSMP will bring USG/T implementing partners together to increase awareness and understanding of opportunities to integrate condoms and household water treatment into their palliative care programs through a "training of trainers" approach. The project will train local NGO partners on the link between unsafe drinking water and health, as well as recommend safe water and hand-washing practices. Partners will then conduct sessions among the 8,000 outreach volunteers at the district and community level to encourage further dissemination of key messages about proper usage and benefits of the products. Partners will be responsible for ensuring that messages and materials are provided to the end users on the use and maintenance of the behaviors and products.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	3,760,000	0

Narrative:

TSMP will continue to support the promotion and distribution of Dume and Lady Pepeta male and female

condoms. Young men, with a focus within higher end socio-economic status, represent the target population. There are approximately nine million young men and TSMP intends on reaching five million of them through mass media efforts ($2.5M). Through the use of IPC events and mass and mid-media outlets, 6,150 truckers and miners will be reached. For women engaged in transactional sex (WETS), hair salon events and Lady Pepeta face-to-face events will allow for 9,810 WETS to be reached with critical product ($650,000). Commercial sex workers will also be targeted through Lady Pepeta face-to-face events, targeting 300 such women ($400,000).

In FY 2012, TSMP will reposition Dume condoms and launch brand extensions, focusing on young men of a higher end socio-economic status (more urban, higher HIV prevalence, higher condom use, higher propensity to purchase condoms). Qualitative research has provided consumer insight on condom preferences and dislikes, which are being used to develop a new look for Dume and a supporting marketing campaign. Coverage for Dume is national (excluding Zanzibar), with a focus on the eight highest HIV prevalence regions and high-risk venues. Promotional activities will include mass media, such as radio, TV, billboards, signboards, and print. Educational and referral activities will take place in small groups and interpersonal approaches during Dume Football tournaments and Road Shows. The budget includes new media campaign development, as well as print media and packaging materials.

Lady Pepeta targets WETS and SWs in more urban high risk zones in all regions, except Zanzibar. A strategic review of Tanzania's national objectives and approach to female condom targeting and distribution will be carried out with all social marketing partners, MoHSW, TACAIDS, and key stakeholders from the NGO and donor sectors. This evidence based consultative redesign has been requested by TACAIDS and will set out global and local evidence to date on the effectiveness of female condom programs, impacting the programming of both T-MARC and PSI/Tanzania who, between them currently, distribute all female condoms in Tanzania. TSMP expects to develop a Lady Pepeta Marketing Plan to include small group IPC activities and public event brand promotion targeted at WETS and SWs that will leverage Dume and other interventions. Coverage for Lady Pepeta is likely to be urban commercial sites, excluding those targeted under the separate Husika project, also implemented by PSI.

Results will be monitored through (a) media monitoring; (b) pre- and post- intervention interviews with IPC target groups; (c) distribution surveys using GPS to measure product availability in commercial outlets and high risk outlets, such as bars and nightclubs; (d) a behavioral survey among males and females (baseline was in 2010/11; follow up in 2012/13). This repositioning is part of the total market approach developed in conjunction with the Salama and CARE male and female condom brand promoted by PSI/Tanzania. Salama will increasingly focus its efforts towards lower socio-economic status and more rural communities. CARE will be repositioned following the stakeholder workshop

described. The project will partner with FHI/ROADS to ensure SW work is scaled-up in FHI areas.

Implementing Mechanism Details

Mechanism ID: 12234	**Mechanism Name: TACAIDS-M&E**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanzania Commission for AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overal goal of this activity is to strengthen the capacity of TACAIDS and partner institutions to monitor and evaluate the national response to HIV/AIDS in Tanzania Mainland. This would include bolstering existing M&E systems that produce data through routine reporting, surveys, evaluations, and surveillance and improve data management, data use, and analytical skills. The implemented activities are aligned with GHI's strategy of improving and strengthening the health systems through improved M&E systems. They also fall in line with PF Goal 6, to improve the management and coordination of data systems, to increase national capacity to implement studies, and to adopt best practices. The geographical coverage includes mainland Tanzania, while target institutions are regions, districts, councils, sub district authorities, and implementers. The national response is evaluated yearly through the national response report, which covers a total of 49 indicators.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12234		
Mechanism Name:	TACAIDS-M&E		
Prime Partner Name:	Tanzania Commission for AIDS		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	100,000	0
Narrative:			
COP 2012 funding will assist TACAIDS to strengthen existing M&E systems that produce data through routine reporting, surveys, evaluations, and surveillance. In routine reporting (monitoring), various organizations, government ministries, departments, agencies, and other stakeholders will be capacitated			

in various areas, such as revising the recording and reporting tools and practicing good data management, data use, and analytical skills. The activities are geared towards strengthening the capacity of the national in response to the HIV epidemic. Data for HIV/AIDS interventions collected at the community levels will be improved. The overal goal of this support is to strengthen the capacity of TACAIDS and partner institutions to monitor and evaluate the national response to HIV/AIDS in Tanzania Mainland. The activities will include the following: (1) Strengthening capacity for data collection, analysis, and reporting for sub national level (regional and district) and community level implementers; (2) Building capacity for data audit, verification, and performance review at national, regional, and district levels; (3) Strengthening supportive supervision and mentoring mechanisms through field visits to community implementers with special focus on documentation and recording for specific HIV/AIDS services to MARPS; (4) Improving documentation of best practices and mechanisms for providing timely feedback to regions, districts, and sub district implementers; and (5) Supporting the integration of the Tanzania's output monitoring system on non-medical HIV interventions with local government management information systems (LGMD). TACAIDS and partner institutions will support Tanzania's efforts to monitor and evaluate the national response for HIV/AIDS. The national response is evaluated annually through the national response report, which covers a total of 49 indicators. Indicators cover prevention, HIV, care, treatment and support, impact mitigation, and an enabling environment.

Implementing Mechanism Details

Mechanism ID: 12238	**Mechanism Name: FBO Networks**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanzania Interfaith Partnerships	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 1,942,355	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,942,355

Sub Partner Name(s)

Christian Council of Tanzania	National Muslim Council of Tanzania	Tanzania Episcopal Conference (TEC)

Overview Narrative

The Tanzania Interfaith Partnership (TIP) is a large FBO umbrella with nationwide reach, composed of FBO members of four major Christian and Muslim FBO networks. In 2010, TIP graduated from being a sub-grantee to becoming a National PEPFAR prime grantee. CCT was selected by the FBO members to provide the secretariat for TIP. Balm In Gilead (international FBO prime grantee) and CDC are continuing to provide technical assistance (TA) to TIP for specific aspects of their program. PEPFAR funding supports TIP for implementation of prevention activities, HIV testing and counseling (HTC) services, as well as care and OVC support.

The TIP program aims to contribute to reducing HIV/AIDS transmission by expanding the capacity of faith-based community organizations to become involved and participate in HIV prevention and care programs. This is accomplished by building the capacity of TIP's four FBO networks to deliver HIV prevention, HTC, and care services. The networks in turn support and provide trainings for individual FBOs at the community level to contribute to a long-term sustainable response. The program is guided by URT's National Multi-sectoral Strategic Framework on HIV/AIDS (NMSF 2008-2012), the National Prevention Strategy (2009-2012), the PEPFAR Partnership Framework (2009-2013), and the new PEPFAR Prevention Guidance. Under the guidance of MOHSW, district and community level interventions are implemented through faith-based networks, religious leaders, trained peer educators, and para-social workers. TIP will continue ongoing monitoring and evaluation in adherence to MOHSW standards.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this

mechanism support Global Fund grant implementation? **Yes**

2. Is this partner also a Global Fund principal or sub-recipient? **Neither**

3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HKID	BAKWATA	50000	Partners will receive additional funds for OVC from USAID to

Cross-Cutting Budget Attribution(s)

Economic Strengthening	75,000
Education	56,000
Food and Nutrition: Commodities	44,000
Food and Nutrition: Policy, Tools, and Service Delivery	34,000
Gender: Reducing Violence and Coercion	22,000
Human Resources for Health	56,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Increasing women's legal rights and protection

Malaria (PMI)

Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID:	12238		
Mechanism Name:	FBO Networks		
Prime Partner Name:	Tanzania Interfaith Partnerships		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	245,725	0

Narrative:

It is estimated that 1.5 million people are affected with HIV/AIDS. TIP and its partners have a long history in provision of palliative care and home-based care services. Using this experience, TIP intends to scale up home-based care services in Kigoma Region. The objective of this intervention is to improve quality of lives of people living with HIV by providing integrated and high quality HBC services through trained community volunteers from churches and mosques. The following are key activities that will be carried out using these funds:

(1) Training of HBC volunteers in care and management of PLHIV: The recommended ratio per community care giver is 1 to 15 clients. TIP is targeting a total reach of 4,000 people for HBC services in Kigoma Region, which is an increase by 1,200 from the previous year's target. This means that there is a need for more caregivers. In the coming fiscal year, TIP will therefore train 120 community providers based on the national curriculum, making the total of trained providers 294. Trainees will be facilitated to gain skills on community mobilization to foster positive living through brief motivation interventions. Trainings on capacity building for HBC providers will be conducted, including psychosocial support, stigma and discrimination to people living with HIV, and establishment and supervision of VICOBA;

(2) Provision of HBC kits: TIP will coordinate the logistics for availability of HBC kits, which are centrally supplied by SCMS, and job aids for providers. TIP will determine the demand for the kits and facilitate distribution to TIP partners;

(3) Linking with clinical services and facilitating referrals systems: The HBC services are linked with the district health services through the home-based care unit. TIP will work with DHMTs to identify

CTCs to establish bi-directional referral systems. Home-based volunteers will be trained on the referral systems, linkages with other service providers, and wrap around services in the area. The purpose is to have 80% of the HBC clients enrolled in facility care;

(4) Linkages with PMTCT: As a strategy for positive prevention and PMTCT, the program will facilitate linkages between HBC services and PMTCT services in Kigoma Region. Through this intervention, it is hoped that the number of children being infected with HIV though their mothers will be reduced. The program will provide direct nutritional support to 175 individuals. TIP will integrate prevention care through PHDP, emphasizing the effects of alcohol use, positive prevention use of treated water, and bed nets; and

(5) Monitoring visits: Conduct supportive supervision visits to monitor the implementation of HBC services, identify opportunities and constraints in services delivery, and monitor data management at all levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	946,630	0

Narrative:

TIP plans to support more than 4,000 OVC, with at least one core service in Kigoma region. With the aim of achieving catalytic, systematic, and sustainable impact among vulnerable households and promoting resilience at the community level, TIP activities will focus on strengthening capacities of local structures, provision of continuum of care, and promotion of HIV prevention activities. In order to ensure conformity of guidelines and quality services at all levels, TIP plans to empower its sub grantees through the existing structures to mainstream plans and OVC programs within district multi-sectoral and MVC committees.

TIP will work closely with the government and other USG technical assistance partners in areas of economic strengthening, nutrition, and quality improvement, as well as the mainstreaming of psychosocial support in OVC programs. Apart from being part and parcel of the communities, faith based institutions and communities are cost effective as they are already in places of need. Therefore, local and national level partnerships and networks will be utilized to encourage communities to participate in providing care and support. Local partnerships, such as family to family care, collaboration with the local government and institutions, will be promoted to address challenges in service provision and reaching vulnerable households.

Integration of OVC and HBC activities will be promoted as a more cost effective approach to reaching

OVC and PLWHIV who live in the same households. Together, with other age categories beginning from less than 6 and 15+, a majority of school aged children (6-14) will be reached in equal numbers of male and female (1,200 each group) as individuals and within their families to ensure they are also reached with other core services in addition to educational support. Services will include health care, spiritual support of which faith based organizations are actively engaged in, and shelter and nutritional support to 2,000 households, including economic strengthening to 1,200 households. This strategy will ensure continuity of care not only to OVCs, but to the entire household.

Systems strengthening will be provided to support village and districts' MVCC committees, advocacy at all levels, and the replication of OVC implementing partners group meetings and forums at district levels. Data updates and the identification of new OVC will be another area that TIP will collaborate with the Department of Social Welfare. In addition, TIP will also offer capacity building of human resources as well as support with resources to ensure that children are identified and data are kept and utilized accordingly, improving quality of services. With the USG technical partner in M&E, TIP plans to coordinate trainings and collaborate with the TIP technical assistance partner, The Balm In Gilead, so as to capacitate the M&E process/systems from the national to the community levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	150,000	0

Narrative:

The Tanzania Interfaith Partnership (TIP) is a large FBO umbrella with nationwide reach, composed of FBO members of four major Christian and Muslim FBO networks. In 2010, TIP graduated from being a sub-grantee to becoming a national PEPFAR prime grantee. CCT was selected by the FBO members to provide the secretariat for TIP. Balm In Gilead (an international FBO prime grantee) and CDC are continuing to provide technical assistance (TA) to TIP for specific aspects of their program. PEPFAR funding supports TIP for implementation of two major prevention activities briefly described below as well as care and OVC support. The prevention components are:

(1) Implementation of 'Time to Talk' (Sasa Tunzungumze), a curriculum-based couples and family-entered communication program targeting youths and adults aged 10-45 years with individual and small group level interventions. The existing youth component is being expanded to increase the focus on couples communications, promote couples HIV testing and counseling (HTC) (this goes hand in-hand with Couples HTC services provided directly by TIP as well as other partners in regions covered by TIP), facilitate disclosure, support discordant couples, and adherence/retention support for PLHIV. TIP trains and implements activities through a large network of peer educators and para-social workers. Protocol development for an outcome evaluation for 'Time to Talk' has begun. Target regions for implementation

of ‘Time to Talk’ are Dodoma, Lindi, Shinyanga, Kigoma, and Zanzibar.

(2) The 'Families Matter Program' (FMP) is a well known structured parent-child communication program that has been adapted and established in Tanzania by T-MARC in 2008-2009. In FY 2012, one TIP FBO member will become involved in the expansion and implementation of the FMP in Dar es Salaam. FMP is currently integrating a new module for child sexual abuse prevention that will later become part of the implemented program in Dar es Salaam, which is also one of the three focus regions for the PEPFAR Gender-Based Violence (GBV) Initiative.

Targets for FY 2012 will reach 20,000 individuals aged 10-45 years with individual or small group level prevention intervention, 7,000 couples through ‘Time to Talk’, and 3,000 parents of teens through FMP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	350,000	0

Narrative:

The Tanzania Interfaith Partnership (TIP) supports demand creation, promotion as well as direct provision of HIV testing and counseling (HTC) services under its program, called 'Our Faith Lights the Way-Together' since 2008. For FY 2012, the project’s goal will be to scale up existing HTC services and reach about 7,260 people in 17 wards of Shinyanga and within an additional new district of Kahama. Under the coordination of MOHSW, TIP will participate to accelerate the couples HTC services within eight high prevalence regions, including Shinyanga region. While TIP supports direct HTC service provision in Shinyanga, TIP is also conducting community mobilization and HTC promotion and referrals activities in numerous others regions, linking patients, and collaborating with other PEPFAR supported HTC partners.

Communities will be mobilized through trained faith based HTC who will promote HTC services. TIP will strengthen outreach services with special emphasis on mobilization of couples, using nationally developed promotional materials. The following activities will be implemented:

(1) Publicity and Message Dissemination: TIP will utilize communication and promotional materials developed for couples HTC by a national level TA provider. If necessary, adaptation to the regional or local context can be made. Local media (FM radio) will be used for community mobilization and dissemination of information about general HTC services available as well as couples HTC;

(2) Counselor Training: In FY 2012, TIP will work with FBO partners to coordinate and conduct trainings for 260 community couple counselors. Training materials developed in countries with

experience of couples HTC, such as Rwanda and Zambia, will be adapted and used for these trainings. Refresher trainings of health care workers will be provided, as needed, particularly for couples HTC services;

(3) Scale up of HTC Services: Through the 'Our Faith Lights the Way-Together' program, TIP FBO members will work with the local faith communities on demand creation and service promotion in 17 wards of Shinyanga region. Faith leaders in the targeted areas will play a key role of mobilizing people to access HTC services, with many of them serving as role models. Trained counselors and providers will conduct HIV road tests and pre/post-test counseling services; and

(4) Referral for Care and Positive Health Dignity and Prevention (PHDP): TIP will work on strengthening post test follow up facilitated by the local faith based institutions, Churches and Mosques Channels of Hope (CMCH). Under this program, faith communities take responsibility for provision of care and support for people living with HIV/AIDS in their own communities. By their very nature as communities of faith, the churches and mosques are called to be healing communities. Faith leaders and selected PLHIV will be trained as peer educators to support PHDP and ART adherence. In addition, TIP is planning to support the establishment of 20 post test groups with at least 30 members each.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	250,000	0

Narrative:

The Tanzania Interfaith Partnership (TIP) is a large FBO umbrella with nationwide reach, composed of FBO members of four major Christian and Muslim FBO networks. In 2010, TIP graduated from being a sub-grantee to becoming a national PEPFAR prime grantee. CCT was selected by the FBO members to provide the secretariat for TIP. Balm In Gilead (an international FBO prime grantee) and CDC are continuing to provide TA to TIP for specific aspects of the program. PEPFAR funding supports TIP for implementation of two major prevention activities briefly described below, as well as care and OVC support. The prevention components are:

(1) Implementation of 'Time to Talk' (Sasa Tunzungumze), a curriculum-based couples and family-entered communication program targeting youths and adults aged 10-45 years with individual and small group level interventions. The existing youth component is being expanded to increase the focus on couples communications, promote couples HIV testing and counseling (HTC) (this goes hand in-hand with Couples HTC services provided directly by TIP as well as other partners in regions covered by TIP), facilitate disclosure, support discordant couples, and adherence/retention support for PLHIV. TIP trains and implements activities through a large network of peer educators and para-social workers. Protocol

development for an outcome evaluation for 'Time to Talk' has begun. Target regions for implementation of 'Time to Talk' are Dodoma, Lindi, Shinyanga, Kigoma, and Zanzibar. (2) The 'Families Matter Program' (FMP) component is described under the 'AB' narrative below. The 'OP' component of TIP's activities, in addition to the above, will support promotion of correct and consistent condom use by selected FBO members. The condom promotion activities specifically target high prevalence regions, as well as Zanzibar, where TIP members have a strong presence and support outreach for key populations, such as sex workers (SW), People Who Use or Inject Drugs (PWUD and PWID), and Men Who have Sex with Men (MSM). Support for community-based interventions regarding HIV transmission associated with alcohol use will be considered for future integration pending further guidance from PEPFAR in regards to effective interventions in his area. the summary of activities and budgted is as follows; CSW: (1)$ 50,000 (2) coverage - 300 (3) activity- outreach activities using peer educators, distribution of IEC materials and referral services, MSM: (1)$ 50,000 (2) coverage - 500 (3) activity- outreach activities using peer educators, distribution of IEC materials and referral services, provision of preventive products, Other: (1) $150,000 (2) coverage – 5000 higher risk group to be reached with condom promotion messages (3) activity- outreach activities using peer educators, sessions after church and mosque services using time to talk manual

Implementing Mechanism Details

Mechanism ID: 12245	**Mechanism Name: UCSF**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of California at San Francisco	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

University of Washington		

Overview Narrative

University California San Francisco's (UCSF) overall strategy is to work with GAP-Tanzania to provide the training, TA, and long-term capacity building to improve HIV prevention and care programs, surveillance systems, and the ability to use results to guide program planning, program improvements, and allocation of resources. To help achieve this, UCSF works with GAP-Tanzania, the USG PEPFAR team, NACP, ZACP, TACAIDS, MOHSW, the National Institute for Medical Research (NIMR), Muhimbili University of Health and Allied Sciences (MUHAS), and other bilateral and multilateral donor agencies to help Tanzanian institutions sustainably reduce HIV transmission, improve HIV/AIDS care and treatment, collect and use data, and manage national programs. The implemented activities are aligned with GHI's strategy of improving and strengthening the health systems through improved M&E systems.

TA is provided to leaders and staff in mainland Tanzania and Zanzibar to improve monitoring and evaluation systems, as well as the usage and management of data for program improvement. UCSF does not directly implement projects, but rather provides TA and support to projects. In-country staff have been hired and capacitated to reduce the need for international travel. In addition, local agencies will require less support over time to conduct M&E activities. UCSF routinely tracks the number of people trained and assesses the quality of the training through evaluations, as well at the outcomes of the TA (e.g. reports and data use).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	12245		
Mechanism Name:	UCSF		
Prime Partner Name:	University of California at San Francisco		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0

Narrative:

UCSF will continue to provide TA in M&E to the national HIV program. UCSF will assist with the finalization and dissemination of the National M&E Plan, as well as the data quality guidelines. In addition, support to finalize the ART Outcomes Evaluation Report will be provided. UCSF will provide data quality, data use, and M&E and cohort trainings, as required and requested by the National AIDS Control Program.

In a technical assistance role, UCSF will increase the capacity to collect and use data for program monitoring and improvement through training and other supportive activities. These activities will increase the national capacity for M&E and eventually allow the national program to sustain their own M&E system will less or no support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

Recent assessments conducted by the Global Fund and PEPFAR have highlighted a major gap in data collection, reporting, and use within the national HIV Program. These gaps in M&E have highlighted a lack of training and capacity in data systems and use as well as general understanding of M&E within the National HIV Program, therefore a need for training and capacity building in these areas is critical.

Following an assessment of M&E training capacity, UCSF will assist CDC/GAP Tanzania in developing a training program addressing the lack of capacity for M&E in the country. UCSF will provide support in

curriculum development, faculty development, and overall management and administration of academic programs. The proposed training program aims to increase national capacity for M&E through pre-service training. Building capacity in M&E will improve the efficiency of all HIV programs by enabling national leaders to prioritize programs based on evidence from their own program. The program will also provide scholarships to a number of students to increase pre-service enrollment and contribute to providing a cadre of new health professionals.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	200,000	0
Narrative:			
UCSF will provide technical support to National AIDS Control Program (NACP) by implementing activities for monitoring programs jointly with district and regional health management teams, and by helping to build leadership capacity at national, regional and local levels. The partner has planned activities for COP 2012 that will help build capacity at the national level to better monitor ART programs. UCSF will assist with the dissemination of the revised care and treatment tools and indicators, and the implementation of the data quality guidelines. This will involve in-service trainings and mentorship. UCSF will also provide in-service training on cohort reporting for patients on ARVs. This activity aims at improving retention of patients on ART. UCSF will provide in-service training with the aim of increasing the capacity to collect and use data for program monitoring and improvement through training and other supportive activities. These activities will increase the national capacity for M&E on care and treatment and eventually allow the national program to sustain their own M&E system will less or no support.			

Implementing Mechanism Details

Mechanism ID: 12246	**Mechanism Name: Columbia**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 18,951,792	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
Central GHP-State	4,326,470
GHP-State	14,625,322

Sub Partner Name(s)

Biharamulo District Council	Bugando Medical Centre	Isingiro District Health Services
Kagera Regional Hospital	Karagwe District Council	KIGOMA MUNICIPAL COUNCIL

Overview Narrative

The goals for the International Center for AIDS and Treatment Program (ICAP) link to the Partnership Framework in Tanzania mainly through building capacity, scaling effective prevention interventions, and laying the foundation for sustainable country programs in Kigoma, Kagera, Pwani, Lindi, and Zanzibar. ICAP plans to operate within all six goals of the PF: service maintenance and scale up of comprehensive HIV care and treatment; prevention through PMTCT, male circumcision, family planning, and STI screening; leadership, management, accountability, and governance through direct support to RHMT/CHMT; sustainable and secure drug and commodity supply; human resources development; and evidence-based and strategic decision-making through regular data analysis, evaluation, and research.

To become more cost efficient, focus will be on improved budgeting, planning, program execution, and fiscal accountability at the district level. The transition plan to a local organization (THPS) will be fully functional during the operational plan timeframe, with technical assistance provided by ICAP. It is anticipated that TPHS will directly manage activities and continue working in partnership with RHMTs and CHMTs to encourage efficiency and quality of services, facilitate establishment of private-public partnerships, improve skills in performance management and accountability for a sufficient and productive workforce, and strengthen human capacity development for strategic information.

Monitoring and evaluation will be done through dedicated M&E and research units. ICAP and THPS will ensure data quality and continuous support for data collection, analysis and evaluation, and overall human capacity development for strategic information at the national level.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	786,408
Food and Nutrition: Policy, Tools, and Service	100,000

Delivery	
Human Resources for Health	1,200,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Mobile Population

Safe Motherhood

TB

Family Planning

Budget Code Information

Mechanism ID:	12246		
Mechanism Name:	Columbia		
Prime Partner Name:	Columbia University Mailman School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,058,168	0
Narrative:			
ICAP will continue working closely with NACP and ZACP and RHMTs/CHMTS to increase enrollment and retention of PLHIV into HIV care program. ICAP will continue strengthening the facility and non facility counseling and testing entry points, and ensuring the linkages to CTC of all individuals testing positive. Furthermore, ICAP will continue to ensure programmatic efficiencies and quality service provision through:			

1. Organization of need-based in-service trainings, clinical system mentorship and supportive supervision as way of capacity building for HCWs;
2. Provision of services such as family planning, STI screening, discordant couples counseling as well as implementation of the entire package of PHDP according to the national guidelines;
3. Infrastructural support including renovations and supply of need based medical equipment;
4. Financial support through sub-grant award, including hiring of additional staff as needed;

Evidence-based data from the previous fiscal year have shown that these interventions improved the retention of clients to care and facilitated the re-introduction of clients to services, which will ICAP will implement to strengthen the retention and adherence of patients enrolled into care:
1. Ongoing adherence counseling by HCWs and peer educators who are themselves PLHIV;
2. Establishment of psychosocial support groups and strengthening of linkages of CTC with community support and home-based care services to maximize adherence and organize successful defaulter tracing activities
3. Strengthened linkages to community-based organizations that provide nutritional, psychosocial and financial support
4. Establish activities to strengthen OIs and management, nutritional support, counseling, and innovative QI activities to improve patient care services and improve retention and minimize loss to follow-up.

ICAP will continue tracking and evaluating clinical outcomes and other performance data through regular monitoring and evaluation of program using data generated from sites on monthly, quarterly and annually basis. Data generated are compiled, analyzed and shared with sites/districts/regions during quarterly data sharing meetings and during the regular site support visits for the purpose of continuous quality improvement.

ICAP will collaborate with Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP, and RHMTS/CHMTS to establish local ownership and hence sustainability of the program. RHMTs/CHMTS will receive capacity building assistance from ICAP to improve HIV program service planning, implementation and furthermore ensure incorporation into the comprehensive council health plans (CCHP).

Through the ongoing palliative care program with Ocean Roads Cancer Institute that has now been rolled out to zonal referral hospitals, the program will ensure drug availability and accessibility through regular supply of oral morphine to lower facilities and pain medication to community level. The implementation strategies will focus on strengthening current palliative care teams at all four Zones and 35 Facilities through mentoring and CME; ensure uninterrupted supply of medication; support training activities at each zone; develop a regional and district mentorship team; and ensure availability of M&E tools and

their use by the supervisory teams.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	354,028	0

Narrative:

In line with the country's national policies and strategic plans for increasing TB/HIV collaborative activities, ICAP will continue strengthening TB/HIV integration at the national, regional, district, and site levels. The strategic direction of the program will be to provide a sustainable program by ensuring the availability of a sufficient number of trained personnel, providing regular on site mentorship and supportive supervision, initiating performance-based awards, and collaborating with CHMT to retain trained staff.

Intensified case finding of TB among PLHIV at CTC, RCH, OPD, and adult/pediatric wards shall be strengthened using the TB screening questionnaire and work-up of TB suspects in accordance with the national diagnostic algorithm. With these funds, ICAP will strengthen CXR reading skill of Health Care Workers through CXR reading mentorship by expert radiologists together with establishment of x-ray digital equipment points at selected health facilities. ICAP will work in strengthening the TB IC measures at all units within supported health facilities. ICAP will support the role out of the national IPT pilot program and continue providing technical assistance in the development and dissemination of childhood TB guideline. TB/HIV data triangulation will be conducted regularly to improve data recording and reporting at CTCs and TB clinics.

ICAP will also continue to scale-up the TB club model through sub granting of a national NGO, which also works to increase community awareness of TB/HIV and educate the public to access early treatment of both diseases.

ICAP, in collaboration with Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP, RHMTs/CHMTs will regularly review and report high-quality data using the national TB/HIV M&E framework and national standard of care indicators to track progress towards the stated objectives and targets. A continuous effort shall be exerted to incorporate TB/HIV activities in the Comprehensive Council Health Plan (CCHP), helping to sustain the program through local ownership. In addition, ICAP will work closely with other partners working on TB/HIV in leveraging additional resources. ICAP's track record in implementation of successful evidence-based program is a basis for planning the proposed activities above.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	246,761	0
Narrative:			

At the national level, ICAP will continue to provide technical assistance to MOHSW in developing and reviewing pediatric HIV guidelines and training curriculum for HCWs, as well as participating in technical working groups and partners meetings. ICAP will spearhead the efforts of the MOHSW in ensuring quality implementation of EID and treatment to reach 75% of all HEI, as per the PEPFAR target.

The implementing mechanism targets the pediatric population infected by HIV in all ICAP operated geographic areas, while aiming to reach at least 10% children among all clients enrolled at all ICAP supported care and treatment clinics. The target will be achieved through formal training, CMEs, clinical mentoring, joint supportive supervision, integration with other HIV/AIDS programs (PMTCT, EID, PITC, TB/HIV and APSS), as well as community linkages. In particular, psychosocial support will be provided through the establishment of psychosocial support groups for children and adolescents to improve well being, retention, and child participation in treatment plans.

To ensure proper functioning of the EID program, ICAP will continue to support the Bugando Medical Centre laboratory for the HIV diagnosis through dry blood sample (DBS) and will expand support to include three zonal referral hospitals. ICAP will also support the availability of uninterrupted supply of reagents and other consumables by creating a strong collaboration with government and non-government organizations involved in the supply chain. ICAP will also be engaged in gap filling purchases and distribution of these supplies and reagents to avoid service interruption.

Furthermore, ICAP will collaborate with Tanzania Food and Nutrition Center (TFNC) to initiate nutritional support at 12 ICAP supported sites to ensure the wellbeing and survival of HIV-infected and exposed infants and children. The facility-based nutritional support activity include routine provision of Nutrition Assessment and Counseling (NAC) and provision of nutritional support for those who are in need through strong collaboration with government and non-government organizations that provide nutritional support. ICAP will also work in the development, adaptation or adoption of nutrition related IEC materials. Annual program review and assessment of 12 additional sites will be conducted at the end of the current COP.

As part of the national quality improvement plan, ICAP will work in building the capacity of district mentors, while performing regular assessments of the national standard of care for pediatric care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HLAB	320,000	0

Systems			

Narrative:

ICAP will continue providing national level laboratory assistance through support to Bugando Medical Center (BMC) in strengthening the early infant diagnosis (EID) service for Lake Zone regions. This will be executed through sub-agreement of BMC to hire key lab personnel, which has proven to strengthen the EID service provided in the region and ensure sustainability.

ICAP will also continue seconding seven staff (PCR Specialist, EID Logistician, Laboratory Epidemiologist, Hematologist, Parasitologist, Microbiologist, Molecular Biologist and Clinical Biochemistry specialist) to the Tanzanian National Health Laboratory Quality Assurance and Training Center (NHLQA-TC) under MoHSW. The partner will continue strengthening Zanzibar laboratory services at Mnazi Mmoja Hospital Pathology Laboratory, to achieve the accreditation scheme of ISO 15189 standards. ICAP will also continue providing support for three regional and two district laboratories to achieve the WHO set standard laboratory accreditation scheme.

Through the Laboratory team, ICAP will actively participate in the national quantification of HIV test kits, reagents and consumables to ensure availability all the time. Furthermore, the partner will continue to procure and distribute these crucial laboratory reagents and consumables to avoid service interruption, when shortages arise.

Additionally, ICAP will continue supporting laboratories in all ICAP supported health facilities in terms of human resource capacity building through training of staff, regular Clinical System Mentorship and need based renovations; strengthening the quality control activity through the different quality assurance schemes; strengthening the sample transportation activity; supporting the lab equipment maintenance; and strengthening the laboratory commodity supply management system. ICAP will continue collaborating with government and NGOs in leveraging resources for strengthening the laboratory system in the country. The partner will also provide material supports through the national system (MSD), including installation of laboratory equipments and gap-filling of HIV test kits and CD4 reagents when stock outs have been confirmed at the MSD.

ICAP will assist laboratories in the operation zone to meet PEPFAR II indicators for measuring the provision of quality laboratory services and provision of critical information for more accurate forecasting, planning and budgeting of laboratory reagents, consumables and equipment.

In collaboration with Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP, and government bodies (RHMT and CHMT), ICAP will continue to conduct regular on site mentorship and supervision to ensure good laboratory practices and laboratory quality control. This collaboration with

strengthen local ownership and hence sustainability of the program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	750,000	0

Narrative:

In FY 2011 and 2012, a total of 10,000 male circumcisions (MC) are planned for Kagera Region. The main geographical coverage areas will be Kagera Mainland and the Lake Victoria Islands, with 55% estimated coverage of MC in Kagera Region. To reach this proposed target, strategies will include outreach campaigns and use of mobile services both in the Mainland and Islands.

The MC program assistant, who is based in Kagera, will be responsible for providing supportive supervision to static sites in the Mainland. Quality assurance activities will follow the WHO guidelines for self assessment and external quality assessment by the PEPFAR and MOHSW team.

Since the main modality in reaching adult men for MC services is through campaigns, a local drama group will be used to disseminate communication information through community mobilization and distribution of IEC materials. In addition to disseminating information, these drama group activities will create demand for people to come out for circumcisions, especially during the campaigns.

MC will be provided as a comprehensive package for HIV prevention which entails risk reduction counseling, STI screening and treatment, HIV counseling and testing, and MC counseling. Sexual partners of MC clients will be encouraged to attend MC services for educational purposes and HIV testing and counseling. Outreach campaigns will aim to sensitize the community about the importance of partners and couples attending MC services together. If a MC client is found to be HIV positive, he is directly linked to an HIV care and treatment clinic through a formal referral process.

In order to have enough human resources to carry out the envisioned campaigns, approximately 48 health care workers will be trained on the MC for HIV prevention package following the national training curriculum using, which uses national materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	405,000	0

Narrative:

ICAP will continue providing support to the Tanzanian MOHSW in developing national guidelines, training, and M&E materials related to HIV counseling and testing. ICAP will also continue strengthening HIV counseling and testing services in Kagera, Kigoma, Zanzibar, and Lindi by:

(1) Strengthening PITC entry points and VCT services in all supported health care facilities;
(2) Conducting focused outreach and mobile VCTs, especially during special events such as World AIDS Day and other national initiative campaigns; and
(3) Supporting provider-initiated and client-initiated HIV testing and counseling as part of the medical male circumcision, prevention with positives, and MARPs services.
The service targets high risk groups, such as discordant couples, MARPs, pregnant women, children admitted in pediatric wards, and those receiving care at RCH clinics and families and siblings of PLHIV in care at CTC.

Capacity building of health care workers through on-the-job training, usage of different approaches of clinical system mentorship, and joint supportive supervision will ensure:
(1) Counseling and testing will be offered to all clients attending health facilities;
(2) The use of national HIV testing algorithm and quality assurance; and
(3) Two-way referral and linkages to other programs, such as adult and pediatric HIV care and treatment services, and tracking or follow-up of HIV-positive individuals, through peer-educators, who were not enrolled in care or treatment after testing positive.

These will be measured by strengthening the M&E system, for example review of referral forms, regular data triangulation between HCT register at all entry points, and pre-ART and ART register at CTC. As part of the evaluation, routine HCT PEPFAR indicators and additional standard of care indicators of the National Quality Improvement Initiative will be regularly collected and analyzed.

ICAP and Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP, will collaborate with the regional and district health management teams (RHMTs/CHMTs) and provide joint supportive supervision and clinical system mentorship using the on-site district mentors and collaborate in systems strengthening by improving timely and accurate forecasting and ordering of HIV testing commodities, hence minimizing gap filling to avoid stock-outs. Continuous efforts to incorporate HIV testing and counseling activities in the Comprehensive Council Health Plans will be emphasized to enhance ownership and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	127,500	0

Narrative:

The allocated budget for commercial sex workers (CSW) is $100,000 with the target of 500 CSWs being reached. Activities for the program will include the purchases and promotion of condoms, STI and TB

screening and management, HIV prevention education messages, referrals to HIV services, and other social services.
ICAP will continue working with ZACP to ensure evidence-based HIV prevention interventions will include behavioral prevention, condom and, stigma reduction, STI management, HIV testing, and linkages to HIV care. Integrated TB screening and referrals for diagnosis and treatment is also provided for the health and welfare of CSW communities. The above interventions have been selected based on the documented successes of the previous years' work of a sexual prevention program in Zanzibar. Furthermore, the activities are integrated into other services and platforms delivered by the national health system.

Quality assurance will be promoted through continuing medical education among HIV care providers, training, standardized IEC and training materials, and supportive supervision. Standardized indicators are assessed and reported on quarterly. Data is reviewed by the program and implementing teams against targets, while gaps are evaluated and addressed. Data reports are shared with ministry officials and local authorities periodically and, when appropriate, disseminated to forums with stakeholders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	900,000	0

Narrative:

The target population of the program will be men and women between ages of 15-45 who use injection drugs (PWID) and people who use non-injection drugs in Mwanza City or Zanzibar (Unguja and Pemba).

There are well-established patterns of injecting and non-injecting drug use in Zanzibar, facilitated by a tourist economy (urbanization, instability among youth, economic instability) and the ease of availability and accessibility through international drug trade routes. While the overall HIV prevalence in Zanzibar is <1%, it is estimated to be 16% among drug users. The patterns of drug use in Mwanza, not yet formally assessed, are known through anecdotal information and observations. Mwanza is the second largest city in Tanzania and is growing quickly.

The program will be implemented in Mwanza City and Zanzibar with an expected coverage of 1,500 PWID (1,000 men; 500 women), 2,000 non-injection drug users (1,500 men; 500 women). Based on available estimates of target population size, this corresponds to 24% of PWID and 33% non-injecting drug users (assumptions: 6000 PWID; 8000 non-injecting drug users).

Evidence-based HIV prevention interventions will include behavioral prevention, bleach kits, medically assisted therapy (MAT), IEC materials, stigma reduction among health care workers, HIV testing, linkage

to HIV care, and linkage to drug recovery programs. Additional interventions, such as needle exchange, may be included as policies are amended. The above interventions are based on study data suggesting the value of safe injection houses, or a similarly stable and safe environment, as a strategy to reduce harm associated with injecting among addicts with high levels of homelessness and mobility. Moreover, evidence-based interventions providing mobile harm reduction service needle exchange, HIV testing, sexually transmitted infections (STIs) screening, and harm reduction information demonstrated to be feasible and effective in reaching an otherwise disenfranchised, high-risk population.

Quality assurance will be promoted through continuing medical education among HIV care providers, standardized IEC and training materials, and training and supportive supervision. Standardized indicators are assessed and reported on a quarterly. Data will be reviewed by the program and implementing teams against targets, while gaps are evaluated and addressed. Data reports will be routinely shared with ministry officials and local authorities and, when appropriate, disseminated to forums with stakeholders. ICAP plays a key role in national committees and government agencies in the mainland of Tanzania and Zanzibar addressing MARPS and drug control. ICAP works in partnership with several community based local NGO implementing partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,004,335	0

Narrative:

At the national and policy levels, ICAP will actively be participating in the national PMTCT technical working group as well as partake in the development and revision of the national guideline and training materials on PMTCT. At the health facility level, ICAP will provide regular clinical system mentorship and supportive supervision by ICAP regional and central technical teams. PMTCT service regions are currently supported in Kigoma, Kagera, and Pwani. Capacity building of RHMTs and CHMTs in will focus on monitoring skills that will enable the teams to follow up on the PMTCT services in their respective regions and facilities. Activities will focus on:
(1) HCT of all ANC attendees and laboring mothers with unknown HIV status using the opt-out approach;(2) HCT of partners of pregnant women coming for ANC and L&D;(3) Determination of CD4 for all identified HIV positive infected women; (4) Stengthened linkages between ANC and labor and delivery wards, with HIV CTCs, TB/HIV service, nutrition centers, and FP clinics; (5) Improved administration of more efficacious regimens;
(6) Initiation of ART for all eligible pregnant women with CD4<350;(7) Initiation of RCH platform to integrate ART services in the RCH clinics of selected high volume facilities;(8) Roll out of the new national PMTCT guideline; (9) Initiation and strengthening of psychosocial support groups in selected high volume health facilities.

ICAP will strengthen its collaboration with organizations that provide community linkages and promotion (i.e. WAMA, SHIDEPHA+, and TADEPA) to increase PMTCT uptake and address issues of stigma, discrimination, male involvement, and couple counseling and testing. The MAISHA ZAIDI campaign on MCH will be extended to focus on HCT, follow up of mother-infant pair, infant feeding options, uptake of CD4, ARVs and retention in care. Community level advocacy for MNCH, community sensitization and mobilization for utilization of services for pregnant mothers will be emphasized. To improve MCH services, ICAP also intends to:

(1) Initiate BEmONC in selected health facilities;(2) Provide ART services in four additional high volume facilities within ICAP supported regions. Space for storage of ARVs will be identified and staff capacity will be built to enable daily ART services. Facilities to ensure timely CD4 enumeration for pregnant women, including transportation of DBS samples from HIV exposed infants, will be put in place;(3) Intensify and scale up cervical cancer screening and prevention using VIA services in Pwani and Kigoma to ensure that HIV positive women are screened per national guidelines. Women who have unknown status will receive HCT as part of the package;(4) Procure refrigerators to be placed in the labor ward of two facilities in each region (a regional and a district hospital) to serve as a mini blood bank, linked with zonal blood centers;
(5) Build capacity of health care providers working at RCH clinics to effectively identify and follow up on HIV positive mothers and children under five in the immunization clinic, mainly through CMEs, clinical mentorship using the pools of district mentors, and supportive supervision.

M&E of the program shall be executed through quarterly program monitoring and annual evaluations. ICAP will continue its effort to use QI initiatives, like the District Mentorship Initiatives, in collaboration with RHMTs and CHMTs to facilitate the incorporation of these activities into CCHPs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	10,725,000	0

Narrative:

ICAP will continue working closely with MOHSW in mainland and Zanzibar, RHMTs and CHMTs in the operating regions to increase early initiation of ART among PLHIV, through community mobilization, HF staff training and mentorship and timely referral from the key entry points (OPD, IPD, PMTCT). By way of supporting the MOHSW in adopting the new WHO adult care and treatment guideline, ICAP will actively participate in the technical working group, reviewing ART management guidelines and training materials. ICAP will also support the subsequent dissimination of the guidelines to HCWs in ICAP supported regions. TA will be provided to the RHMTs and CHMTs to ensure TB/HIV co-infected

patients, children, discordant couples, and pregnant women with CD4 up to 350, are enrolled into ART. ICAP will continue to ensure the provision of family focused care and treatment programs in all supported facilities. ICAP will also continue to ensure programmatic efficiencies and quality service provision through various activities:

1) Coordinate needs based in-service trainings, clinical system mentorship (CSM), on-the-job training, and supportive supervision as a way of capacity building of HCWs. To increase efficiencies, ICAP will strengthen the use of the different approaches of CSM, like CMEs, telephone mentorship, MDT, etc.
2) Continue supporting innovative strategies like family clinics at CTC; early ART initiation at TB clinics
3) Infrastructural support, including renovations and supplying medical furniture
4) Support of materials, including installation of laboratory equipment and gap filling of ART and OIs drugs
5) Regular assessment of standard of care related to ART and providing feedback to the health care providers and RHMT and CHMT members
6) Strengthen the innovative District Mentorship Initiative by recruiting additional district mentors and conducting a joint mentorship program with the ICAP mentors with the aim of building the capacity of the district mentors
7) Financial support awarded to sub grant partners, including hiring of additional staff, as needed

ICAP will support retention of patients initiated on ART by:

1) ART adherence counseling by health care providers and peer educators who are PLHIV. Data from the last fiscal year show that peer educators have traced up to 70% defaulters and have been successful at re-engaging them into ART
2) Conducting and strengthening outreach treatment services

ICAP will continue tracking and evaluating clinical outcomes and other performance data through regular program monitoring and evaluation. Data will be generated from sites on a monthly, quarterly, and annually basis. Generated data will be compiled, analyzed, and shared with sites, districts, and regions during quarterly data sharing meetings and during regular site support visits for the purpose of continuous quality improvement

ICAP will collaborate with Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP, RHMTS, and CHMTS to establish local ownership and, hence, sustainability of the program. ICAP will continue building the capacity of RHMTs and CHMTS to improve ART service planning, implementation, and evaluation. Additional COP 2012 funds will go to support ART in Mtwara, following closure of CHAI in the area. While treatment services will be implemented, the partner will focus on developing local skills for transitioning activities to the government.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	PDTX	1,061,000	0

Narrative:

At the national level, ICAP will continue to provide technical assistance to MOHSW to develop and review pediatric HIV guidelines and training curriculum for HCWs, as well as participating in technical working groups and partners' meetings.

The implementing mechanism will contribute to scaling up pediatric treatment for HIV infected children 0-15 years of age in order to reach at least the 10% target of all those who are initiated on ART within all ICAP supported CTCs. ICAP will work with RHMTs, CHMTs, and health facilities in rolling out the new WHO guidelines to initiate ART for all children less than two years of age. The provision of a quality, comprehensive, family-focused, and sustainable pediatric ART program will be achieved through formal training of service providers and supervisors (RHMTs, CHMTs, and district mentors), provision of regular clinical system mentorship and joint supportive supervision, integration with other HIV/AIDS programs areas (PMTCT, PITC, TB/HIV and APSS, laboratory, and pharmacy), as well as linkages with community-based organizations, community mobilization, and having child participation in all ICAP supported care and treatment clinics.

As part of the innovative models, ICAP will assist in strengthening and establishing 18 child-friendly clinics to create a conducive clinical environment where the entire family with children can be regularly assessed and pediatric clinical equipment, including toys and learning materials, are available for the clients; this model will be linked to the pediatric and adolescent psychosocial support groups to further reduce lost to follow up, improve long-term outcomes, and facilitate transitioning to adult services. ICAP will continue integrating the provision of ART at RCH clinics through the establishment of the RCH platforms at 15 high volume sites with the aim of making HIV care and treatment services accessible for the mother and child in a one-stop shopping concept. This, in turn, will improve pediatric ART service by creating a friendly environment for the clients (the mother and child), therefore leading to better adherence and retention on ART. The RCH platforms will also be linked to nutrition support programs and other community based activities, which again will enhance the pediatric ART service positively, i.e. increasing enrollment, initiation of ART, and retention into care and treatment.

Efforts will also continue to strength the national pediatric care and treatment M&E through collaboration with USG and non-USG partners. The site level data collection, analysis, and use for continuous quality improvement shall be strengthened through on-site mentoring of health care workers, data clerks, and data managers. Data sharing during monthly multi-disciplinary teams and quarterly regional and district data review meetings shall be continued.

ICAP will collaborate with Tanzanian Health Promotion System (THPS), a local NGO founded by ICAP,

RHMTs/CHMTs to establish local ownership and hence sustainability of the program. ICAP will continue building the capacity of RHMTs and CHMTs to improve ART service planning, implementation, and evaluation while supporting the incorporation of activities into the comprehensive council health plans.

Implementing Mechanism Details

Mechanism ID: 12247	**Mechanism Name: Harvard**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Harvard University School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,150,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
Central GHP-State	257,840
GHP-State	892,160

Sub Partner Name(s)

Dar es Salaam City Council		

Overview Narrative

Since November 2004, the Harvard/MDH program has served the Dar es Salaam region by enrolling over 116,000 PLHV into comprehensive HIV care and support, whereby over 76,000 have been initiated on ART. The program has served as a role model in providing quality HIV care and treatment in 50 health facilities as well as PMTCT services to 180 RCH clinics. The program is now transitioning its obligations in program management and clinical services to MDH, a local NGO.

For COP 2012, the MDH goal is to build district capacity to provide quality ART services through increased access to ART while maintaining comprehensive care for patients on ART. To do this, critical gaps in service coverage and strengthened capacity must be prioritized. The following activities are aimed at addressing these critical gaps:

(1) Maintaining quality of care and treatment services within the existing 50 public and private sites;
(2) Supporting districts to identify innovative, cost efficient models of care while identifying priority areas for program support; and
(3) Strengthening health systems to improve efficiency and effectiveness.

Harvard will support MDH in building up the existing M&E system where all HIV indicators will be reported, using data from available MOH tools, to train health care providers on data management and utilization for quality improvement. HSPH will assist MDH with data analysis through the development of process and outcome indicators using the clinical data and national CTC2 database as feedback for site staffs, districts, and MOHSW.

Harvard will provide TA through distance learning and targeted mentorship to MDH and clinic staff, focusing on data management, QI finance and grants, and effectiveness of training.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12247

Mechanism Name:	Harvard		
Prime Partner Name:	Harvard University School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0

Narrative:

Harvard School of Public Health (HSPH) will continue to support the local partner, MDH, to maintain and strengthen provision of integrated high-quality HIV care and support aimed at extending and optimizing quality of life for HIV-infected clients and their families. These services will include TB screening, diagnosis prophylaxis and treatment, STI screening including cervical cancer primary screening, psychosocial counseling, gender based violence services, and food by prescription will be initiated at all sites.

As a TA provider, HSHP wll be implementing similar support activities across a spectrum of technical areas. HSPH will provide TA in the area of data collection and management through weekly calls between MDH and the Boston M&E Team, periodic site visits, and assistance with statistical programming. HSPH M&E, QA and clinical mentors will assist to develop and improve site-based data analysis, quality improvement initiatives, and targeted TA programs for facility-based care and support services.

A training specialist will assist the MDH training unit to perform assessments of site capacity and provide appropriate needs-based training; assist the HR unit to develop a system for tracking staff training records and needs; and lead development of the advanced ART Training Programs for the Mnazi Moja Center of Excellence. HSPH will support international clinical preceptors to travel to Tanzania to provide advanced ART and resistance case management and didactic trainings. HSPH M&E team will also develop training programs on data collection, management and analysis for site-based clinical personnel.

The functions of the Temeke Reference Lab will also receive support

HSPH will address any other TA needs identified by HRSA CIASS and CDC assessments to ensure a smooth transition of program management activities from Harvard to MDH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	300,000	0

Narrative:

The Harvard/MDH PMTCT Program currently supports 90% (180/200) PMTCT sites out of 214 RCH

facilities, of which 14 are supported by PASADA. HIV Early Infant Diagnosis (EID) of HIV is performed at 44% (80/180) of the facilities. Using the district approach, MDH will support scale up of quality PMTCT services by providing technical assistance through district PMTCT teams to conduct on-the-job training and mentorship in comprehensive PMTCT services. This will include couples counseling, counseling on family planning, and infant feeding, targeting 100% (200) RCH site coverage.

As a TA provider, HSHP wll be implementing similar support activities across a spectrum of technical areas. HSPH will provide TA in the area of electronic data collection and management for PMTCT. HSPH M&E, QA and clinical mentors will assist to develop and improve site and district PMTCT data analysis, quality improvement initiatives, and targeted TA programs.

A training specialist will assist the MDH training unit to perform assessments of site capacity and provide appropriate needs-based training to supported PMTCT sites; enhance patient tracking and referral systems to reduce loss to follow up; assist the HR unit to develop a system for tracking staff training records and needs; and lead development of advanced PMTCT training programs for Mnazi Moja Center of Excellence. The program will support the functions of the Temeke Reference Lab. HSPH will support international clinical preceptors to travel to Tanzania to provide advanced ART and resistance case management and didactic trainings. HSPH M&E team will also develop training programs on data collection, management and analysis for site-based clinical personnel.

HSPH PEPFAR admin team will support MDH and other sub-grantee finance and admin units to develop IT and financial management systems for budgeting, accounting, time and effort reporting, and payroll. This team will also address any other issues raised in the annual A-133 and financial audits as well as assist the Grants Management team in the development of systems for sub-recipient selection, contracting and monitoring. Health Systems Strengthening will receive support with assistance in HR, supply chain management, governance and developing leadership skills. HSPH will address any other TA needs identified by HRSA CIASS and CDC assessments to ensure a smooth transition of program management activities from Harvard to MDH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	500,000	0

Narrative:

Harvard School of Public Health (HSPH) will continue to support our local partner MDH to provide quality ART services to reach more people who are in need of ARV drugs, improve ART M&E systems, ensuring availability of ARV drugs and drugs for OI prophylaxis and treatment, establish efficient systems for the procurement and supply chain management of ARVs and other drugs, and ensure strong laboratory

services and infrastructure.

As a TA provider, HSHP wll be implementing similar support activities across a spectrum of technical areas. HSPH will provide TA in the area of data collection and management through weekly calls between MDH and the Boston M&E Team, periodic site visits, and assistance with statistical programming. HSPH M&E, QA and clinical mentors will assist to develop and improve site-based data analysis, quality improvement initiatives, and targeted TA programs.

A training specialist will assist the MDH training unit to perform assessments of site capacity and provide appropriate needs-based training; assist the HR unit to develop a system for tracking staff training records and needs; and lead development of the advanced ART Training Programs for the Mnazi Moja Center of Excellence. HSPH will support international clinical preceptors to travel to Tanzania to provide advanced ART and resistance case management and didactic trainings. HSPH M&E team will also develop training programs on data collection, management and analysis for site-based clinical personnel.

HSPH PEPFAR admin team will support MDH and other sub-grantee finance and admin units to develop IT and financial management systems for budgeting, accounting, time and effort reporting, and payroll. This team will also address any other issues raised in the annual A-133 and financial audits as well as assist the Grants Management team in the development of systems for sub-recipient selection, contracting and monitoring. Health Systems Strengthening will receive support with assistance in HR, supply chain management, governance and developing leadership skills. HSPH will support professional development of the MDH executive leadership and senior management team, including an induction program and training for the Board of Members and Board of Directors. HSPH will address any other TA needs identified by HRSA CIASS and CDC assessments to ensure a smooth transition of program management activities from Harvard to MDH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	150,000	0

Narrative:

Currently, 7% of patients enrolled in ART in Dar es Salaam are children under the age of 15 years. Up to 80 (40%) of RCH sites in the region implement EID and approximately 60% of children are born to mothers living with HIV, which has lead to their being tested for HIV using DNA PCR.

At Infectious Disease Clinics, special pediatric HIV care and treatment services operate daily, however, all other care and treatment supported sites have a special day dedicated for pediatric services. The program has a member in the TWG for pediatrics care and treatment and has taken an active role in the

review of the national guidelines on the management of pediatric HIV/AIDS. In addition, pediatric friendly clinics have been initiated.

As a TA provider, HSHP wll be implementing similar support activities across a spectrum of technical areas. HSPH will provide TA in the area of collection and management of pediatric treatment data, through weekly calls between MDH and the Boston M&E Team, periodic site visits, and assistance with statistical programming. HSPH M&E, QA and clinical mentors will assist to develop and improve site-based data analysis, quality improvement initiatives, and targeted TA programs.

A training specialist will assist the MDH training unit to perform assessments of site capacity and provide appropriate needs-based training; assist the HR unit to develop a system for tracking staff training records and needs; and lead development of Pediatric Treatment Programs for Mnazi Moja Center of Excellence. The program will support the functions of the Temeke Reference Lab. HSPH will support international clinical preceptors to travel to Tanzania to provide advanced ART and resistance case management and didactic trainings. HSPH M&E team will also develop training programs on data collection, management and analysis for site-based clinical personnel.

HSPH PEPFAR admin team will support MDH and other sub-grantee finance and admin units to develop IT and financial management systems for budgeting, accounting, time and effort reporting, and payroll. This team will also address any other issues raised in the annual A-133 and financial audits as well as assist the Grants Management team in the development of systems for sub-recipient selection, contracting and monitoring. Health Systems Strengthening will receive support with assistance in HR, supply chain management, governance and developing leadership skills. HSPH will support professional development of the MDH executive leadership and senior management team, including an induction program and training for the Board of Members and Board of Directors. HSPH will address any other TA needs identified by HRSA CIASS and CDC assessments to ensure a smooth transition of program management activities from Harvard to MDH.

Implementing Mechanism Details

Mechanism ID: 12249	**Mechanism Name: MOHSW**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A

Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 500,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the program is to ensure that the National Health Laboratory Services and Training schools are strengthened through human resource capacity building and infrastructure improvement. The overall objective is to strengthen National Health Laboratory Services in URT, covering all levels of laboratory services in the country and all groups of people, including adults and children, irrespective of gender.

The main strategies are to build human resource capacity and improve infrastructure within the existing government system, enhancing sustainability and provision of cost effective quality laboratory services. In order to implement these strategies successfully, collaborations will be initiated with the private sector and other NGOs under the Public Private Partnership framework. The Program will also continue to convince URT to increase the budget for laboratory services over time. Furthermore, monitoring the project's progress against financial expenditures using performance indicators will be evaluated twice a year with corrective actions taken, if needed.

No extra vehicle will be required, however maintenance costs of the four existing program vehicles will need to be budgeted, including the costs for insurance. Maintenance of the laboratory building and laboratory equipments, including a standby generator as a power back up, will also be required.

This support to MOHSW is in line with USG/T commitments in the Partnership Framework on service maintenance and scale-up (Goal 1), Leadership, Management, Accountability, and Governance (Goal 3) and human resources (Goal 5).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12249		
Mechanism Name:	MOHSW		
Prime Partner Name:	Ministry of Health and Social Welfare, Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	500,000	0

Narrative:

The Diagnostic Services Section (DSS) of the Ministry of Health and Social Welfare (MOHSW), working in collaboration with the National AIDS Control Programs (NACP), oversees national laboratory services and provides leadership as well as technical assistance to institutions of the national laboratory system so they may establish and sustain efficient laboratory services. The DSS develops policy guidelines, sets agendas, coordinates national laboratory activities, and interacts with donors.

The major strengths of the DSS include the participation and support of laboratory regulatory authorities such as the Private Health Laboratory Body (PHLB) and the Health Laboratory Professional Council (HLPC), donor support, and public-private partnerships. Despite these strengths, the DSS currently has limited capacity to effectively manage the National Health Laboratory Strategic Plan. This lack of institutional capacity represents the fundamental problem that COP 2012 funds will address. USG/T provided previous assistance to the MOHSW to complete the National Health Laboratory Strategic Plan

2009-2015. USG/T will continue supporting the institutional capacity building to MOHSW DSS to better plan, manage, and direct the development of a national health laboratory system. The main goal of COP 2012 funds is to support the following areas: - Coordination and policy development - Implementation of Lab Quality Systems through National Health Laboratory Quality Assurance and Training Center (NHLQATC) - Implementation and coordination of laboratory continuing education program through NHLQATC - Facilitation of the implementation of Laboratory Information System - Provision of maintenance and service contracts of lab equipment nationally - Local capacity building to carry out nationwide HIV Drug Resistance surveillance.

Implementing Mechanism Details

Mechanism ID: 12728	**Mechanism Name: Data warehouse**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Research Triangle International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 233,281	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	233,281

Sub Partner Name(s)

Regenstrief Institute	University of Washington	

Overview Narrative

The purpose of this project is to provide TA to strengthen the health management information systems (HMIS) capacity within MOHSW. The project team is providing TA specifically to the Monitoring and Evaluation Strengthening Initiative (MESI), a national initiative, in the eight work packages that have been

planned, including areas in HMIS software development, systems integration and information communication technology (ICT), data use, systems strengthening, project management, and administration.

The MESI has been developed to support the HSSP III (2009-2015) and is aligned with a core principle in GHI related to improving and strengthening the health system. The project team is also supporting the ICT Unit within MOHSW to leverage ICT activities. This project's target population for TA is MOHSW personnel.

In order to reduce costs, local consultants will be requested to provide TA to MOHSW, rather than hiring ex-pat staff. A full-time local technical staff person will be seconded to the MOHSW 90% of the time, which will help to build capacity and reduce staffing costs in hiring international staff. The project is also working with MOHSW to use its own resources for travel (vehicle and per diem) to regional sites to reduce project costs.

To date, M&E plans have focused on activity monitoring related to TA requests, ensuring that activities are completed. Once the local staff person is hired, they will work to expand and track the M&E plan for the MESI.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVSI	CPHI, RI	200000	TA to MOHSW MESI

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12728		
Mechanism Name:	Data warehouse		
Prime Partner Name:	Research Triangle International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	233,281	0

Narrative:

RTI and its sub partners will provide TA to MOHSW Monitoring and Evaluation Strengthening Initiative (MESI), specifically focusing on HMIS strengthening objectives and related planned activities, including providing TA to the MOHSW ICT Unit. The ICT Unit supports the MESI as well as being responsible for all ICT at the MOHSW. The MESI five-year work plan includes use of Global Fund, and other donor funding, in a coordinated project involving several different implementers and partners to achieve MOHSW HMIS strengthening objectives. RTI support will focus on providing TA to activities under the MESI work plan, which includes project management and assistance; HMIS software development, systems integration, and ICT; and data use and systems strengthening.

In FY 2012, TA for project management and assistance will include provision of seconded Project Manager/Systems Analyst (PM), 90% staff time, to MOHSW to work with each of the eight MESI work areas. The main goal will be to revise the current work plan and update the overall five-year work plan in all of the eight work areas. The PM will also be responsible for assisting all work area leads, managing their activities and tracking timelines and budgets, while also assisting MOHSW to improve their skills in project management.

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TA will also be implemented to achieve the enterprise architecture (EA) objective, which includes finalizing the EA and data integration plans. The project will work closely with MOHSW to offer assistance while managing the software vendor who is customizing the DHIS-2 system. Key milestones include hosting the EA workshop with all stakeholders to agree on a timeline for revisions of the EA and finalizing the DHIS-2 requirements and design documentation. TA activities will also focus on developing the draft Data Use and Dissemination Strategy and related plans. Implementation of the strategy will require providing TA to MOHSW to develop the data use and dissemination monitoring framework. Key milestones include drafting the data use and dissemination strategy and developing a draft dissemination monitoring framework. The ICT Unit will require TA in implementing the current ICT activities identified in the ICT Unit Roadmap. Key milestones for implementation will include finalizing the master facility list and owner of this list, completing the draft software and hardware technology roadmap for MOHSW, completing setup of MOHSW internal project portfolio tracking system, setting up an ICT Unit technical advisory group and governance structure, creating a library of ICT Unit standard operating procedures, and creating an ICT communication plan.

Implementing Mechanism Details

Mechanism ID: 12738	**Mechanism Name: Pamoja Tuwalee**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,000,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,000,000

Sub Partner Name(s)

Baraza la Misikiti Tanzania	Deloitte Consulting Limited	PASADA
Wanawake na Maendeleo - WAMA		

Overview Narrative

Family Health International (FHI) implements Pamoja Tuwalee, a five-year cooperative agreement that aims to improve the quality of life and well-being of OVC and their households by empowering households and communities to provide care and support. The project's objectives are to increase the capacity of communities and local governments to meet the needs of OVC and their households; increase the capacity of households to protect, care for and meet the basic needs of OVC; increase OVC household access to comprehensive services; and empower OVC, particularly females, to contribute to their own well-being. The program operates in 25 districts in the Coast Zone, targeting 43,000 OVC and their households. The project also contributes to the first goal of the Partnership Framework, which aims to maintain and scale-up services to reduce morbidity and mortality and improve the lives of Tanzanians affected by HIV/AIDS. It also supports the Global Health Initiative Immediate Result 1, relating to increased access to quality maternal, child, and reproductive health services.

Using sustainable approaches such as promotion of local ownership and strengthening of LGA and communities will ensure cost efficiency over time as these entities gain capacity to implement program interventions with less external support. Key structures to be strengthened include LGAs, most vulnerable children's committees (MVCCs), and 10 civil society organizations that will deliver services at the community-level. FHI will monitor program implementation as addressed in the M&E plan, as well as report progress to the national OVC data management system. In addition, FHI will support LGA to conduct supportive supervision through field visits at the various levels.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	73,262
Food and Nutrition: Policy, Tools, and Service Delivery	14,936
Gender: Reducing Violence and Coercion	7,476
Human Resources for Health	350,280

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)

Budget Code Information

Mechanism ID:	12738		
Mechanism Name:	Pamoja Tuwalee		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	2,000,000	0

Narrative:

Family Health International (FHI) is an international organization that has implemented Pamoja Tuwalee in Dar es Salaam, Zanzibar, and the Coast Zone since 2010. The program aims to improve the quality of life and the well-being of OVC and their households by empowering households and communities to provide comprehensive, sustainable care, and support. The key program strategies primarily support the USG/T priorities of increasing the capacities of households and communities and strengthening linkages between services. FHI's key strategies include improving integration of the program with other health and social service initiatives to increase sustainability and empowering key stakeholders to meet their own needs. These major activities respond to critical gaps in the national OVC response, specifically weaknesses in local capacity and ownership. In particular, FHI will strengthen the capacity of 15 local government authorities (LGAs) to implement the National Costed Plan of Action by facilitating incorporation of MVC activities and budget allocations into the Medium Term Expenditure Framework, a mechanism that guides budgeting and planning at local levels. Furthermore, the program will support

improved collection, management, and use of data captured in the national OVC database. FHI will train and support local civil society organizations to deliver services to vulnerable children. Collaborating with various partners, the project will link beneficiaries to specialized services, particularly economic strengthening, psychosocial support, and nutrition. In a coordinated effort with partners, FHI will develop various referral systems to ensure access to comprehensive services for vulnerable children and their households. For instance, FHI will partner with the UJANA HIV prevention project and link vulnerable youth to appropriate reproductive health and prevention education activities through youth clubs. To address the high levels of physical and sexual abuse recently detailed in the Tanzania Violence Against Children Report, FHI will work with SEMA Tanzania, a program that sponsors a helpline for children, to increase support to children who have experienced abuse. In addition, one district in Dar es Salaam will pilot the 'One Stop Centre' child protection model, currently implemented by Save the Children, UK in Zanzibar.

Implementing Mechanism Details

Mechanism ID: 12757	**Mechanism Name: RTI-BPE**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Research Triangle International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 490,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	490,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this mechanism is to strengthen the abilities of local institutions and scientists in Tanzania to independently conduct research and evaluation studies in HIV/AIDS. The project aims to support

PEPFAR and the Government of Tanzania in improving health evaluation initiatives and obtaining high-quality, timely outputs. This is achieved through strengthening research capacity and infrastructure of local institutions to independently conduct research and evaluation studies. The project responds to objectives in the PFIP, GHI and the Tanzanian HSSPIII in numerous ways. The PFIP ensures that USG support is in line with Tanzanian government priorities, of which a data-driven approach is key to "improving the use of relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision making". One of GHI's main goals to "foster sustainable effective, efficient and country-led public health programs", while the HSSPIII has an objective to develop a comprehensive M&E and Research Strategy and to enhance surveys and operational research efforts in the health and social welfare sectors in Tanzania. This project targets government institutions in the Dar es Salaam and Mwanza regions conducting research and evaluation in Tanzania. Providing higher proportions of technical assistance and support within Tanzania, each project year will increase cost efficicieny. With greater proportions of technical assistance performed in-country and increased capacity within local organizations (e.g. NIMR and NIMR Mwanza), future evaluation activities will be expected to be supported by local institutions with lower level of technical support. M&E plans will follow the requirements and schedule of project progress reports.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12757		
Mechanism Name:	RTI-BPE		
Prime Partner Name:	Research Triangle International		

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	190,000	0

Narrative:

RTI will provide technical assistance to support strengthening the research and evaluation capacity of local institutions. Capacity building will take place through training, mentoring, and on-the-job learning from technical experts in the area of data management, program evaluation, statistics, clinical trial research and qualitative research. Local consultants or agencies may also be contracted to provide qualitative and quantitative data abstraction, collection, cleaning and entry, and data management or other relevant skills as needed for project implementation.

RTI will develop approaches to improving the utilization of research and evaluation evidence in programming and policy by URT. RTI will also support the monitoring, evaluation and utilization of the National HIV Health Research and Evaluation agenda, and support the coordination with other agendas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	300,000	0

Narrative:

RTI provides technical assistance to local organizations to execute evaluations and research in line with URT/USG shared priorities, in particular relating to HRH research and evaluation. For COP 2012, RTI will provide technical assistance for ongoing improvements at the National Institute for Medical Research (NIMR). This technical assistance would eventually strengthen the overall support for operational research to CHMTs. RTI will focus on two activities in particular: Mwanza data management and Internal Review Board (IRB) secretariat support.

RTI experts will provide data management expertise to NIMR Mwanza’s data management unit to :

- improve its capacity to support large scale research and evaluation studies

- develop NIMR Mwanza's ability to be a data center for other institutions - develop NIMR Mwanza's ability to serve as a center of excellence for building capacity of other research organizations in Tanzania. RTI will also support the NIMR IRB secretariat in the implementation and monitoring of the strategic plan, through mentorship activities developed in collaboration with NIMR and CDC. This may include the reorganization of job functions as well as the implementation of administrative procedures to facilitate the submission, registration and certification process, the tracking of ethical review submissions, reviews, approvals, and other functions. RTI will continue to support the NIMR IRB to address gaps identified in the Gap Analysis conducted in Year 1. This may include continued work on reviewing and updating standard operating procedures and ensuring that clear instructions and appropriate instruments are made available to investigators to facilitate the submission and review process.

Implementing Mechanism Details

Mechanism ID: 12758	**Mechanism Name: MUHAS-TAPPS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Muhimbili University College of Health Sciences	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,320,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,320,000

Sub Partner Name(s)

Blue Cross od Tanzania	Texas University	

Overview Narrative

The goal of Tanzania AIDS Prevention Program (TAPP) is to reduce HIV transmission and provide care

and treatment for people who inject drugs (PWID) and other MARPS in Tanzania. This aligns itself with the second goal of the PF, which prioritizes accessible and efficacious prevention programming targeting drivers of the epidemic. The project targets MARPS and their sexual or injecting partners through community outreach by facilitating access to services, including methadone treatment, ARV, STI, and TB treatment. Secondarily, outreach services promote harm reduction by distributing condoms for sexual risk reduction and bleach kits for injection risk reduction.

Coverage of services will be in Dar es Salaam, although an integrated bio-behavioral survey will be conducted in Tanga and Arusha urban centers with the expectations of expanding interventions for MARPs in these locations.

TAPP works within the government structure, mainly Muhimbili University, for administrative activities and through Muhimbili Hospital to access the health care delivery system for medically assisted therapy (MAT), ART, and TB treatment, as well as HTC (with the except of mobile services).

The MAT services at Muhimbili Hospital serve as a pilot for MOHSW to incorporate activities into its annual budget and scale out similar services to accredited health facilities for managing opium addiction. TAPP works with local NGOs sub partners in this capacity.

Monitoring and evaluation involves actual number counts of individuals reached and services provided. An electronic real-time data collection method will enable real-time data capture and processing.

Even though no new vehicles will be purchased, there are still running costs of two mobile caravans that conduct mobile outreach serv

Cross-Cutting Budget Attribution(s)

Human Resources for Health	375,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
TB

Budget Code Information

Mechanism ID:	12758		
Mechanism Name:	MUHAS-TAPPS		
Prime Partner Name:	Muhimbili University College of Health Sciences		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	370,000	0

Narrative:

Muhimbili University of Health and Allied Sciences (MUHAS) TAPP HIV counseling and testing (HTC) targets the general population, couples, and MARPs through mobile and static facility-based services. HTC services are also offered in 101 health care facilities with providers trained in provider-initiated testing and counseling (PITC). In Dar es Salaam, HIV seroprevalence is estimated at 9%. HTC results in PITC portray prevalence of 11% while that in the facility and mobile services is 8.9%. PITC is offered in health care settings while client initiated services are offered at the static Muhimbili Health Information Center and the mobile caravan services. PITC is also offered for those persons accessing medically assisted therapy (MAT) services.

The HIV testing algorithm is a vertical algorithm starting with SD Bioline as a first test. For those who test positive a second test, Determine, is used and if the tests are discordant, Unigold, is used as a tie-breaker. This is the national testing algorithm approved by the MOHSW. During FY 2012, gains in integrating alcohol screening and brief motivational intervention will be solidified and MUHAS TAPP will ensure that all of its staff and the PITC trainees receive training and supportive supervision to address the issue of alcohol use among their clients.

Currently, escorted referrals to other services are only offered to MARPs populations, therefore tracking of service outcome is clearly linked to the program. General population clients are assumed to have concluded their referrals. Following training in quality HTC services, the newer quality assurance model of HTC services, which is supported by CDC Headquarters, is introduced. Quality control is achieved through testing of proficiency panels from the National Public Health Laboratory. Utilization data is stored in an electronic format and entry is done within real time or as close as possible.

The TAPP PITC trainees reached 16,459 (secondary HTC data) patients who were additionally referred to CTC services (1,637). A nationwide shortage of HIV test kits limited PITC activity in the current year. With reference to couples, MUHAS TAPP now has 20% of its clinic population come as couples for client-initiated services both at facility and mobile services. Training and service provision targeting couples will continue to be offered to previously trained PITC trainees. Promotional activities around HTC for demand creation and target markets will be offered to the general population, MARPs, and couples.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	0

Narrative:

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CSWs and MSMs are the target population; MSM's approximate cost is $100,000 reaching a target of 1,500 with networking and community outreach work; CSW's approximate cost is zero, reaching a target of 3,000 with community outreach work.

In FY 2011, two organizations serving Men who have Sex with Men (MSM) will consolidate and strengthen their activities of national MSM networking and MSM outreach in Dar es Salaam. The initial target audience is MSM aged 15 years and above. Population estimates and HIV prevalence among MSM are yet to be established, though various stakeholders have activities underway to establish this information.

In the current year, partners are defining the package of services for MSM based on existing guidelines and best practices in similar low-resource settings in line with identified needs of MSM in Tanzania, as identified from ongoing surveillance activities.   Services will include, but are not limited to, HIV testing and counseling (HTC) diagnosis and treatment for sexually transmitted infections (STI), condom and lubricant promotion and distribution, and health promotion communication and referrals for relevant additional health services, including ART.   To facilitate sustained quality care for MSM and other MARPs, health care providers in selected facilities will receive sensitization training to MARPs-friendly service provision.

The national network NGO will host an annual bonanza (networking en masse) and three quarterly meetings that will consolidate the gains of the previous year.   The second NGO/CBO staff will receive training and supportive supervision for community outreach aimed at prevention of HIV transmission, including procuring and promoting condoms and lubricants for safer sex and facilitating referrals to health facilities for management of STI, which at the same time will sensitize health care providers to become less judgmental when offering services to MSM.   HTC will be offered through mobile caravan services as well as existing health and non health facilities.

The community outreach strategy will be used as the intervention.   Master training for NGO leads (CEO, Program Coordinator, Community Outreach Coordinator, and Community Outreach Trainer) will form a basis for offering cascade training.   Master trainers will then offer training to the outreach workers who will become the implementers of the program.   Screening and brief motivational intervention for alcohol use will be integrated to MSM services.

The training packages to be provided will include a cue card for offering such services and TAPP supervisors will offer supportive supervision to ensure fidelity to the program.   Service data will be entered in real time benefiting from M&E mechanisms established from the program targeting PWID.

The project primarily targets people who inject drugs (PWID) and MSM with outreach activities and services, but also attracts a significant number of sex workers who also benefit from these services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	850,000	0

Narrative:

People who inject drugs (PWID) in Dar es Salaam have been found to have HIV prevalence of 42%, whereas the general population prevalence is 8%. PWID also exhibit higher sexual behavior risks, including multiple sexual partners, low condom use, and selling sex, particularly female PWID. The project contributes to providing a comprehensive package of HIV prevention and care and treatment services to PWID by offering medically assisted treatment (MAT) for addiction, HIV testing and counseling (HTC), diagnosis and treatment for sexually transmitted infections (STI), condom promotion and distribution, health promotion communication, viral hepatitis counseling and testing, bleach needle cleaning kits, screening for TB, and referral for relevant treatment, including ART.

Among clients currently receiving MAT from the project, the prevalence of Hepatitis C is 70% while that of HIV is 50%, concurring with recent studies, including one dissertation that shows similar trends among PWID. In addition to the injection risk, use of drugs has been financed through formal and informal sex work. For this reason, assessing and treating STIs is a critical component that is necessary to reducing STIs and HIV risk.

The project aims to provide MAT to 400 clients this year, for which medication and supplies procurement is included under this program area budget code. Supplies for syringe cleaning kits, condoms, and communication materials are also included in this category. During the fiscal year, 150 community outreach workers will be trained, while complimentary activities of developing targeted messages and facilitating community mobilization will be conducted. Clean needle syringe access is critical to turning the tide of the HIV and hepatitis epidemics; as such support for partner-led activities to initiate needle-syringe programs (NSP) will be initiated.

While referrals for other clinical care (e.g. HIV, TB) are to be made to existing partner health care facilities, challenges are expected, particularly during the initial months of stabilization on MAT. To alleviate this, integrated services at the MAT clinic for HIV care and treatment, as well as TB treatment, will be offered. Upon stabilization, clients can be linked to other care and treatment facilities where referrals can be tracked to maintain linkages with IDU services.

The project targets male and female PWID in all three municipalities of Dar es Salaam, expanding from Kinondoni Municipality where current activities have begun. With the availability of additional funding, expansion of services may include the cities of Tanga and Arusha, which will be guided by ongoing surveillance in these locations.

Supervisory mechanisms are in place with regular monitoring and evaluation of daily activities through sub partner organizations' mechanisms, which will be backed up by scheduled and ad hoc supervisory interactions with TAPP supervisors. A database is in place to manage MAT clients data and quality of services will be ensured through current close supportive supervision at this initial treatment site, which is the first in the country.

TAPP works in close partnership with MOHSW and the Drug Control Commission, which are mandated to oversee all prevention, care and treatment services related to drug use. Existing stakeholder platforms facilitate joint planning for complementary service provision to the population in need.

Implementing Mechanism Details

Mechanism ID: 12810	**Mechanism Name: Pamoja Tuwalee**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A

Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 6,490,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	6,490,000

Sub Partner Name(s)

BAKWATA National HIV/AIDS Program	Network of Children, Youth and Women Infected/affected by AIDS (CHIYOWONET)	

Overview Narrative

PACT Tanzania implements Pamoja Tuwalee, a 5 year cooperative agreement that aims to provide coordinated and sustainable care for most vulnerable children and households infected/affected with HIV in the Lake and Southern Zones of Tanzania targeting 55700 OVC with one core service, 27850 with food and/or nutrition service and 6960 households with economic opportunity/strengthening support in FY12. The objectives of the project are to increase local ownership and capacity to support OVC to access community-based care and support; strengthen the capacity of local government authorities and civil society to provide quality services to OVC and their households; and replicate effective multi-sectoral coordination structures that include the private sector at district and village levels. The program also contributes to the goal of the Partnership Framework, which aims to maintain and scale up services to reduce morbidity and mortality and improve the lives of Tanzanians affected by HIV/AIDS. The objectives also contribute to GHI Strategy IR1,2 and 3 that relates to increased access to quality maternal, child, and reproductive health services.

PACT's program approach contributes to the sustainability of service delivery to vulnerable households by strengthening LGA and civil society capacity.   In addition, sustainability is built through PACT's use of the WORTH economic strengthening model as a platform to strengthen capacity of households and mobilize communities around critical issues.

PACT will continue to collect program data as identified in the M&E plan, which includes mandatory PEPFAR indicators. In FY12, PACT will also contribute to the evidence base by documenting experiences with pilots in child protection and child health integration models in the Lake Zone.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	230,256

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Family Planning

Budget Code Information

Mechanism ID:	**12810**		
Mechanism Name:	**Pamoja Tuwalee**		
Prime Partner Name:	**Pact, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	6,490,000	0
Narrative:			
PACT Tanzania is an international organization that has implemented OVC programs in Tanzania with			

support from PEPFAR and Global Fund for more than five years. PACT Tanzania has implemented the Pamoja Tuwalee program in Southern and Lake Zones since FY 2010 and aims to strengthen OVC households and community safety nets. The program primarily supports the first goal of the Partnership Framework, which is related to service maintenance and scale up to improve the quality of life of people affected by HIV, particularly most vulnerable children (MVC). The project targets roughly 2,000 MVC households per district.

In FY 2012 and FY 2013, PACT will continue to support delivery of health and social services to vulnerable households through grants and technical assistance to local organizations. Areas of priority include use of PACT's WORTH model to strengthen household economies and mobilize community members around critical issues such as gender-based violence, child protection, and HIV prevention. PACT also plans to engage the private sector in supporting program activities, particularly in increasing and expanding WORTH groups and providing health and social service provision to vulnerable households.

In FY 2012, PACT will also support continued roll-out and strengthening of para-social workers in targeted districts and most vulnerable children's committees (MVCC) at the community-level to coordinate care and support services for MVC and their households. In response to findings from a recent UNICEF supported Violence Against Children Report, the USG and URT have allocated additional resources to PACT in FY 2012 to pilot and assess a 'one-stop center' model for child protection in Mwanza. The proposed model will build on their existing child protection activities and will contribute to building the evidence-base in effective child protection strategies. In addition, PACT will also be an implementing partner of the Lake Zone Integration Initiative, which aims to pilot a continuum of care approach for child health and development through establishment of strategic linkages between PACT (OVC), URC (child health) and Baylor International Pediatric AIDS Initiative. Pact will also implement and assess gender-based violence activities with additional allocations from the global GBV initiative. Planned activities include developing safe havens for children who have experienced physical or sexual abuse and community sensitization efforts regarding the effects of abuse against women and children. In addition, PACT will train individuals that work at the district-level, including stakeholders, such as social welfare officers, police, teachers, and prison staff, to address child abuse and gender-based violence.

In FY 2013, PACT will also expand activities into the Southern Highlands Zone and serve OVC beneficiaries previously supported by the Walter Reed Program/Department of Defense (WRP/DoD). This transition will involve an increase of $2.74 million in PACT's budget from the WRP/DoD activity. Transition and start-up activities in Southern Highlands will commence early in FY 2012 to ensure continuity of services for the OVC beneficiaries. PACT will work closely with the WRP/DoD to assess the capacity of the current sub partners in order to identify sub grantees which will continue to implement the program.

Implementing Mechanism Details

Mechanism ID: 12818	Mechanism Name: CRS Follow on
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 13,882,967	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
Central GHP-State	930,685
GHP-State	12,952,282

Sub Partner Name(s)

Archdiocese of Mwanza	Babati District Council	Bugando Medical Centre
Bukumbi Hospital	Bunda Designated District Hospital	Bunda District Council
Christian Social Services Commission	Coptic Hospital	

Overview Narrative

Local Partners Excel in Comprehensive HIV&AIDS Service Deliver (LEAD) builds upon AIDSRelief program to ensure PLHAs in Manyara, Mara, Mwanza, and Tanga regions have access to ART and quality care. Through LEAD: PLHIV and their families have expanded access to care, treatment, and support services; local partners provide quality care and support; and government partners provide quality services beyond project period.

LEAD will continue to work with RHMTs and CHMTs to strengthen the capacity of health facilities. LEAD will provide technical support to local partner CSSC to transition to additional districts. Multi-disciplinary teams will provide on-site mentorship on clinical and programmatic aspects through didactic sessions and mentoring of health facility staff. The program will expand use of the district mentors' approach,

supporting providers to use a similar mentoring practice for lower health facilities. These approaches will ensure efficiency and initiation of new knowledge.

Districts will integrate financial resources into CCHPs in order to leverage additional resources from URT and other donors. LEAD will continue to advocate to URT to absorb eligible HCWs into government payrolls, hence increasing ownership and sustainability of care and treatment services.

The program will build on existing, innovative M&E systems that are in line with the national M&E system. Additionally, LEAD will focus on supporting health facilities to improve their capacity in data demand and information use.

The project intends to purchase five vehicles to replace part of its current fleet, some of which are old and in poor condition. It is also very challenging to cover visits to PMTCT sites, which grew 15 times in FY 11, with the current number of vehicles.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	157,195
Human Resources for Health	1,277,570

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood

TB

Budget Code Information

Mechanism ID:	12818		
Mechanism Name:	CRS Follow on		
Prime Partner Name:	Catholic Relief Services		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	666,299	0

Narrative:

The LEAD project will utilize the "Three Ones" principle of adhering to "one national coordinating AIDS authority, one national AIDS strategy, and one monitoring and evaluation framework" to achieve the most effective and efficient use of resources, ensuring rapid action and results-based management. All strategies and activities to be implemented are within the Tanzania national health sector and multi-sectoral strategic plans and the national guidelines.

LEAD will support HIV care and support in four program areas, which include comprehensive adult care and treatment, TB/HIV, PMTCT of HIV, and pediatric care and treatment. Through family-centered activities, LEAD will serve PLHIV and their families from birth to end of life care. LEAD will also work on increasing access to the full continuum of care for PLHIV and their families and envisions a URT healthcare system linking care across community services, healthcare workers, local facilities, and government. Through improved case management of community and facility resources at different locations and a focus of supporting the entire family at one place, LEAD will purposefully engage women as access points to the family.

Activities at the treatment facilities, which focus on family centered approaches and community levels, will target couple and male involvement as well as ensure that the girl child receives needed care, treatment, and support. This will be achieved through on-site mentoring of providers in 36 hospitals and surrounding health centers. The on-site mentorship will be covered by all the components, including clinical adult and pediatric ART, TB/HIV, PMTCT, community-based treatment support, continuous quality improvements, nursing care, and laboratory services. LEAD will also utilize the identified and trained mentors to continue to provide supportive supervision in their respective districts.

The targeted mentoring will be guided through with data and chart reviews while all the facilities providers

will receive mentoring focusing on adult and pediatric treatment, specifically on prevention, diagnosis, and treatment of opportunistic infections and other HIV related complications. Clinical and Laboratory management of patients on treatment will also be an important theme during the on-site mentorship. To enhance retention, LEAD will focus on utilizing the available volunteers to follow up and track patients who have missed appointments and find them before they are completely lost.

As part of working with existing structures in the regions and district, LEAD will work closely with district and other stakeholders to identify and collaborate with partners already providing support to PLHIV support groups. This will strengthen the linkages between programs and increase access to full continuum of care for PLHIV.

The project will provide in-service on-site training and technical assistance to strengthen the capacity of the district. M&E tools developed by MOHSW will be utilized to collect strategic information as to ensure quality and timely information is reported out to support clinical care, programmatic outcomes, and informed decision making.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	256,878	0

Narrative:

To be in alignment with country policy, partner activities will maximize entry points for HIV diagnosis and treatment and screening for TB. To accomplish this, LEAD plans to strengthen the TB 3I's strategy in health facilities that will link to ART and TB services through its network of partners that provide quality HIV care and treatment. On-site didactics mentoring on TB diagnosis will be the focus activity, while mentoring will be done in 36 facilities and surrounding health centers. Proper TB diagnosis mentoring will range from clinical assessment to improved laboratory TB diagnosis.

LEAD will continue supporting and strengthening the ability of care and treatment clinics in Manyara, Tanga, Mara, and Mwanza regions to make ensure all HIV infected clients, including those from PMTCT and newly diagnosed clients from other sections, are screened for symptoms of active TB. Moreover, the TB suspects will be evaluated for TB diagnosis using the national TB diagnosis algorithm while non-TB suspects will be initiated on Isoniazid Preventive Therapy (IPT). Patients with TB/HIV co-infection with TB will be referred to TB clinics for treatment. The TB/HIV co-infected patients who are referred from TB clinics will be received at a care and treatment clinic (CTC) and provided with quality HIV services.

Intensified TB care finding (ICF), IPT and infection control (IC) will be scaled up, along with the increase

of ART services to primary health facilities.
LEAD supported regions will collaborate with other partners implementing collaborative TB/HIV activities, such as PATH in Mwanza, SHIRIKI project in Mara, and NTLP in Tanga, Mara, and Manyara, to ensure the efficient referral, linkages, and follow up of patients are provided and access to full continuum of care is increased.

LEAD has a direct intention of keeping the TB/HIV activities sustainable, ensuring there is integration of activities into the existing health system, involving regional and district health management teams in the activities, incorporating the activities in the district health plans, and building capacity of local authorities, coordinators, and health care providers on TB/HIV collaborative activities.

LEAD will collaborate with the NACP and NTLP to strengthen the existing national M&E systems for collaborative TB/HIV services in the four regions of Tanga, Manyara, Mwanza, and Mara. Also, LEAD intends to ensure the TB screening tool will be implemented at all 90 sites, including having the IPT eligibility assessment forms at all four selected sites to initiate on phased IPT implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	162,509	0

Narrative:

Improving pediatric enrollment is a key component for improvement of pediatric HIV care services. LEAD intends to scale up the pediatric enrollment using three approaches to target pediatric patients. The first is to offer counseling and testing to all children accessing all services at health facilities. LEAD will provide direct mentorship to facilities reaching pediatric patients and collaborate with partners providing PITC services to increase PITC services for pediatric patients.

The second approach is to identify and test exposed infants as part of PMTCT and EID initiatives. The program will provide one PMTCT training to cover facilities who have untrained staff, which will be followed up by on-site mentoring. This will take place simultaneously with the efforts to ensure the required commodities for the testing are also available. LEAD will also support the transportation of the DBS samples to and from the lab back to the facilities.

The third and last group is the group of children from other services outside the facilities, which will include OVC, or from support groups in the community. Reaching out to this group of children will be achieved by collaborating with stakeholders in the districts who are implementing services targeting OVC and other vulnerable children groups. The collaboration will be through meetings and sharing activity plans. The collaborations with stakeholders will not only increase enrollment in the facility but will also

provide access to the services, such as support groups and PwP for the pediatric population within the facilities.

LEAD considers integration with routine pediatric care and maternal health service to be of the highest importance, therefore LEAD will facilitate and follow up the monthly facility coordinating meeting where all the departments meets with the CTC staff to present challenges and solutions to integration issues.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	120,000	0

Narrative:

In continuing to provide quality care, improvement of laboratory services to support ART services is essential. LEAD will continue to provide on-site technical support to 56 laboratories and mentorship on Quality Assurance for HIV rapid testing, diagnosis of opportunistic infection (OI), HIV disease staging, drug safety monitoring tests, and commodity inventory management at facility level. Additionally, the LEAD laboratory team will provide on-site training on diagnostic techniques for cryptococcal, hepatitis, tuberculosis, as well as malaria testing and perform hands on training on the operations and maintenance of key equipment.

In order to ensure the quality of laboratory service and monitoring implementation of quality management system, LEAD will conduct trainings for 40 staff on laboratory quality management system. The training will be followed up with post training on-site visits to evaluate the impact of the training and to ensure a continuation of step-down training. LEAD's regional laboratory specialists will continue to provide mentorship to district laboratory managers for efficient laboratory management of quality systems. In collaboration with MOHSW, the regional and district laboratory technologists will assist on participation in all available national EQA programs for HIV testing, CD4, hematology, chemistry, AFB microscopy, and malaria.

LEAD will support the on-going process of laboratory accreditation in four regions. Bugando Medical Centre Laboratory will continue to receive technical support towards accreditation using ISO 15189 standards. The laboratory quality specialist will continue to provide support on quality improvement and maintenance by working with BMC laboratory staff to accomplish planned activities and perform collective actions on gaps identified through assessments. LEAD will support post annual assessment learning sessions to 40 staff to improve quality management systems focusing on 12 quality elements and proper utilization of laboratory services. Production of documents and standard working tools will be supported to meet ISO 15189 standards. LEAD will also support annual performance assessment fees

to be conducted by an accreditation board and their assessors.

Other laboratory accreditation activities will support five laboratories in their accreditation processes, based on a WHO-AFRO established stepwise approach, which uses a 0-5 star scale. This is regarded as an affordable, sustainable, effective, and scalable model. Through mentorship and supportive supervision, the team will help lab staff to develop culture quality and improve documentation related to quality management system. LEAD will support national assessors to perform annual interim assessments using the WHO-AFRO checklist to measure progress on the stepwise star system. Production of documents and standard working tools will be supported to meet the required standards. The target for stepwise star system is for all five laboratories to attain the minimum of two stars.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,164,334	0

Narrative:

The LEAD program will support health facilities to provide comprehensive PMTCT services, HIV counseling and testing for pregnant women, ARV prophylaxis for HIV positive pregnant women, and EID and treatment of eligible infants. Expectations are to ensure 80% of women attending antenatal clinics are counseled and tested for HIV, while linking those identified as HIV positive into care where a more efficacious regimen will be administered according to the new PMTCT guidelines.
Furthermore, the program will support facilities to ensure all HIV exposed infants are identified and tested, linking infants who are HIV positive into care and treatment services. To achieve this, the program will continue to provide TA, on-site mentorship, and supportive supervision to partner facilities through close collaborations with RHMTs and CHMTs. Health care providers from lower health facilities will participate in on-site trainings within 16 district facilities, thus helping to facilitate immediate initiation of the adopted PMTCT recommendations.
Utilizing the district approach, the project will support, facilitate, and mentor districts on commodities management to ensure adequate availability of HIV test kits, ARVs, CTX, PMTCT M&E tools, and other commodities. Based on a best practice implemented during the AIDSRelief program to increase the quality of PMTCT practices, health care providers from poorly performing facilities will have the opportunity to visit stronger performing facilities to learn and identify ways of improving services in their respective facilities.
Medical supplies will also be procured so that quality clinical evaluations of pregnant women are conducted within the RCH clinics and labor wards. In addition, renovation of 10 RCH clinics and labor wards will further improve conditions in which PMTCT services are delivered.
LEAD will continue to work closely with district reproductive and child health coordinators (DRCHCOs) to collect and analyze data in order to make informed strategic programmatic decisions that will strengthen

existing district M&E structures. The SI associates will also provide mentoring to complete MOHSW's PMTCT M&E tools. To increase efficiency in reporting, LEAD will expand IQSMS services, an innovative technology developed during the implementation of AIDSRelief, to an additional 150 PMTCT sites. This approach will also ensure improved timeliness of PMTCT data reporting.
Linkages between CTC, RCH, TB/HIV, and VCT will be strengthened by facilitating monthly coordination meetings, allowing the various hospital departments to share challenges and identify solutions.
Community linkages and male involvement is of paramount importance to increasing PMTCT uptake, reducing stigma, and retaining HIV infected women into care and treatment. By meeting with these stakeholders at the district level, the project will ensure proper utilization of the existing community structures to increase access to continuum of care.
The project is expected to reach 700 PMTCT sites, requiring intensive supportive supervision to respective facilities. The project will utilize previously trained district mentors and identify additional district mentors who will provide technical assistance, supportive supervision, and other PMTCT related technical knowledge. To provide overall supervision, joint supportive supervision visits will be conducted with district mentors and DRCHCOs to ensure the process is sustainable.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	8,373,844	0

Narrative:

In ensuring the provision of quality HIV services, LEAD project will continue to provide technical assistance to partner facilities. The technical assistance will consist of on-site mentorship to 36 hospitals and their surrounding health centers. The providers from the health centers will be invited to participate in didactic lectures and mentorship at the district facilities receiving the LEAD mentors.

To further build the capacity of the regional health teams, LEAD will build upon the district mentors approach to ensuring long lasting and sustainable quality HIV service provision at district levels.
Conducting joint technical assistance visits and supportive supervision with the district mentors will be a fundamental activity to guarantee the transition of technical knowledge. LEAD will also strengthen monitoring and evaluation capacity of the districts by promoting routine data quality audit (DQA) and data utilization at facility level in collaboration with CQI teams, RHMTs, and CHMTs.

Utilizing already created hospital quality improvement (QI) teams, technical assistance from the QI team will focus on mentoring teams on conducting chart reviews and interpreting and analyzing data collected from chart reviews and produced reports. The QI teams will be supported to become a driving force towards ensuring data is used for planning and improving programmatic and treatment outcomes. The teams will continue to receive technical assistance and mentorship from the project.

Strengthening the adherence support in the facilities will be a vital role of LEAD to improve retention of patients starting ART. LEAD will support this process through on-site mentorship of adherence providers in 36 hospitals. Providers will receive guidance on establishing an active appointment system and immediately will follow up of patients with missed appointments. Two zonal clinical and treatment adherence trainings, reaching 72 providers, will be conducted and performance of trainees will be followed up during the on-site mentorship.
LEAD is expected to reach 90 facilities where 73,010 individuals are expected to receive care and treatment services including the provision of ART, cotrimoxazole prophylaxis and TB screening. LEAD will also continue working with other stakeholders in the districts to access available resources in areas where LEAD is currently not supporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,139,103	0

Narrative:

The focus of this budget will be utilized in the implementation of activities to increase the enrollment of children in care and on ART by increasing access to high quality HIV care and treatment. In scaling up pediatric treatment for HIV infected children, LEAD will focus on building capacity of the health care providers and the regions. A centralized training will be conducted for 30 health care providers. Additionally, the program will provide on-site training and mentoring to health care providers to promote improved clinical skills in clinical and laboratory monitoring of children on treatment and adherence support. On-site mentoring sessions will also provide the opportunity for the program to support sites in the implementation of the new WHO guidelines on pediatric ART guidelines. LEAD will also link with the Baylor Pediatric program by financially supporting clinical providers to attend a Baylor pediatric attachment program, which has been observed to provide clinical providers with skills that have resulted in significant improvement to children retention.

Identification and testing of exposed infants will be a key outcome activity in increasing enrollment of children in the facilities. During on-site mentoring sessions, LEAD staff will specifically target RCH staff to identify and test exposed infants and to link HIV+ children into care. Supporting the district in ensuring the availability of dried blood spot (DBS) collection kits will be an important step towards improving identification and diagnosis for infants and children. LEAD will support the transportation costs of the collected DBS samples and also facilitate the communication of results from the testing facility.

Providers in the RCH sections, outpatient sections, and pediatric wards will receive technical on-site

trainings and mentoring in the provision of counseling and testing of children and in improving intra facility referral systems. To increase infants and children enrollment, LEAD will expand on the EPI/HIV integration pilot project implemented in two sites during the AIDSRelief program into six facilities. Close collaboration with other implementing partners is key to improving pediatric enrollment into care. LEAD will work with partners currently implementing PITC activities in order to utilize the support and fulfill the provision of comprehensive care. Utilization of support from other partners will also include both URT and non-governmental partners who are supporting orphans and vulnerable children (OVC) and home-based care (HBC) services by collaborating with partners and other stakeholders in accomplishing the increase of access to the full continuum of care. Working with partners supporting home-based care will include supporting volunteers who will also be utilized in tracking and retaining children in care. LEAD will also facilitate the provision of MOHSW job aids and guidelines to healthcare providers. The providers will also receive on-site mentorship on pediatric related data management, which will include accessing and utilization of the data.

Implementing Mechanism Details

Mechanism ID: 12823	**Mechanism Name: EGPAF Follow on**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 9,868,402	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
Central GHP-State	4,503,107
GHP-State	5,365,295

Sub Partner Name(s)

AICC	ARUSHA MUNICIPAL COUNCIL	

Overview Narrative

EGPAF will support MOHSW in strengthening the provision of integrated high-quality HIV care, treatment, and support aimed at extending and optimizing quality of life for PLWHIV throughout the continuum of HIV care. Capacity building for CHMTs will be aimed at improving oversight of service provision at facilities, including supportive supervision, mentoring, and management. Previous work that was initiated under Track 1.0 funding will continue with the ultimate goal of transitioning responsibility to local government. EGPAF will work at 124 sites in the regions of Kilimanjaro, Arusha, Tabora, and Lindi.

The program objectives are to build a foundation for sustainability by strengthening overall technical, management, and leadership capacity of the RHMTs to support the CHMTs in health planning, budgeting, and quality improvement; empower the local government authorities to create and coordinate linkages and referral networks, eliminate duplication, and ensure sustainability of testing, care and treatment, and TB services in the HIV continuum of care in order to provide high quality patient service delivery among implementing partners in the regional health care system; and ensure a continuation of quality care and treatment services, with a focus on improving pediatric enrollment.

Program data collection, monitoring, and evaluation will take place on a regular basis with quarterly data analysis reviews. Efforts are on-going to improve data quality, including building the capacity of service providers through on-site mentorship and supportive supervision.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	387,500
Human Resources for Health	562,500

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
TB
Family Planning

Budget Code Information

Mechanism ID:	12823		
Mechanism Name:	EGPAF Follow on		
Prime Partner Name:	Elizabeth Glaser Pediatric AIDS Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	355,576	0

Narrative:

EGPAF will support HBHC through a focus on strengthening the provision of integrated high-quality HIV care and support aimed at extending and optimizing quality of life for PLWHIV from the time of diagnosis throughout the continuum of HIV care. To do this, leadership, management, and accountability of the CHMTs must be strengthened, CHMTs' human resources need to be improved, and evidence-based and strategic decision-making must be made by utilizing improved data. EGPAF will work with the respective districts and oversee the provision of services at 124 sites in the regions of Kilimanjaro, Arusha,, Tabora and, Lindi* with the aim of having 60,414 adults on HIV care. The target group for HBHC activities are HIV-infected men and women not eligible for treatment (CD4 counts higher than 350).

EGPAF's support to lower level health facilities and hospitals is aligned with the MOHSW and PEPFAR country strategy. Active acceleration of growth will occur during this COP period in order to achieve greater reach of patients enrolled and retained on care. Cost effectiveness strategies towards scale up not only will increase the number of sites, but will also involve an increase in the number of patients. Policy changes, such as the 2010 WHO guidelines, will help facilitate this by increasing patients at the same sites. In line with other COP strategies, EGPAF will ensure care and treatment services are brought close to the patient through outreach services and further integration into existing facilities that

can provide care and support.

EGPAF will ensure referral and tracking systems are strengthened to minimize the loss to follow-up of pre-ART clients through improving linkages between HIV care, support, treatment and prevention sites, other health facilities, and the community. Activities have been enhanced to focus on diagnosis and management of opportunistic infections, pain and symptom management, and integration with other key services (PMTCT, RCH, FP, TB etc). Activities will support and extend nutritional assessments and counseling in all supported sites. EGPAF will integrate and expand positive prevention services in all supported facilities while providing continued support, strengthened coordination, and collaboration mechanisms between partners in the operational regions. Capacity will be built of local government and civil society for sustainable service provision for PLWHIV.

EGPAF will continue to support on-going efforts to improve data quality, including building the capacity of service providers through on-site mentorship and supportive supervision. Adult care data collection, utilization, and reporting will continually be addressed and data quality audits performed.

*Shinyanga will be covered and reported by EGPAF (41 sites) through September 2012, at which time, local affiliate AGPAHI will take on full responsibility for the region.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	218,018	0

Narrative:

EGPAF will support HVTB through a focus on strengthening the provision of integrated high-quality TB/HIV activities, which are aligned with URT’s policies and strategic plans for TB and HIV, the National Multi-sectoral HIV/AIDS Framework (2008-2012), and the Health Sector HIV/AIDS Strategic Plan III (2009-2015). It is estimated that around 15% of new patients enrolling into ART would be present with signs and symptoms of advanced HIV, however, diagnosing TB among this group remains difficult. In response, EGPAF piloted a provision of IPT to PLWHIV which is consistent with the national guidelines.

EGPAF will continue to support and strengthen TB/HIV coordinating committees at all levels, including supportive supervision, on-the-job trainings and mentorships, and quarterly review meetings and interdepartmental meetings. The main activity during this COP year is to maintain services related to the implementation of the Three I's.

Support of on-going efforts to improve data quality, including building the capacity of service providers through on-site mentorship and supportive supervision, will continue to be prioritized. TB/HIV data

collection, utilization, and reporting are some of the challenges that are being addressed. The focus will be on registers, CTC2 cards, and updating databases as well as ensuring that existing HIV care and treatment M&E tools capture TB/HIV indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	145,845	0

Narrative:

EGPAF will support PDCS through a focus on strengthening the provision of integrated high-quality pediatric HIV care and support aimed at extending and optimizing quality of life to the target population of HIV-exposed and infected infants, children, and adolescents. PDCS activities will take place at 124 sites in the regions of Kilimanjaro, Arusha, Tabora, and Lindi* with the aim of having 6,712 children on care and support.

Active acceleration of growth will occur during this COP period, achieving greater reach of patients enrolled and retained on care. Cost effectiveness strategies toward scaling up will not only increase the number of sites, but will involve an increase in the number of patients. Expanded efforts to early infant diagnosis (EID) and integration with other service sites, such as RCH clinics, will help facilitate this. Activities promoting integration with routine pediatric care, nutrition services, and maternal health services include emphasizing identification of infected infants through PITC at all contact points and routine assessment of exposure status at RCH. This will be combined with the strengthening of EID services. EGPAF will scale up cotrimoxazole (CTX) prophylaxis for HIV-exposed and infected children and adolescents, as well as diagnosis and management of tuberculosis and other opportunistic infections (OI's), palliative care, and psychosocial support. Additionally, lab diagnostics will be strengthened in collaboration with HLAB and EID funded activities.

Quality improvement activities will be implemented at the site levels (district hospitals and lower-level health facilities (LLHF)) that provide pediatric care. Activities will incorporate strategies that include quality management teams and indicator mapping that is done through supportive supervision, on-the-job training, and clinical mentorship. Quality improvement activities will measure performance of key indicators in order to identify strengths and develop strategies to address pediatric care challenges at the site level. A strong health systems strengthening focus is part of EGPAF’s overall program strategy and aims to reach care sites.

Community mobilization and linkage activities include creation of children’s and teens’ clubs; community-based care, including under five child survival interventions; and community HIV supported services. These activities will be achieved through training and on-site mentorship, establishment of

coordinating committees with community-based organizations, advocacy, and community mobilization. Additional activities include providing nutrition assessment, counseling and support, and kids' corners in CTC clinics.

EGPAF will continue to support ongoing efforts to improve data quality, including building the capacity of service providers through on-site mentorship and supportive supervision. Pediatric treatment data collection, utilization, and reporting will continually be addressed and data quality audits will be performed.

*Shinyanga will be covered by and reported from EGPAF (41 sites) by the end of FY2012, at which time AGPAHI will take on full responsibility for the region.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	120,000	0

Narrative:

EGPAF will support HLAB through a series of mentorship and capacity building activities towards laboratory accreditation of five district labs and Kilimanjaro Christian Medical Center (KCMC). These activities will focus on accurate forecasting, planning and budgeting for laboratory support for program activities; expanded coverage of laboratory testing in the geographic area; development of training activities focused on laboratory management; and quality assurance of laboratory testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	7,797,764	0

Narrative:

EGPAF will support HTXS through a focus on strengthening the provision of integrated high-quality HIV ART treatment aimed at extending and optimizing quality of life for PLWHIV through the implementation of activities focused on ensuring adherence and retention of patients on treatment. HTXS activities will take place at 124 sites in the regions of Kilimanjaro, Arusha, Tabora, and Lindi with the aim of enrolling 10,929 new adults on ART. Shinyanga region will be covered by and reported from EGPAF (41 sites) through September 2012, at which time AGPAHI will take on full responsibility for the region. This transition will focus on building the capacity of local partners in financial accountability, technical support, program oversight, including planning and implementation, and monitoring and evaluation.

EGPAF's support to lower level health facilities and hospitals is aligned with the MOHSW and PEPFAR country strategy. Active acceleration of growth will occur during this COP period in order to achieve

greater reach of patients enrolled and retained on care. Cost effectiveness strategies towards scale up not only will increase the number of sites, but will also involve an increase in the number of patients. Policy changes, such as the 2010 WHO guidelines, will help facilitate this by increasing patients at the same sites. In line with other COP strategies, EGPAF will ensure care and treatment services are brought close to the patient through outreach services and further integration into existing facilities that can provide care and support.

EGPAF will conduct supportive supervision, on-the-job training and clinical mentorship. Furthermore, EGPAF will conduct quarterly review and interdepartmental meetings, between CTC, lab, and in the community. Capacity building and providing service delivery will be of focus to assist in the transition of ART sites from international partners in the supported regions. EGPAF will evaluate clinical outcomes and other performance data through regular supportive supervision visits, quarterly data review, and annual data quality assessments.

EGPAF aims to improve retention of patients initiated on ART by focusing on high quality HIV services at existing sites by identifying problems along with strategies that will lead to increased retention of patients on ART. Activities to mitigate above challenges will be met with supportive solutions, such as on-the-job training, on-site mentorship, advocacy, community mobilization, defaulter tracing, and updating of tools for tracking and retention, with a focus more on clinical mentorship, supportive supervision, and adherence to consolidation of in-service ART trainings in the zonal training centers. All activities will be interlinked, with referrals to and use of a comprehensive care and treatment package, including ART provision, cotrimoxazole prophylaxis, and TB screening.

EGPAF will continue to support ongoing efforts to improve data quality, including building the capacity of service providers through onsite mentorship and supportive supervision. Adult treatment data collection, utilization, and reporting are continually being addressed and data quality audits performed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,231,199	0

Narrative:

EGPAF will focus on strengthening the provision of integrated high-quality pediatric HIV care and treatment aimed at extending and optimizing quality of life for pediatrics through the implementation of activities focused on earlier identification and improved access to treatment, based on the new WHO guidelines. PDPX activities will take place at 124 sites in the regions of Kilimanjaro, Arusha, Tabora, and Lindi* with the aim of enrolling 1,817 new children on ART. The target population is HIV-exposed and infected infants, children, and adolescents.

Active acceleration of growth will occur during this COP period, achieving greater reach of patients enrolled and retained on care. Cost effectiveness strategies toward scaling up will not only increase the number of sites, but will involve an increase in the number of patients. Policy changes, such as the 2010 WHO guidelines, will help facilitate this by giving more patients at the same sites and further integration into existing sites, i.e. RCH clinics.

EGPAF will implement revised WHO treatment guidelines to improve access to pediatric ART, including treatment of all HIV infected children <24 months; enhance the identification and diagnosis of HIV for infants and children through EID; increase PITC in in-patient and out-patient settings, immunization, OVC, and TB/HIV clinics; improve follow-up services for HIV exposed infants and children; and improve tracking and retaining children in care and treatment.

EGPAF will conduct supportive supervision, on-the-job training and clinical mentorship. Furthermore, EGPAF will conduct quarterly review and interdepartmental meetings, between CTC, lab, and in the community. This will strengthen the pediatric HIV skills of health care providers. They will provide job aids and guidelines, and ensure availability of essential commodities such as pediatric ARV formulations.

EGPAF will implement activities to support adherence in pediatric populations, improve retention on treatment, and establish functional linkages between programs and within the communities to reduce losses to follow-up and improve long-term outcomes. Activities will include strengthening referrals and linkages both within facilities and between facilities and community services, increased advocacy, community mobilization, defaulter tracing, and updating of tools for tracking and retention.

Activities will focus on integration of pediatric HIV treatment services into MCH and RCH platforms of service delivery and linkages with nutrition support programs and community-based activities, programs, and services. Additional activities include expanding EID services to high volume sites, introducing the use of SMS printers to distribute DBS-PCR results back to EID testing sites, and orienting service providers on the use of SMS printer technology.

EGPAF will continue to support ongoing efforts to improve data quality and capacity to collect data, including building the capacity of service providers through on-site mentorship and supportive supervision. Pediatric treatment data collection, utilization, and reporting will continually be addressed in collaboration with the USG and national program. In addition, data quality audits will be performed.

*Shinyanga will be covered by and reported from EGPAF (41 sites) through FY2012, at which time AGPAHI will take on full responsibility for the region.

Implementing Mechanism Details

Mechanism ID: 12827	Mechanism Name: Tanzania Capacity and Communication Project
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 7,151,265	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	7,151,265

Sub Partner Name(s)

Aggrey and Clifford	Care International	Femina/Health Information Project
Kilimanjaro Productions	Media for International Development	Text To Change

Overview Narrative

Tanzania Capacity and Communication Project (TCCP) provides mutually reinforcing quality interventions at individual, community, services, and policy levels. TCCP's mandate encompasses key elements of the HIV continuum of care such as sexual prevention, HTC, PMTCT, ART, including adherence and retention in care, as well as OVC. In addition, TCCP is working in family planning, safe motherhood, and child survival. Aligned with the GHI strategy of increasing impact through strategic coordination and integration, this allows for a holistic approach to promoting adoption of healthy behaviors and services, with numerous opportunities for synergy and economies of scale for cost savings and maximum impact.

TCCP works at the national level as well as in eight priority regions of Dar es Salaam, Iringa, Mara, Mbeya, Mwanza, Pwani, Shinyanga ,and Tabora. A heightened focus will be on Iringa, the region with the highest HIV prevalence in the country. TCCP target populations vary according to specific behavioral objectives. For example, the radio distance-learning program focuses on community volunteers while

the TV serial drama focuses on adults of reproductive age, specifically families.

TCCP also has a mandate to build capacity for sustainable BCC systems. TCCP is working with MOHSW, local NGOs, and institutions of higher education to ensure that systems are in place for message harmonization, coordination, and sustainability.

A baseline of key indicators has already been established through a national household survey in the first year. An external midterm and endline surveys will be conducted. With a strong internal research team, TCCP conducts numerous pre-tests and other formative research to inform campaign development and execution.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	12827

Mechanism Name:	Tanzania Capacity and Communication Project		
Prime Partner Name:	Johns Hopkins University Bloomberg School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	200,000	0

Narrative:

(For background, see TCCP's HVOP budget code narrative as well as TCCP's implementing mechanism narrative)

Specific BCC interventions on OVC include integrated messaging in support of the National Costed Plan of Action (NCPA), the strategy developed by the Department of Social Welfare, and the communication strategy developed by the four USG OVC partners. This funding will be a continuation of the support provided by STRADCOM. This will include continuation of a radio campaign developed for OVC for the NCPA. The main objective will be to continue to foster a conducive environment for the care of vulnerable children.

Communication activities for OVC include the use of radio, video, print, community outreach activities, mobile phone SMS, and the internet.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	750,000	0

Narrative:

(For background, see TCCP's HVOP budget code narrative as well as TCCP's implementing mechanism narrative)

Campaign activities for VMMC include integrating messages in the on-going television serial drama; directing radio distance learning programs at village health volunteers; and broadcast the radio magazine programs on regional and national stations.

The specific VMMC messages include continuing the consistent and correct use of condoms, required abstinence period after surgery, importance of testing, and promoting the service to older men in collaboration with USG/T VMMC service providers. TCCP will work in close coordination with the USG/T service providers, Jhpiego and IntraHealth. The focus for these activities is in Iringa.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	2,175,154	0

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Narrative:
(For background, see TCCP’s HVOP budget code narrative as well as TCCP’s implementing mechanism narrative) Campaign activities utilizing AB messaging include continuing with multiple and concurrent partnerships (CP) campaign on the dangers of CP and safe means of avoiding CP; continue modeling appropriate behavior change on CP in the on-going television serial drama; continue with community outreach activities in the priority regions; community outreach CP activities in radio distance learning programs directed at village health volunteers (avoiding expensive workshops); CP in radio magazine programs on regional and national stations; continuing at maintenance level Fataki campaign on cross generational sex and Chonde Chonde campaign on alcohol and GBV. Communication activities for AB include the use of radio, video, print, community outreach activities, mobile phone SMS, and the internet. The CP campaign, in collaboration with PSI, illustrates the commitment on harmonization of behavior change communication messages and jointly adhere to the national and USG/T priority objectives. Cost sharing of $1 million from KfW has been allocated.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	450,000	0

Narrative:
(For background, see TCCP’s HVOP budget code narrative as well as TCCP’s implementing mechanism narrative) Specific behavior change communication interventions on HTC include the importance of testing, PITC, and couple’s HTC. These are integrated into the ongoing television serial drama, radio distance learning program, radio magazine programs on regional and national stations, and on independently produced videos and TV programs. The TV serial drama allows the modeling of appropriate behavior with testing in a realistic and powerful manner. The weekly radio diaries of PLHIV will continue to help reduce stigma and promote testing. Communication activities for VCT include the use of radio, video, print, community outreach activities, mobile phone SMS, and the internet. TCCP will closely collaborate with USG/T VCT service providers to promote couple's HTC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	2,180,000	0

Narrative:

Target Population / Coverage / Activity: Target populations for these activities include young men and women (aged 15-24) and older men and women (25+). According to mass media results as measured by Synovate Omnibus Survey August 2011, TCCP's Chonde Chonde alcohol campaign has the ability to reach 14+ million people. IPC activities are expected to reach 60,000 people in four regions. The activity incorporates mass media as well as interpersonal communication activities to address current drinking norms and risky behaviors associted with alcohol abuse. These funds will be used to expand and continue this campaign.

TCCP's underlying theoretical framework is the Integrated Change Model. Central to this model is the belief that creating the desire for change across all levels of society is at the heart of real progress. As any intervention with the aim of long-term, generational change requires attention to individual, social, and structural factors. Thus, TCCP's interventions will catalyze the desire for change by shifting perceptions of risk and efficacy at the individual behavioral level and norms and priorities at the socio-political and cultural level. When people want change, they will allocate resources, enforce policies, demand better services, participate in community processes, and choose healthier practices.

Campaign activities include integrating the correct and consistent use of condoms into ongoing and expanded concurrent partnerships (CP) and alcohol campaigns; the television serial drama; radio distance learning program; radio magazine programs on regional and national stations; and independently produced videos and TV programs.

Communication activities for behavior change include the use of radio, video, print, community outreach activities, mobile phone SMS, and the internet.

As part of key USG/T and GHI strategies, the integration of condom messaging in various TCCP platforms allows for mutually reinforcing quality interventions to be implemented and scaled in a cost effective mode. Synergy and increased impact is expected to be achieved by integration of key behavior change messages with other key interventions of HTC, VMMC, PMTCT, and ART.

TCCP is also addressing another key USG/T objective of capacity building of individuals and organizations. Through the ACE mentoring program, TCCP is supporting a cadre of entry level and mid-career professionals in BCC along with providing targeted long-term on the job training supplemented with seminars and course work. They are placed in key organizations including ministries, parastatal organizations, USG partners, NGOs, and private companies.

TCCP innovative radio distance learning program directed at community volunteers provides an alternative to expensive workshops. This approach will be evaluated to learn more about the effectiveness of using radio to train community volunteers.

Through AfriComNet and faculty from the John Hopkins University Bloomberg School of Public Health, TCCP is working with educational institutions, such as the Iringa Primary Health Care Institute and Muhimbili University, to transfer and institutionalize state of the art behavior change communication. In addition, TCCP is working with the private production houses to improve production value in order to increase their audience, while at the same time demonstrating how health messages and behaviors can be integrated into popular entertainment programs and films.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	700,000	0

Narrative:

(For background, see TCCP's HVOP budget code narrative as well as TCCP's implementing mechanism narrative)

Specific PMTCT interventions include an integrated campaign on safe motherhood, including ANC, malaria prevention, and safe delivery; PMTCT being integrated into a FP campaign; PMTCT literacy is integrated into the ongoing television serial drama; a radio distance learning program; national and regional radio magazine programs; and an independently produced videos and TV programs. The safe motherhood and FP campaigns are also supported by the President's Malaria Initiative (PMI) and USAID's Health Office.

Communication activities for PMTCT include the use of radio, video, print, community outreach activities, mobile phone SMS, and the Internet.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	696,111	0

Narrative:

(For background, see TCCP's HVOP budget code narrative as well as TCCP's implementing mechanism narrative)

Specific behavior change interventions on treatment include integrated messaging on treatment literacy on the TV serial drama, weekly diaries by people undergoing treatment on regional and national radio

stations, and production of CTC support materials. Treatment literacy will include living positively, adherence, retention, continuity of care, pediatric treatment, couples testing, use of condoms, and avoidance of alcohol. The mass media objectives are to mainly reduce stigma and encourage people to get tested by explaining how treatment works. In light of treatment scale up, TCCP will enhance focus on messaging around adherence and retention in care, acknowledging that the full impact of USG/T's treatment efforts depends on maintaining people on treatment in order to see a reduction in HVI incidence. CTC support materials will be targeted for people on treatment as well as their relatives and friends.

Implementing Mechanism Details

Mechanism ID: 12829	**Mechanism Name: IPC TA MOHSW**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 800,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	800,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of Jhpiego's program is to provide technical assistance to MOHSW's Health Services Inspectorate Unit (HSIU) to strengthen IPC practices and prevent biomedical transmission of HIV and other bloodborne pathogens. The objectives for the program are to develop guidelines, policies, and standards; coordinate and transition IPC activities; implement quality improvement (QI) of IPC at hospitals; build capacity of IPC training and supervision; provide IPC supplies; advocate for IPC into district budgets; and conduct monitoring and evaluation. The program supports the Partnership

Framework through capacity development, QI, integration of services, and behavior change activities. The program has national coverage with the primary target population being health care workers.

Jhpiego and the HSIU have developed a cadre of national IPC trainers, which allows for travel to be more cost effective. QI teams at individual hospitals will be revitalized to conduct the daily work of addressing IPC issues. Jhpiego will develop an e-learning course on basics of IPC to reduce the time needed for in-service training while covering larger numbers of health workers quickly.

CDC and HSIU have developed a transition plan for IPC by FY 2013. In FY 2012, Jhpiego, HSIU, and CDC will regularly review the transition plan, evaluate progress, and make adjustments. The National IPC trainers will ensure that there is a lasting cadre of experts to continue the work.

Jhpiego and HSIU will monitor and evaluate program indicators and focus on building capacity at HSIU to develop a reporting mechanism for PEP and a surveillance system for healthcare associated infections.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	56,000
Human Resources for Health	328,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities
Safe Motherhood
TB
Workplace Programs

Budget Code Information

Mechanism ID:	12829		
Mechanism Name:	IPC TA MOHSW		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	800,000	0

Narrative:

JHPIEGO will implement activities in IPC per objectives and approaches described in the overview narrative. The activities address injection safety, phlebotomy, management of HCW occupational exposure to blood-borne pathogens, and health care waste management (HCWM). The coverage and scope of activities described below addresses integration of IS and HCWM into HIV services, promotion of country ownership, sustainability, partnerships, QI, M&E, and commodity security.

For PEP, JHPIEGO will develop a short training package to be delivered to facilities and PEPFAR partners. Part of the transition will be to develop a plan and budgeting tools for HCWM to help districts address IPC and HCWM. Further guidance on HCWM will include various types of final disposal for different facilities. JHPIEGO will assist HSIU, Tanzania Food and Drug Authority (TFDA), and HCWM to write a directive on how to dispose of expired medicines. With technical expertise from the Quality and Safety Research Group at John Hopkins Hospital, JHPIEGO will work with larger hospitals to implement a safe surgery checklist.

JHPIEGO supports HSIU as the leader of the national QI forum and provides financial and technical support for annual meetings. JHPIEGO will serve as technical lead for all PEPFAR partners on IPC, HCWM, and PEP integration into programs.

In FY 2012, JHPIEGO's Standards Based Management and Recognition (SBMR) process will be implemented in all regional hospitals and Zanzibar, and expanded to select district hospitals. Working with QI teams and national IPC trainers, HCWs at facilities will receive on-site coaching to improve the quality of IPC as measured by national standards. Hospitals reaching set criteria will be recognized by MOHSW as high performing.

Thirty-one national IPC trainers have skills in training, QI, supervision, and site strengthening and are a

sustainable cadre of experts. JHPIEGO will create a web blog for IPC information to support their efforts. JHPIEGO will work with professional associations to deliver education in topics of IPC, HCWM, and PEP while an IPC e-learning course will reduce the need for in-service training. In safe phlebotomy, JHPIEGO will work with MOHSW and Becton Dickinson (BD) to roll out guidelines, SOPs and training. JHPIEGO will provide buffer stocks of IPC supplies while advocating Medical Stores Department (MSD) to incorporate new supplies into procurement systems and ensure availability of current products. HSIU, along with TFDA, MSD, Pharmaceutical Supplies Unit (PSU), and HCWM, will conduct inspections of the quality of IPC supplies at the facility level, while JHPIEGO supports the monitoring tools and inspection plan. JHPIEGO and the HCWM program will provide TA to PEPFAR partners, RHMTs, and CHMTs to determine appropriate HCWM for their facility. Renovations and repairs for varying types of HCWM facilities will be set up in five to eight model sites. JHPIEGO will support the HSIU Advocacy Strategy for IPC, including HCWM planning and budgeting tools, supplies forecasting, and training for HCWs. JHPIEGO will monitor data from QI assessments in the SBMR database and pilot the national PEP reporting. Results from an evaluation study on client and provider perceptions of injection practices and on healthcare acquired infections (surgical site infections, puerperal sepsis, neonatal sepsis) will be support modifications for COP 2012.

Implementing Mechanism Details

Mechanism ID: 12861	**Mechanism Name: Pamoja Tuwalee - Africare**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Africare	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,900,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,900,000

Sub Partner Name(s)

Chama cha Uzazi na Malezi Bora Tanzania (UMATI)	Futures Group	Tanzania Home Economics Association (TAHEA)
TBD		

Overview Narrative

Africare implements Pamoja Tuwalee, a five-year cooperative agreement that aims to improve the well-being of OVC households using sustainable approaches. The project targets vulnerable children and their families in Central Zone. The main objectives are the project are to strengthen the ability of local government authorities (LGAs) to plan, coordinate, manage, and monitor the OVC response at local levels; increase access to quality, community-level health and social services; support child protection systems and increase child participation in problems affecting OVC; and strengthen capacity of Tanzanian institutions to provide leadership in addressing OVC issues.

The program contributes to goal one of the Partnership Framework, which aims to maintain and scale-up services to improve the lives of Tanzanians affected by HIV/AIDS. It also contributes to the Tanzania Global Health Initiative strategy that is focused on increased access to quality maternal, child, and reproductive health services.

Africare's program approach builds sustainability and efficiency by partnering with LGAs to establish ownership of program interventions. Africare then builds the capacity of the LGAs to meet their commitments. The project also trains and provides grants to 18 local organizations. Training of community volunteers is a key component of the project as it is anticipated that volunteers will remain within the communities long after the project ends.

Africare will continue to collect program data as identified in their M&E plan, which includes mandatory PEPFAR indicators. In addition, baseline data will be utilited to strategically target communities for service packages.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	50,000
Education	10,000
Food and Nutrition: Policy, Tools, and Service Delivery	100,000
Gender: Reducing Violence and Coercion	150,000

Human Resources for Health	3,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	12861		
Mechanism Name:	Pamoja Tuwalee - Africare		
Prime Partner Name:	Africare		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	2,900,000	0

Narrative:

Africare is an international organization that has implemented OVC programs in Tanzania with support from PEPFAR since 2006. Africare's approach of supporting community-level most vulnerable children's committee (MVCC) members, para-social workers, peer educators, and others supports the PEPFAR OVC priority to strengthen community safety nets for vulnerable children. The project targets households that are considered "most vulnerable," such as those that comprise of children or caregivers infected and affected by HIV, children with disabilities, children or elderly heads of households, and households in high HIV prevalence areas that live below the poverty line.

Africare will continue to support delivery of health and social services using a household approach through grants and technical assistance to local organizations. Adoption of a household approach to service delivery reflects evidence that vulnerable children are best cared for through support to the whole household. One strategy that Africare will continue to use involves provision of birth certificates and health access cards, as needed, at the point of identification. In addition, Africare will focus its resources on strengthening households, primarily through economic strengthening and service linkages. To increase local ownership of interventions, Africare will continue to work with districts to appropriately allocate resources for the OVC response and engage community leaders and LGAs in program planning and implementation. Africare will also concentrate on mobilizing communities to support care activities for vulnerable households and address stigma and discrimination of vulnerable children and their families. By implementing an evidence-based approach to HIV prevention in adolescents, Africare will target vulnerable youth with life skills, reproductive health education, and psychosocial support.

In Iringa, the region with the highest prevalence of HIV, scale up HIV prevention strategies will be implemented using funds from the global gender-based violence (GBV) initiative and funds targeted for HIV prevention amongst youth. GBV activities will focus on women and girls, offering protection services against physical and sexual violence, which will also include community-level outreach to change social norms that contribute to GBV and HIV transmission. Meanwhile, youth prevention activities will be centered on economic strengthening and life skills to reduce vulnerability and transactional sex.

Through the use of baseline data, plans to tailor interventions primarily at the community-level with specialized support to individual households will be conducted. Although this approach is in contrast to a general service delivery strategy, the outcome will be increased efficiencies. Africare will document this experience to contribute to the evidence-based research in this area.

Africare has been challenged with slow program start-up, which may have resulted in gaps in services to children who previously received services under former mechanisms in Africare's catchment regions. However, in FY 2011 adjustments have been made to improve and meet required targets, mainly by

combining its baseline activity with the government MVC identification process.

Implementing Mechanism Details

Mechanism ID: 12906	**Mechanism Name: CSSC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Christian Social Services Commission	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,160,025	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
Central GHP-State	133,107
GHP-State	2,026,918

Sub Partner Name(s)

Bugando Medical Centre		

Overview Narrative

The overall goal of the project is to improve the quality of HIV care, treatment, and support services while working towards the sustainability of ongoing programs in Tanzania. The main objectives are to improve access to quality PMTCT services for HIV positive pregnant women in Mwanza and Mara regions; increase access to treatment for HIV/AIDS through ARV drugs and services for HIV positive people; and build and strengthen technical and institutional capacity of local partners for the sustainability of health and HIV/AIDS service delivery.

The program will contribute to the various principles and goals as outlined in the PF strategy in support of the national response to HIV/AIDS. The PF supports national plans and emphasizes capacity building to strengthen the ability of stakeholders to plan, manage, and improve a sustainable national response to HIV/AIDS.

The target population will be the general community, especially adult, pediatric, and pregnant women. CSSC will focus on building and strengthening the technical and institutional capacity of the district councils and LPTFs to effectively plan and coordinate comprehensive HIV/AIDS services, collaborate with councils and other stakeholders to ensure decentralized HIV and health programs are aligned with national guidelines, and build linkages between facility and community based programs for continuum of care and sustainability.

M&E will include methods of verification to track progress and measure the effectiveness of the program, which will be implemented through supervision, data collection, and verification reports. CSSC plans to procure another vehicle as the existing fleet is inadequate for effective support, monitoring and supervision of the 9-10 sites added for COP 2012.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

Construction/Renovation	72,000
Human Resources for Health	2,132,025

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

TB

Budget Code Information

Mechanism ID:	12906		
Mechanism Name:	CSSC		
Prime Partner Name:	Christian Social Services Commission		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	145,725	0

Narrative:

CSSC will continue to collaborate with the district councils to support LPTFs to link and strengthen collaboration with the existing community care and support groups to intensify patient identification, support adherence for ART and TB treatment, follow-up of patients, improve clinical and nutritional mentoring, and increase regular supportive supervision. The limited engagement of health personnel in HBC services necessitates the involvement of community support groups and the community at large in the provision of these services. There are a number of challenges and gaps, which have been noted, that need to be addressed to effectively improve linkages between the health facilities and the communities in order to facilitate efficient, seamless, and effective referrals.

CSSC will work in four districts, to address challenges identified during regular supportive supervision and mentorship. CSSC will hold coordination meetings with stakeholders and collaborate with community care and support groups. CSSC will also perform community advocacy for HIV services and capacity building, through training of health care providers. The program will focus on training 40 adherence counselors to maintain and improve patients' ARV adherence, execute TB case findings, and conduct proper follow up of patients in the community. It will continue to provide on-site TA and mentorship to staff in order to improve patient retention and adherence counseling for treatment and follow-up.

The program will also train a minimum of four peer educators and lay counselors from each LPTFs in order to support the clinical teams at the CTCs to improve exit interview counseling and follow-up of

patients in the community. Further, the program intends to support the LPTFs to strengthen and establish PLHA support groups at the facility and community levels that link with other support groups, encourage new enrolled patients to adhere to treatment, track lost to follow-up, etc.

CSSC will make use of existing structures and leadership at the council and community to advocate and sensitize the community on the use of available CTC and PMTCT services. Regular quarterly program review meetings, which include the district council teams, LPTFs CTC staff, and the program team, will be held to review and discuss the information and data collected from the sites, patient enrollment and retention status, program implementation challenges, and strategies to rectify them. CSSC will also support biannual stakeholders meeting for the four districts to share and discuss the program implementation status, areas for improvement, collaboration in HIV/AIDS and other services, and future sustainability.

In order to effectively involve the community in supporting HBC services and patient adherence to treatment, collaboration with the district councils to plan two campaigns on PMTCT, EID, CTC services, and adherence to ARVs within the four districts will be initiated. Further BCC materials will be developed and disseminated for the purpose of educating, sensitizing, and promoting self care and adherence to ARVs and widely shared information on available care and treatment services. The developed materials will be distributed during community sensitization meetings, at LPTFs-CTC and RCH clinics, and to remote and hard to reach areas. Periodic review and documentation of the achievements and challenges of HBC services will be done for the purpose of sharing and planning.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	97,150	0

Narrative:

CSSC will continue to strengthen TB/HIV collaborative activities in the 17 supported LPTFs, including RCH units focusing on proper screening using nationally adopted screening tools and identifying, referring, and treating TB/HIV co-infections according to the national 3Is strategy scaling up initiative. Through strengthening the referral system between CTC and TB units, the entry points for HIV prevention, care, and treatment will be effectively utilized. To facilitate the implementation of this strategy, CSSC will ensure constant availability of TB screening tools in potential entry points (CTC, TB clinics, and reproductive and child health unit), sensitize facility staff to administer TB screening tools during clinic days, and link TB suspects with laboratory services. Moreover, CSSC will also support the referral of TB suspects with negative sputum to the nearest available chest x-ray services for further diagnosis.

CSSC plans to improve the linkages between CTC and TB units to properly manage CTC clients diagnosed with TB/HIV co-infection. Emphasis will be made on TB infection control, including increasing the number of LPTFs managing TB/HIV co-infection under one roof as an effective infection control strategy. Other infection control strategies will focus on having a BCC program at both the facility and the community level using existing volunteer groups. To facilitate this, CSSC will equip 20 HBC providers with skills on intensified case finding and proper follow-up of TB suspects in the community.

With regard to building the capacity of the staff in TB/HIV co-infection management, CSSC aims to train 20 staff from these facilities on 3Is protocol based on the national curriculum, which includes implementing three facilitators for five days, as well as linking them with training opportunities offered by other TB/HIV implementing partners. In addition, CSSC will collaborate with MOHSW and Bugando Medical Center to conduct training for 20 LPTF laboratory staff on AFB smear for TB diagnosis. CSSC will continue to equip the staff with knowledge and skills on TB/HIV co-infection management through routine on-site mentorship, technical assistance, and quarterly joint supportive supervision in collaboration with district TB/HIV focal people and other TB/HIV partners to ensure sustainability of the TB/HIV program.

CSSC will support the refitting of four LPTF TB units, four TB diagnosis microscopes, and provision of national guidelines and job aids. CSSC will implement the national TB/HIV M&E framework and tools in tracking the progress of the TB/HIV collaborative activities in all 17 LPTFs, including facilitating linkages of M&E activities with CQI activities for improving good patient outcome levels by providing good clinical and health practices.

From each LPTF, two staff will be oriented on proper documentation of TB/HIV cases, transcription of TB/HIV information into the CTC2 form, and following-up accurate data filling that will be used for generating monthly and quarterly reports. Furthermore, CSSC will implement planned TB/HIV activities based on best practices and lessons learned from the first year, including improved administering of the TB screening tool, good clinical practices, and establishment of ‘under one roof’ TB/HIV management in two sites of Sengerema.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	97,150	0

Narrative:

CSSC will support the 17 LPTFs in integrating pediatric care and support services into MNCH services to improve access for children to HIV/AIDS care and support services, including EID, nutrition assessments, growth and developmental assessments, adherence, and psychosocial counseling to optimize the quality

of life for HIV infected children and their families. This integration is cost effective because it creates a system whereby HIV exposed infants and infected children access services in one clinical setting, which reduces the need for referrals and shifting service providers.

CSSC will strengthen and support linkages into pediatric care and support services for HIV exposed infants and infected children identified in potential catchments areas (such as ANC, MCH and RCH clinics, labor ward, pediatric ward, OPD, outreach services and community) to increase the pediatric enrollment rate. To increase pediatric enrollment, CSSC's clinical team will conduct on-site mentorship and TA visits on a monthly basis in all supported LPTFs to equip staff with skills in improving pediatric care and support services according to the national guidelines, including EID, preventing and treating OIs, adherence, clinical monitoring and management of infected children, facility-community linkages, and integration with MNCH services as well as PWP activities. In addition, LPTF staff will be mentored on how to integrate HIV services, such as EID, during outreach MNCH services and link with local OVC partners.

Quarterly joint reviews with other implementing partners and district mentors will be conducted in monitoring the quality of services offered as well as provision of essential equipment, such as pediatric BP machines, weighing scales, tape measures, and oxygen concentrators to improve the quality of pediatric care services. Furthermore, essential reference materials, including job aids and guidelines for pediatric care and support services, will be supported by CSSC.

CSSC plans on training 30 staff on EID for six days using the national guidelines. To increase retention and tracking of children enrolled into pediatric care and support, CSSC will engage and orient existing lay counselors and community groups in four supported districts to participate in increasing pediatric enrollment. CSSC will also develop and support LPTFs with tailor-made client tracking forms, which will be used to capture details for demographic information and allow for easy follow-up and tracking of the enrolled children in the community. CSSC will strengthen laboratory services in supported LPTFs, including linkages to Bugando Medical Centre Reference Laboratory, for CD4 percentage measurement and EID. CSSC will support transportation of the collected DBS and CD4 samples to Bugando and also facilitate the communication of results from the testing facility to increase the turn-around time. Procuring pediatric OI drugs through a buffer system will help deal with OI drug shortages at the national pipeline.

To raise awareness of the importance of enrolling pediatrics into care, CSSC will use IEC materials to sensitize and promote pediatric enrollment. One community group per district will be involved in promoting enrollment. CSSC will also support the establishment of pediatric friendly clinics in four district hospitals to provide friendly and conducive environments for service provision, eventually leading

to an increase of retention rates of pediatrics.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	100,000	0
Narrative:			

CSSC will focus on increasing access and utilization of PMTCT services in the 17 LPTFs in line with the PEPFAR country strategy, Global Health Initiative and related MDGs (3, 4, and 6) as well as improving access to efficacious prophylactic interventions to prevent transmission of HIV to infants. Strengthening tracking systems of HIV-positive pregnant women and exposed infants, increasing access to both HIV staging and ART for eligible pregnant women, and strengthening linkages of HIV infected pregnant women contribute to the full continuum of HIV care. So far, CSSC has managed to build and strengthen working relationship with HIV/AIDS stakeholders in supported Districts with a particular emphasis on increasing PMTCT uptake. Moreover, CSSC has advocated for the integration of EPI/HIV services to improve maternal and child survival. CSSC plans to conduct the following activities: counseling and testing of 80% of pregnant women attending Antenatal Clinics to increase the number of pregnant women with known HIV status, and providing Antiretroviral therapy to all HIV infected pregnant women and prophylaxis to HIV exposed infants within 72 hours after delivery. This will be done cost-effectively using both existing skilled facility staff and national supply chain systems for PMTCT related commodities such HIV test kits, reagents and ARVs to reduce unit cost per client. In addition, linkages between RCH and CTC will be strengthened to improve access for clients to CD4 testing, ART, adherence and other care and support services. Volunteer groups will be engaged in facilitating bi-directional linkage and improving retention rates of clients. Biannually, CSSC will involve 4 community groups (1 from each District) that are comprised of 10 people, each to mobilize and sensitize the community by using songs & cultural dances for 3 days. Groups will also address barriers that hinder PMTCT services uptake such as low male involvement, gender based violence and undesirable traditional practices such as widow inheritance and cleansing which are common practice in the program area. Also, IEC materials will be developed and distributed to promote PMTCT services uptake in all 4 supported Districts. For effective implementation of planned activities, a 12 day PMTCT training will be conducted for 30 staff from supported LPTFs using 6 facilitators as per National Curriculum. LPTF staff will be equipped with PMTCT skills such as feeding counseling, care and supportive services and an effective bidirectional referral and tracking system of clients to improve retention rate. Furthermore, accurate documentation, data use and reporting and timely ordering of PMTCT related commodities will be emphasized during quarterly on site mentorship. Also, LPTF’s staff will be mentored on implementing EPI/HIV integration. Task shifting strategies will be utilized in LPTFs with shortage of staff. In addition, CSSC will build the capacity of regional/district health systems to sustain the services provided through engaging 2 Regional and 4 District RCH Coordinators from the 4 Districts and Regions in mentorship/supportive supervision

visits to monitor the quality of services offered twice a year. CSSC will also facilitate the availability of national guidelines and job aids to the supported LPTFS as well as essential equipment for PMTCT service such as BP machines, weighing scales and HB machines for quality service delivery.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,720,000	0

Narrative:

CSSC will strengthen health systems by improving HIV clinical monitoring and management, availability of supplies, and CTC community linkages. To address supply shortages, CSSC will conduct quarterly on-site mentorship visits of LPTF staff that will focus on proper inventory management. In addition, CSSC will also build capacity of two pharmacy staff on pharmaceutical management for three days, while two additional staff will be trained on pharmacovigilance for three days to improve therapeutic management of adults on treatment. Therapeutic committees within the four district hospitals will be strengthened to improve information sharing on drug issues. In order to buffer the shortages of supplies, CSSC will procure these commodities on the basis of 30% of patients on care and treatment.

Infrastructure support includes pallets and shelves for the 17 LPTFs, four air conditioners, and 17 wall thermometers for temperature monitoring. To strengthen laboratory services, two six-day trainings will be held for 20 participants using three facilitators each on QA system and inventory management. Also, the CSSC laboratory focal person will conduct a five-day joint on-site supportive supervision training on a quarterly basis within each district, as well as providing job aids, SOPs, and guidelines to improve lab services. In addition, biochemistry machines and hematology analyzers for the two newly established district hospitals will be procured, along with supporting routine preventive maintenance for the CD4 and biochemistry machines and hematology analyzers, which are in five supported hospitals.

To improve patient flow and services, refitting of four CTCs will be done in highly congested LPTFs. A six-day basic ART training for 60 staff using 10 national facilitators will be held to improve clinical outcomes of adults on treatment. CSSC will also advocate to the facility owners on the importance of allocating key CTC staff, including adherence counselors and community outreach workers. The CSSC clinical team will provide on-site mentorship and TA to the LPTFs for five days on a monthly basis to equip staff with skills in clinical assessment and management.

Support of triage equipment, such as furniture, BP machines, weighing scales, and thermometers will be purchased to increase effective clinical monitoring of patients. Through its vast community experience, CSSC will increase retention of patients on ART through strengthening CTC-community linkages, such as patients’ attachment to PLHA support groups and the use of two lay counselors, each in the 17 CTCs,

to give health talks during CTC clinics. To improve data demand and information use (DDIU), CSSC will purchase six computers and printers for six LPTFs. Moreover, DDIU will be used as part of the CQI strategy to activate CQI teams in four district hospitals to improve patient outcomes. CSSC will conduct two six-day trainings to 20 LPTF staff, with three facilitators each, on data collection and CTC2 database/IQ tool. Also, CSSC will train 20 district mentors for six days using seven facilitators, as per the national curriculum, who will be engaged in quarterly joint supportive supervision to promote sustainability of ART service delivery. To improve programmatic efficiency, three CSSC staff will continue to strengthen LPTFs' key operating systems, such as human resources and financial grants management through on-site mentorship and TA.

Implementing Mechanism Details

Mechanism ID: 12926	**Mechanism Name: HUSIKA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,045,177	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,045,177

Sub Partner Name(s)

Engender Health	Femina/Health Information Project	Tanzania Marketing & Communications Company, LTD

Overview Narrative

Husika is designed to reduce HIV transmission among at-risk populations, MARPs, and their sexual partners. Through the promotion and implementation of a core package of essential services, Husika will increase correct and consistent male and female condom use and health seeking behaviors for target populations. Husika's design supports the priorities set out in the PFIP and GHI strategies.

Husika will be active in seven regions: Dar, Iringa, Mbeya, Tabora, Shinyanga, Mwanza, and Mara. Activity models will vary depending on the region, prevalence and needs of the population. Husika will prioritize commercial sex workers (CSWs), women engaged in transactional sex (WETS), and male clients of CSWs and WETS. Formative research for activities targeting MSM will be implemented in FY13 (FY12 COP).

As the prime, PSI has maximized cost efficiencies through cost-shares and collaboration with activities under the GF Round 4 HIV RCC. This includes cost sharing on operational costs, research, targeted interventions with CSWs and clients, and nationwide condom social marketing. Husika will build the capacity of local CBOs to provide services in the community and create a sustainable knowledge base of CSW peer educators for lasting social change. PSI and T-MARC will implement actvities targeting street-based and brothel-based CSWs. EngenderHealth will provide linkages to services, and gender and advocacy support with CBOs. Femina's communications promote condom use, health seeking behavior and address social norms around sexual behaviors and concurrent partnerships.

M&E includes using unique identifier codes to track interpersonal communication and access to health services, and customer satisfaction surveys to monitor quality of supported provider services.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	179,118

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	12926		
Mechanism Name:	HUSIKA		
Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	0	0

Narrative:

Husika will leverage Femina and EngenderHealth's exisiting capacity in Tanzania to reach will reach women engaged in transactional sex (WETS) and clients of sex workers.

Femina's targeted mass media activities will include messages about abstinence and fidelity as effective means of HIV prevention, particularly highlighting the risk of HIV transmission and concurrent partnerships. Femina will allocate two pages of its Sio Mchezo magazine every month to provide key messages on HIV prevention, including partner reduction, linkages to health services (including HCT, FP, and STI testing and treatment), and condom use. Femina will also develop and coordinate a radio talk show that will address social norms around sexual behaviors, including multiple and concurrent partnerhsips, myths and misconceptions on condom use, and encourage access to health services. The primary target audience for communication will be WETS aged 18-29.

EngenderHealth will adapt its Men as Partners (MAP) communication tools (already being used in Tanzania under the CHAMPION Project) to train CBOs in the Husika regions to improve targeting and lasting behavior change amongst likely clients of CSWs and men likely to engage in transactional sex with WETS. Through evidence-based, interpersonal communication approaches, CBOs will target these men (particularly in high risk settings and hot zones) with clear messages about the risk of HIV transmission associated with transactional/commercial sex and concurrent partnerships. In addition to clear messages about abstinence and fidelity, the MAP communication will also promote condom use, and health seeking behavior for HIV testing and STI testing and treatment. Training will be provided to CBOs in all seven Husika regions. EngenderHealth will provide supportive supervision using checklists developed in FY12.

M&E will focus on reach and recall evaluations for WETS and potential clients of sex workers reached through targeted mass media and IPC channels. Feedback and insights recieved through program implementation will guide in refining messages to ensure they resonate with the target audience.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	2,045,177	0

Narrative:

Husika will target three primary target groups: CSWs, WETS, and clients and male partners of SWs and WETS.

A total of 3,000 CSWs, 5,000 WETS, and 6,000 clients will be reached. All interventions with these groups will promote correct and consistent condom use (including free condom distribution), and promote health seeking behavior. Formative work to develop an evidence communication strategy and tools for reaching MSM will be implemented.

Promotion of consistent and correct condom use and condom distribution efforts will cut across all target groups. GF funding will be leveraged for condom procurement and distribution. Husika will also support targeted demand creation and condom placement in hotzones . The program will also include ree distribution through CSW peer educators and outreach. Condom availabity in hotzones will be monitored annually.

The sex worker program will be segmented by street- and brothel-based programs. PSI will scale up a branded (Shosti) street based sex worker program to five regions (Mwanza, Shinyanga, Mbyea, Mara, and Tabora), building on experiences of a pilot implemented in Dar es Salaam and Iringa in FY12.

Activities will focus on outreach activities including peer education programs to promote condom use and provide linkages to services. Based on international best practice with CSWs, PSI will pilot a case management system that uses outreach workers as "case managers" for individual CSWs. These case managers will be responsible for support and follow up of sex workers accessing health services. Mobile health services will be scaled up to reach two more regions (Mwanza and Mbeya), building on lessons learned from a pilot implemented in Dar es Salaam in FY12. Mobile health services include a van with HCT and STI services made available in hotzones during communication events with sex workers. T-MARC will continue to expand IPC activities (face-to-face) with brothel based sex workers in Mwanza, Dar, Shinyanga, Mbeya, Iringa, and Mara (leveraging activities under TSMP). Face-to-face communications will involve the promotion of male and female condoms and provide referals to health services. CSW contacts will be tracked using a unique identifier code (UIC) system developed by PSI and shared with TMARC. T-MARC will rely on the promotion of mobile populations implemented through TSMP to reach bar girls (WETS) as well as potential clients of sex workers in key industries (mining, fishing) and transport corridors within Husika regions, including Iringa, Mbeya, Mwanza, Mara and Shinyanga. Small group discussions will be held with each target group to promote condoms and provide linkages to health services. PSI will reach potential clients of sex workers and WETS in hotzones where streetbased sex worker Shosti programs are implemented, and will leverage GF supported condom social marketing activities in bars and nightclubs. Communications will focus on condom use and health seeking behavior for HCT and STIs. M&E activities include routine monitoring using UIC, program reports, regular field qualitative supportive supervision by program staff, quarterly technical supervision from senior technical staff, annual surveys of outlets in hotzones stocking condoms. and technical support from the PSI network and HQ. PSI has the existing trained staff able to provide this level of quality assurance and leverages cost share from the GF for these activities.

Implementing Mechanism Details

Mechanism ID: 13013	**Mechanism Name: Blood Technical Assistance**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Association of Blood Banks	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 650,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	650,000

Sub Partner Name(s)

Johns Hopkins University Bloomberg School of Public Health		

Overview Narrative

The American Association of Blood Banks (AABB) will provide technical assistance in the areas of management and coordination; implementation of national standards in donor selection, blood collection, laboratory testing and processing, and distribution of safe blood; transfusion practices; and monitoring and evaluation. Strengthening the monitoring of supervisory and audit reports, non-conformances, statistical process monitoring, and staff follow-up will also be key focus areas.

AABB will provide mentorship to reduce Transfusion Transmissable Infections (TTIs). Ongoing mentorship and training will be provided in donor selection, blood collection, laboratory testing, component production, and distribution of blood. System quality will be strengthened by the implementation of Good Manufacturing Practice (GMP) guidelines for all blood processes. The application of the overall quality plan will assist in expediting the acreditation process in two blood center zones.

Techinical assistance will be provided in the areas of: training plan development; trained personnel follow-up; blood safety curriculum review in training institutions; and NBTS capacity to manage student interns. Opportunities to practice blood transfusions will be strengthened through innovative laboratory-based strategies to enhance appropriate practices, pilot implementation of haemovigilance, and evaluate blood usage in selected zones.

The capacity of NBTS to conduct internal quality and operational audits, data collections, and data analysis, while instituting corrective actions will be strengthened. These activities represent the initial

implementation of activities necessary for NBTS to seek semi-autonomous status and alternative funding mechanisms in the future.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	650,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Safe Motherhood

Budget Code Information

Mechanism ID:	13013		
Mechanism Name:	Blood Technical Assistance		
Prime Partner Name:	American Association of Blood Banks		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	650,000	0
Narrative:			
For COP 2012, AABB will provide ongoing systems strengthening mentorship to NBTS by building capacity in overall management and coordination through zonal and national monitoring supervisory tool reports, program sustainability through implementation of a road map to attain autonomy, and monitoring customer feedback and mentorship in regional BTS models. Additional mentorship will support NBTS to implement international and national standards. AABB will conduct competency assessment and			

training in donor selection, blood collection, laboratory testing, components production, and distribution based on standard operating procedures. Quality of testing will be monitored through internal and external proficiency testing and continuous review of testing algorithms and technologies. Component production and use by clinicians will be increased through a gradual training of clinicians. This will be monitored by observing increases in component distribution in NBTS zones.

Training will be provided through implementation of the revised NBTS training plan, which includes follow-up on trained personnel. Structured on the job training will be implemented for both current and new personnel. In collaboration with other stakeholders, assessment of blood safety carriculum in selected tertiary institutions will be conducted and curriculum reviewed, while the capacity of NBTS to absorb student attached to NBTS during field project will be strengthened.

The quality system will be improved through mentoring of the implementation of GMP guidelines to ensure quality assured blood and products; conducting internal audits and management reviews to monitor non-conformance in all blood safety processes; implementing of Blood Computer Establishment Computer system will be expanded into four additional zones, rolling out accreditation from one accredited zone to a total of three zones through locally NBTS trained mentors; and developing of NBTS' capacity to conduct routine operational assessments (internal audit).

Facility based zonal mentorship in appropriate use of blood and products will be provided in collaboration with facility management; increase in component production and distribution; review actual needs evaluation reports; implementation of haemovigilance and monitoring facility utilization statistics.

In collaboration with other partners, AABB will mentor NBTS to conduct M&E of blood safety processes through statistical process monitoring, supervising non-conformances and ensuring appropriate corrective and preventive processes are in place; and monitoring the effectiveness of training provided.

Implementing Mechanism Details

Mechanism ID: 13262	Mechanism Name: MOHSW Blood
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	3,200,000

Sub Partner Name(s)

Tanzania People Defense Force (TPDF)	Tanzania Red Cross Society	

Overview Narrative

The overall goal of this activity is to strengthen and maintain a sustainable national blood transfusion service in order to provide adequate and accessible safe blood collected from Voluntary Non-Remunerated Blood Donors (VNRBDs). Areas of focus include Monitoring and Evaluation, quality systems, finance, and human resource management. The main objectives are to strengthen the coordination and management of NBTS, which includes operations in various zones with two sub partners to improve geographical and facility safe blood coverage.

Strategies to collect safe and adequate blood will rely on technical assistance, equitable distribution of funds to zones based on population and other parameters, establishment of more collection and distribution blood satellite sites, renovation of laboratory space, implementation of a blood computer system, and incinerator repairs to ensure quality blood products and safety. Management, organizational coordination and capacity will be strengthened through implementation of the human resource management manual. In order to improve efficiency, the procurement, logistic and supplies systems will be strengthened. Since 80% of blood collected in all zones is through mobile drives, the purchase of additional vehicles to stenghern recruitment and collection is planned.

Training and mentorship to develop excellence in safe blood operations will be conducted with an eye to program sustainability. Advocating for increased URT funding, developing and strengthening Public Private Partnerships, and linking to other programs to leverage other funding will be priorities in order to reduce dependency on USG.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,500,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13262		
Mechanism Name:	MOHSW Blood		
Prime Partner Name:	Ministry of Health and Social Welfare, Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	3,200,000	0
Narrative:			
For COP 2012, NBTS will implement activities to develop, review, produce, and disseminate various NBTS guidelines; strengthen infrastructure to ensure effective operation, transportation, and distribution of blood and blood products; work with relevant TA to implement mobilization of low risk donors; and			

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strengthen recruitment strategies through implementation of a revised advocacy plan. COP 2012 funds will both establish new satellite sites and strengthen existing sites. Attracting more blood donors will be targeted through producing and disseminating effective IEC materials, and through the formation of donor clubs at schools and colleges. Investments will also go toward improving linkages with organizations supporting HIV counseling and testing for negative HIV donor referrals. Roll out of the blood computer system to remaining zones will help facilitate the tracking of donor information from donor to recipient.

In order to improve the provision of safe blood to health facilities, NBTS plans to increase blood components production to 40% of the total collection. This can be achieved after the renovation of adequate laboratory space and the installation of equipment. Hospital clinicians will also be trained to ensure rational blood usage and through the formation of hospital committees which will be supervised by zones.

This project will support the on-going strengthening of a quality system. Training and mentorship will expedite the accreditation process for two zones. Refresher training, mentorship and skills building in testing and processing through updated testing technologies will develop capacity in donor selection and counseling in order to reduce the prevalence of HIV and other TTIs in donated blood to less than 2%. This project will also review and implement the testing algorithm in blood group serology and TTIs testing. In order to have continued quality services in all zones, preventive maintenance of equipment and facilities will be scheduled on regular bases.

NBTS will undertake improvements in program finance to ensure sustainability by identifying other sources of funding. Revenue generation strategies will be developed along with finding creative ways to increase government funding. Regular internal and external audits will be conducted, thus strengthening the procurement system. The project will also advocate and develop related documents to establish NBTS as a semi-autonomous institution.

NBTS will implement a monitoring and evaluation plan by strengthening supervisory tools and conducting quarterly supportive supervision to the zonal centers and health facilities. It will conduct semi-annual

zonal managers and stakeholders meeting to assess implementation of program activities; train staff on and implement monitoring and evaluation frameworks; develop and implement an operational research road map; create a clients' services charter; and produce and disseminated statistical analysis on blood safety indicators on a quarterly, semi-annually, and annual basis.

Implementing Mechanism Details

Mechanism ID: 13301	**Mechanism Name: Pamoja Tuwalee**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: World Education	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,589,294	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,589,294

Sub Partner Name(s)

(No data provided.)

Overview Narrative

World Education Inc. (WEI)/Bantwana Initiative implements "Pamoja Tuwalee" in the Northern Zone. Pamoja Tuwalee is a five-year cooperative agreement that aims to improve the physical, psychosocial, and economic well-being of MVC and their households. The program will meet its goals by increasing access to and utilization of care and support services to 100,000 vulnerable children; strengthening human and organizational capacity of local structures to care for OVC; and increasing community awareness of, including having child participation in, advocacy efforts to promote social protection of targeted children.

The program is implemented in collaboration with the local government and aligned with national program, policy, and frameworks, as well as the first goal in the PF that relates to service maintenance and scale-up. Coordination with LGAs is central to the WEI strategy, which advocates to LGAs on the

importance of providing human and financial resource support to MVC in their communities and works with them in planning and implementing activities to ensure local ownership.   Capacity building of local partners further supports sustainability.

WEI adopts financial control policies that ensure efficiency and necessity of all program expenses.   It also actively seeks collaboration with other stakeholders to leverage knowledge, materials, and resources.   WEI uses a web-based M&E system to track services to beneficiaries and other performance indicators.   Additionally, M&E training is conducted to build partner capacity in data collection, use of monitoring tools and practices, and reporting. Community-based trainers will be trained to verify monitoring activities at the partner level.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HKID	TEWOREC, AFRIWAG, ELCT - Pare Dicese	76155	WEI/Bantwana will facilitate distribution of school uniform to 1,000 MVC which were not distributed before the Global Fund close the program. The value of the school uniform is $ 17,200 was procured through the Global Fund funding. WEI/Bantwana will facil WEI/Bantwana will facilitate distribution of start-up kits to 33 tailoring and 31 capentry MVC. The start up kits was procured through the funding from The Global Fund with the value of $ 11,600. WEI/Bantwana will sensitize 372 MVC households (1,486 MVC WEI/Bantwana will facilitate distribution of

			WORTH books and provide technical support to the WORTH groups. The books were printed by the Global Fund before the closure of the program with the value of $ 2,340

Cross-Cutting Budget Attribution(s)

Economic Strengthening	150,800
Education	92,800
Food and Nutrition: Commodities	45,000
Food and Nutrition: Policy, Tools, and Service Delivery	91,000
Gender: Reducing Violence and Coercion	59,000
Human Resources for Health	21,000
Water	10,800

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**13301**

Mechanism Name:	Pamoja Tuwalee		
Prime Partner Name:	World Education		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	2,589,294	0

Narrative:

WEI is an international organization that has been implementing OVC programs throughout Eastern and Southern Africa for several years through its Bantwana Initiative. USG/T provided WEI, which is new to Tanzania, with a cooperative agreement to implement Pamoja Tuwalee based on the successes of the Bantwana Initiative throughout the region. The goal of WEI/Pamoja Tuwalee is to improve the physical, psychosocial, and economic well being of most vulnerable children (MVC). The program supports the PEPFAR OVC priorities related to strengthening community-level safety nets by emphasizing coordination with and capacity building of community structures that offer efficient and sustainable care, protection, and support to children and their households.

WEI works to strengthen local civil society to improve organizational effectiveness and technical capacities. Establishment of most vulnerable children's committees (MVCC) to mobilize and coordinate services for vulnerable households is another critical activity that WEI supports. In addition, a school-based model for service delivery, which involves building the capacity of school communities (i.e., teachers and school committees and boards), and conducting school-based health assessments are implemented. The school-based approach is modeled on WEI's successful intervention in Swaziland where 37 schools were mobilized and actively supported MVC in their community, leading to improved access to primary healthcare and referrals, livelihoods, child protection, nutrition, HIV- prevention, and PSS.

Current guidance on OVC programming emphasizes the need for more sustainable approaches. A critical priority in FY 2012 will be to improve the quality of service delivery by supporting service providers to implement more sustainable strategies than those under PEPFAR I, which mainly focused on emergency service provision. This includes adopting a household-focused approach that emphasizes integration of economic strengthening and livelihood activities to reinforce families' long-term caring capacities. WEI's expertise in strengthening household capacity to care for MVC will be leveraged to support partners in shifting from a focus on procurement and distribution to a more qualitative, comprehensive model of MVC care and support. Target populations include vulnerable children and their households, civil society organizations, teachers, MVCCs, LGAs, and local leaders.

WEI will also pilot resources and interventions from other countries in the region where Bantwana

Initiative operates. For example, WEI anticipates adapting and developing a child protection booklet successfully used in Uganda, which relies on child participation through kids clubs and child advisory committees and can be used as a tool for educating and exploring issues of protection with children. To promote integration of services, WEI also plans to implement a referral system originally developed in Zimbabwe, which includes a service provider directory that enables WEI/Bantwana partners, teachers and community -based counselors to refer children to local service providers. Through these program innovations, WEI will contribute to the evidence-base of successful models for OVC care and protection in Tanzania.

Implementing Mechanism Details

Mechanism ID: 13327	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13343	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13348	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13350	**Mechanism Name: Service Provision Assessment**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: ICF Macro	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 250,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since the early 1990s, ICF Macro (formerly Macro International at MEASURE DHS) has been providing technical assistance to the National Bureau of Statistics (NBS) on the Mainland Tanzania and Office of the Chief Government Statisician (OCGS) in Zanzibar in the area of enabling the the two sister institutions to undertake major national surveys especially Demographic and Health Survey (DHS) and HIV/AIDS and Malaria Indicator Survey (HMIS). Furthermore, ICF Macro supports the two institutions on undertaking disseminations of the key findings at various levels: national, zonal, regional, and district with corresponding information package which suit the various audiences. ICF Macro's ultimate goal is to sustain the skills of these national institutions which are mandated to undertake such national surveys.
Its activities are in direct support of PF Goal 6 to improve the use of relevant and comprehensive evidence in HIV-related planning and decision-making as well as of GHI Ir 2 for Improved health systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	13350		
Mechanism Name:	Service Provision Assessment		
Prime Partner Name:	ICF Macro		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	250,000	0

Narrative:

ICF Macro (formerly Macro International at MEASURE DHS), has been responsible in providing technical assistance in conducting three national surveys on HIV/AIDS and two others on Malaria Indicators (HMIS) in both Mainland Tanzania and Zanzibar. The assistance has always been channelled through the Office of the Chief Government Statistician (Zanzibar) and National Bureau of Stastics (Mainland Tanzania).

For the second time, in collaboration with Tanzania Commission for AIDS (TACAIDS), Ministry of Health and Social Welfare (MOHSW), USG/T, and other stakeholders, ICF Macro will be providing technical assistance to both NBS and OCGS on the dissemination of key findings at national level of the 2011-2012 THMIS. ICF Macro will also provide technical assistance to both NBS and OCGS on how to conduct a post-enumeration evaluation. Findings from the evaluation will help improve future similar surveys

Implementing Mechanism Details

Mechanism ID: 13351	Mechanism Name: PROMIS
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Northrup Grumman	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 450,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	450,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism is to support the development of the PEPFAR Records Organization Management Information System (PROMIS), with the goal of supporting the PEPFAR Tanzania team on the reporting of the semi annual progress results (SAPR) and the annual progress results (APR). By supporting the progress report activities, the PEPFAR country team will improve program planning and decision making by using readily available and timely data.

PROMIS software is used by all PEPFAR Tanzania USG implementing agencies and implementing partners who operate across Tanzania. The PEPFAR Tanzania team has invited other PEPFAR countries to use the system, hence other countries use the system will share in the development and maintenance costs. It is expected that if more countries eventually use the system, the cost that countries will have to contribute will be minimized, even though countries will still receive high quality data from the SAPRs and APRs. Thus, the PROMIS will reduce the time country SI teams will have to spend on S/APR submissions, including data cleaning, which will enable the SI teams to spend more time on capacity building and technical assistance to host governments on SI issues.

The mechanism will build capacity to local in-country SI teams on data management, system administration, and later will build capacity to local in-country software development companies which will

assist country teams with any software development issues.

The mechanism is being monitored through weekly steering committee meetings which review the costs and activity progress against a pre-determined set of work packages, milestones and deliverables for the software development team.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13351**		
Mechanism Name:	**PROMIS**		
Prime Partner Name:	**Northrup Grumman**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	450,000	0
Narrative:			
The mechanism will provide ongoing support towards the maintenance and use of of the PROMIS software.			

PROMIS is used by the Tanzanian country team for SAPR and APR reporting to gather information from partners. The USG team will use PROMIS to provide them with ongoing access to the data to improve the teams ability to analyze the data and use the information in program planning. The information from PROMIS will also be used to make strategic decisions. This mechanism will help PEPFAR to have readily available program data and hence support monitoring and evaluation activities. This mechanism and the PROMIS system provides support to the full inter-agency team and the system is used by the USG to fulfill OGAC reporting requirements. If funds from other countries become available to supplement this mechanism, the partner will be able to develop new features in addition to the limited set supported by COP 2012 fundings from Tanzania.

Implementing Mechanism Details

Mechanism ID: 13355	**Mechanism Name: ZACP**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 179,682	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	179,682

Sub Partner Name(s)

Pangaea Global AIDS Foundation		

Overview Narrative

In 2004, the Ministry of Health and Social Welfare (MOHSW), through the Zanzibar AIDS Control Program (ZACP), was awarded its first five-year Cooperative Agreement (CoAg), which came to an end in

August 2009. The main focus of that CoAg was to enhance HIV/AIDS prevention, care and treatment services in Zanzibar, support multiple program areas, and interventions and services. These interventions and services included abstinence and faithfulness (AB), youth and faith-based organization prevention interventions, interventions for key populations (formerly called most-at-risk populations), prevention of mother-to-child transmission (PMTCT), HIV testing and counseling (HTC), antiretroviral treatment (ART) services, management of sexually transmitted infections (STIs), laboratory support and services, and strategic Information, which included surveillance, monitoring and evaluation (M&E), and human capacity development (HCD).

Recently, ZACP was awarded a new CoAg, which intends to scale up and synergize the invested efforts by the Zanzibar MOHSW and the government at large. This also builds upon a five-year experience of implementing PEPFAR supported HIV/AIDS program funded through the CDC. Through this support, HIV related services and interventions will target all HIV infected Zanzibaris living in the five regions and 10 districts of Zanzibar with a special focus on the key populations.

ZACP has developed a one-year costed M&E plan based on its M&E framework, which will be used to track the progress of the proposed activities. A car will be purchased to support outreach services for key populations. Explorations into this has shown that buying a car would be half the cost if the car was to be rented.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Military Population

TB

Workplace Programs

Family Planning

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	13355 ZACP Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

Home-based care (HBC) is recognized as one of the key interventions for persons infected with HIV. While HBC services on Zanzibar strive to be comprehensive in all ten districts, the care is not comprehensive, quality varies considerably, and does not include all of the components that are now standard-of-care for HBC. To-date, 123 health facilities provide home-based care services within 10 districts, while more than 204 health care providers and 270 HBC community volunteers have been trained and are involved in the provision of HBC services. ZACP intends to use these funds to ensure provision of comprehensive and quality care is at all levels by coordinating and harmonizing HBC implementation in Zanzibar.

The community HBC providers are working under the supervision of facility based providers. ZACP will develop and roll out a quality framework for HBC services to ensure that all of the components are now standard-of-care, including the offer of HIV counseling to family members and close linkages with prevention and care services are delivered consistently and with quality. Attention will be paid to

strengthening of community-based activities in particular.

ZACP will hold coordination meetings for HBC stakeholders at all levels that will serve as a platform for sharing experiences and identifying and disseminating innovative approaches. ZACP will also provide guidance in the implementation of HBC services through development of different strategic documents, including an HBC strategic plan, SOPs and training materials for HBC, and conducting comprehensive supportive supervision to regions, facilities, and non-governmental implementing partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	8,682	0

Narrative:

The Zanzibar Ministry of Health and Social Welfare (MOHSW) has adopted the WHO TB/HIV Collaborative Policy Guidelines, which address TB and HIV jointly. The Policy guidelines clearly demonstrate the need to fight the dual epidemics and provide the basis for action in collaborative TB/HIV activities by the Zanzibar TB and Leprosy Program (ZTLP), the Zanzibar AIDS Control Program (ZACP), and other stakeholders to work synergistically to reduce the burden of TB/HIV co-infection. ZACP will finalize, print, and distribute adopted WHO (and Mainland) guidelines and patient monitoring system (PMS) tools to support training of health care providers on the new PMS tools and strengthen collaboration between ZACP, NTLP, GFATM, and other stakeholders involved in TB/HIV interventions. Support will continue to be coordinated at the national level.

With these funds, ZACP, in collaboration with ZTLP, will scale up and improve collaboration and coordination of TB/HIV activities. The ZACP will continue to utilize the existing health workers by integrating collaborative TB/HIV activities in facility health care services plans. Health care workers from TB clinics and CTC will be trained on TB/HIV collaborative activities using national policy guidelines and training curricula. The program will conduct awareness of TB/HIV co-infection campaigns for patients, staff, and communities by developing, printing, and distributing TB/HIV IEC materials. This will encourage TB patients to get tested for HIV and empower HIV infected patients to demand TB screening routinely.

ZACP, in collaboration with ZTLP and other implementing partners, will continue to sensitize the community on TB/HIV by enhancing ex-TB/HIV patient clubs and promoting community leaders, including adding a TB/HIV component into primary and secondary school health subjects. ZACP will ensure printing and distribution of TB screening tools among care and treatment sites. ZACP will also ensure the incorporation of pediatric TB services into all the TB/HIV activities and observe gender mainstreaming.

Biannual meetings will be conducted between ZACP and ZTLP staff to enhance collaboration between the two programs and increase referrals and linkages between CTC and TB clinics. TB/HIV "under one roof" services will be improved and scaled up to other TB diagnostic centers. ZACP and ZTLP, in collaboration with other partners, will continue scaling up the 3I's at Mnazi Mmoja Hospital and Chake-Chake Hospital as pilot sites with the possible expansion into new two sites.

The funds will also be used to build capacity of ZHMTs and CHMTs in the implementation and monitoring of collaborative TB/HIV activities. ZACP will ensure ZHMT and CHMT include TB/HIV activities in their Comprehensive Council Health Plan (CCHP) to encourage sustainability and ownership. The program has already adopted the revised PF and PEPFAR II indicators. In addition, an M&E plan and tools have been updated to incorporate revised indicators. The indicators will be reported quarterly at district, zonal, and national levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The Strategic Information (SI) Unit of the ZACP is the custodian of health sector HIV data in Zanzibar. The unit is mandated to coordinate, collect, store, retrieve, and analyze various types of data for planning and policy formulation. Simultaneously, the unit has good capacity for data handling; hence, it will complement efforts of the HMIS unit within MOHSW within the production of health data required by stakeholders.

The SI Unit provides data collection tools on care and treatment, PMTCT, HIV counseling and testing, home-based care, laboratory, STI services, and HIV surveillance. Support under this application will help to continue and consolidate these efforts and increase capacity to monitor and evaluate HIV/AIDS interventions and services in Zanzibar.

The SI Unit is working in collaboration with other ZACP units to better link health sector HIV information to the national HIV data set. Data are collected from public, private, and CBO health facilities. ZACP also collaborates with other government ministries, local and international organizations, and technical experts to implement SI activities.

SI activities supported under this program include antenatal clinic (ANC) surveillance and M&E capacity strengthening among program staff and district healthcare workers, which are aligned with

implementation of the HIV/AIDS M&E framework.

ANC HIV surveillance will be repeated at 20 sites using the PMTCT approach. Additionally, trend analyses will be performed on three data points (2008, 2010 and 2012) for those sites which participated in the three previous rounds of ANC. ANC surveillance data will be compared to PMTCT counseling and testing data in order to assess the feasibility of replacing ANC surveillance with PMTCT as the main source of data for monitoring the HIV epidemic in the general population in Zanzibar.

Human capacity development is being targeted through in-country trainings as well as external opportunities. The SI team conduct trainings for unit coordinators and health care workers from health care facilities on data management, basic epidemiology and specific research methods, monitoring tools and data management for ANC/PMTCT comparison study. A workshop on data auditing and verification will take place for district data managers. The program will encourage participation of SI staff in regional and international trainings and conferences; in addition, mid- to long-term SI capacity building opportunities will be explored, including linkages with Training Program in the Fields of Epidemiology Laboratory (FELTP) in Dar and Monitoring and Evaluation in Ethiopia.

As for implementation of the health sector HIV M&E framework, it has been translated into an operational plan in year one. Operationalization of the framework has commenced on sensitization of health care workers and stakeholders on the M&E plan, guidelines and standard indicators. As mentioned above, capacity building for health workers in data use, and adaptation of data collection tools on all ZACP projects will be done in this year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	0	0

Narrative:

Zanzibar National Blood Transfusion Services is responsible for the collection of blood by relying on voluntary, non-remunerated donors and the safe processing, storing, and distribution of safe blood and blood products to health facilities. It is also responsible for advocacy, training, and monitoring the appropriate utilization of blood and its products in the hospitals. The overall program goal is to establish, strengthen, and sustain a nationally coordinated blood transfusion system in order to ensure availability of an adequate supply of safe blood from voluntary, non-remunerated donors from low risk populations. By June 2014, the Zanzibar National Blood Transfusion Services objectives are to increase access and utilization of safe blood and products and strengthen the quality management system.

To increase accessibility and utilization of safe blood and products, the following activities will be

implemented:
(1) Mobilize and collect enough blood to increase coverage to 6,500 units per year;
(2) Scale up blood components production to 40%;
(3) Strengthen the blood collection and distribution satellite center;
(4) Fractionate 10% of blood and components into pediatric units;
(5) Roll out training to clinicians on rationale use of blood and components;
(6) Train more staff on counseling so as to multi-task, such as increase post donation counseling to 65% and attracting more safe donors;
(7) Train staff on customer care to improve donor and other clients care;
(8) Create and support more in and out of school donors clubs to increase pool of safe donors; and
(9) Develop and implement donor recognition guidelines.

Strengthening the quality management system will require the following activities:
(1) Strengthen proper use of donor questionnaire and counseling in order to reduce HIV and other TTIs prevalence;
(2) Review and implement testing algorithms in serology and TTIs test and implement proficiency testing (with NBTS);
(3) Undertake EQUAS, IQAS, and NQAS each year;
(4) Develop and implement SOP competency assessment and training packages;
(5) Develop and implement NBTS national GMP guidelines;
(6) Implement use of preventive maintenance and other guidelines;
(7) Develop and implement safety and waste management guidelines;
(8) Prepare and implement disaster management plans; and
(9) Procure needed equipments for laboratory and BECS.

3. Financial management and sustainability strengthened by 2014. Its activities are: 3.1 Computerization of financial recording and reporting system
3.2 Develop and implement revenue generation strategy
3.3 Perform Blood unit cost estimate
3.4 Develop Plan and Implement cost recovery mechanism
3.5 Advocate for increased government and other source of funding

4. Strategic linkages expanded and strengthened by June 2014. Its activities: 4.1 To implement existing and establish 2 new technical linkages and partnerships internally and externally (e.g. exchange

program, linkages with relevant programs)
4.2 Regularly participate in stakeholders meetings
4.3 Facilitate Quarterly meetings of National Transfusion Committee
4.4 Revive the 2 and establish 3 new hospital transfusion committees
4.5 Attend National and International Forums on Blood Transfusion Services

Taking into consideration that this Phase aims at strengthening the systems and sustainability, new strategic plan with above objectives was recently formulated to address this need.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

Surveillance conducted with pregnant women in antenatal care (ANC) settings has documented an HIV prevalence of <1% on the islands. Higher HIV infection rates have been documented among women compared to men (5:1 respectively). At the same time, data has shown an annual increase in the number of clients diagnosed as HIV-infected. Studies conducted with key populations such as female sex workers (FSW), people who inject drugs (PWID), and men who have sex with men (MSM) revealed HIV prevalence up to 16% among these groups.

Based on this data, it is necessary to raise public awareness about behaviors that put individuals at the risk of contracting or transmitting HIV and other sexually transmitted diseases. The likelihood of transmitting HIV is greatly increased for those who have multiple, casual and/or high-risk sex partners, and engage in unprotected sex. All sectors at the various levels are involved in enhancing public awareness, particularly at the community level, to empower the community to develop culturally appropriate approaches in prevention of HIV transmission. These include being faithful to the same partner, practicing abstinence, and delaying engagement in sexual debut among youth. At the same time, use of and access to HIV services among key populations need to be promoted with faith-based organizations and communities playing an important role in both promoting service up-take as well as assisting with reduction of stigma and discrimination that are affecting these groups. Support to functional youth and faith-based initiatives that positively promote abstinence, faithfulness, partner reduction, and delayed sexual debut as well as assist with promotion of effective biomedical services and reduction of stigma and discrimination in a holistic manner are recognized as an important strategy for the prevention of HIV among Zanzibaris.

Activities will be implemented in collaboration with teachers and faith-based leaders currently working with ZACP. These leaders are interwoven with and supported by community members. As a result,

their activities are propagated and sustained. At the same time ZACP has started a process, with the assistance of a PEPFAR/CDC funded technical assistance (TA) partner, to build capacity among ZACP technical staff across program areas and to improve the quality of information education and communication (IEC) materials developed by the program. An IEC Officer has recently been recruited to support these activities and improvements.

The activities and produced materials will play a particularly important role in increasing the demand, up-take, and adherence to effective HIV interventions and treatment. Monitoring and evaluation will continue to be conducted quarterly and performance be reported during quarterly progress reports as well as during annual/semi-annual PEPFAR progress reports.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

The ZACP Counseling Unit (CU) coordinates the Zanzibar HIV testing and counseling (HTC) program through development of policies and guidelines, training protocols and manuals, and standard operating procedures and job aides. ZACP also provides supervision and technical guidance to HTC implementing partners, strengthens training of counselors to secure the required quantity and quality of services, and monitors the progress of implementation of HTC services through reports from district authorities, NGOs, and other stakeholders. While quality assurance (QA) efforts are lead by the laboratory unit, the HTC staff participates in HTC QA activities.

Through support provided under this agreement, past accomplishments include the development of the Zanzibar HTC guidelines and training manuals; the establishment of provider initiated testing and counseling (PITC) services at various hospitals, health centers, and primary health care units; training of health care workers in PITC; establishment of an HTC coordination forum; procurement and distribution of HIV kits for HTC service sites; and production and distribution of IEC materials to promote HTC. All these activities will continue into the next funding cycle with particular attention being paid to implementation of PITC in services, such as TB and STI clinics, where the proportion of HIV-infected and/or high risk clients is likely to be high.

In FY 2012, establishment and provision of HTC services that provide easier access to HTC services for key populations, such as sex workers (SW), people who inject drugs (PWID), and men who have sex with men (MSM) will be strengthened. This will include the increased use of mobile HTC strategies. For individuals testing HIV-positive, linkages will be made with various programs, including palliative care/home-based care and HIV treatment. Work will be completed in collaboration with various

implementing partners including, ICAP, CHAI, Global Fund, and other ART and TB partners.

ZACP will continue to support integration of HTC in HMIS and training on M&E tools. ZACP will also provide support in the use of the tools in day-to-day operations. All supported sites will use MOHSW daily registers and monthly summary forms, which will harmonize recording and reporting of HTC services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Surveillance conducted with pregnant women in antenatal care (ANC) settings has documented an HIV prevalence of <1% on the islands. Higher HIV infection rates have been documented among women compared to men (5:1 respectively). At the same time, data has shown an annual increase in the number of clients diagnosed as HIV-infected. Studies conducted with key populations such as female sex workers (FSW), people who inject drugs (PWID), and men who have sex with men (MSM) revealed HIV prevalence up to 16% among these groups.

Based on this data, it is necessary to raise public awareness about behaviors that put individuals at the risk of contracting or transmitting HIV and other sexually transmitted diseases. Combined with outreach efforts, condom promotion and distribution and the use of and access to HIV services among key populations need to be promoted with faith-based organizations and communities playing an important role in both promoting service up-take as well as assisting with reduction of stigma and discrimination that are affecting these groups.

ZACP will facilitate special clinical services for key populations at times of the day that are easily accessible to PWID and other key groups. The clinic will have a welcoming environment, offering services for STI, TB, and HIV care and treatment. In collaboration with the management of correctional facilities, ZACP will also establish similar services in correctional facilities. To complement static facilities offering the specialized services, ZACP will collaborate with NGO stakeholders to offer outreach HTC and relevant clinical services through a mobile facility.

In addition, ZACP has started a process, with the assistance of a PEPFAR/CDC funded technical assistance (TA) partner, to build capacity among ZACP technical staff across program areas and to improve the quality of information education and communication (IEC) materials developed by the program. An IEC Officer has recently been recruited to support these activities and improvements.

The activities and produced materials will play a particularly important role in increasing the demand, up-take, and adherence to effective HIV interventions and treatment. Monitoring and evaluation will continue to be conducted quarterly and performance be reported during quarterly progress reports as well as during annual/semi-annual PEPFAR progress reports.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

Drug use plays a key role in the HIV epidemic in Zanzibar, whereby studies conducted in 2007-2008 have found HIV prevalence of 0.6% in the general population and 16% in people who inject drugs (PWID) on the main island of Unguja. ZACP is implementing a multi-year PEPFAR/CDC funded project aimed at creating an enabling environment and strengthening provision of effective HIV prevention, care, and treatment services on Zanzibar with specific interventions for PWID and other key populations. Specifically, the project fosters innovative approaches to offer the UN-recommended comprehensive package of services for HIV prevention and care for PWID, including outreach, condom promotion and distribution, HTC, STI screening and management, TB screening and treatment, overdose treatment, as well as linkages into ART for HIV+ PWID services.

The main focus is clinical services for PWID, which fall directly under ZACP's mandate under the Ministry of Health. The project will provide a forum in which ZACP, in collaboration with partners in HIV prevention and with PWID involvement, will continue to develop or improve tools, materials, standards, and guidelines for implementing and monitoring of HIV intervention and services for PWID.

Under this project, the ZACP, in collaboration with various stakeholders, is developing a plan for the provision of drug dependency services for PWID in Zanzibar that will contribute to reduction of HIV transmission and improve health outcomes for male and female PWID. This plan includes training of health care workers to provide comprehensive services for PWID, such as assessment of individual substance abuse and other risk factors, provision of HTC services, screening and treatment of STIs, condom promotion and distribution, injection use related risk reduction strategies, treatment for drug related emergencies, and the provision of medically assisted treatment services. This plan also includes initiation of a pilot site for provision of medication assisted treatment (MAT) to 100 clients with opioid addiction in Unguja, where initial studies identified the highest concentration of this population.

On-going surveillance will determine future MAT scale-up. Pangea will be contracted as the technical assistance (TA) provider for guidelines, protocol, and material development. ZACP will facilitate special clinical services for key populations at times of the day that are easily accessible to PWID and other key

groups. The clinic will have a welcoming environment, offering services for STI, TB, and HIV care and treatment. In addition, screening services for viral hepatitis will be introduced and hepatitis B vaccination will be offered to individuals who are found to be uninfected. In collaboration with the management of correctional facilities, ZACP will also establish similar services in correctional facilities. To complement static facilities offering the specialized services, ZACP will collaborate with NGO stakeholders to offer outreach HTC and relevant clinical services through a mobile facility.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	171,000	0

Narrative:

Currently, there are 50 sites at the RCH clinics providing PMTCT services (33%). In the coming years, ZACP aims to further expand PMTCT services in antenatal clinics (ANC) and maternity hospitals with the goal of achieving 80% of all pregnant women tested and 85% of those who are HIV positive to receive interventions. To achieve this goal, ZACP is planning to strengthen existing services as well as scale up availability and accessibility of PMTCT services in the islands.

PMTCT services will be established in 100 RCH clinics after a needs assessment is conducted. The qualified clinics will be supplied with HIV test kits, vacutainer tubes, protective gears, haemacue machines, and drugs, which include cotrimoxazole and ARVs for prophylaxis.

A minimum of one PMTC provider will be trained on PMTCT services in each new site, while 90 health care providers will be placed in Unguja and 60 in Pemba. Within the old sites, health care workers will receive refresher training to orient them with the revised PMTCT guidelines that have incorporated the new WHO recommendations. PMTCT providers will also receive other supportive trainings, including training on family planning and infant feeding. PMTCT guidelines and job aids will be printed and distributed to all sites. PMTCT sites will receive ARVs for prophylaxis from the nearby CTC sites and transport allowance will be provided to health care providers sending samples for CD4 testing.

Using a standard supervision tool, supportive supervisions will be conducted bi-annually followed by supportive meetings with PMTCT staff to discuss different issues related to PMTCT implementation with the main objective of increasing the quality of services. PMTCT coordinators will receive a short course of training on management to help strengthen the staff capacity at the central level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

HIV care and treatment services were initiated in Zanzibar in 2005. By 2010, eight ART clinics were operational in both Unguja and Pemba. All of the eight clinics carry out HIV testing with four of the clinics carrying out full-blood tests (FBT), including CD4 counts. Of these eight clinics, seven are public and one is a private health facility. The USG is one of the main supporters of treatment services in Zanzibar, through assistance to the ZACP at the national level as well as direct support at points of service through local and international implementing partners. Through this funding opportunity, ZACP will improve accessibility of care and treatment services by scaling-up treatment services, specifically the decentralization of services to the lower-level health centers, and empowering local health authorities to oversee the expansion of these services. $250,000 will specifically go toward the initiation of early treatment for the focus groups in Phase I of rolling out the new WHO treatment guidelines. To achieve this, ZACP will train more health care workers who work in potential health facilities for care and treatment services on comprehensive HIV/AIDS management, including adult and pediatric ART training, training on adherence counseling, and post exposure prophylaxis. Through quarterly supportive supervision and mentorship program, ZACP will monitor the quality of services and clinical outcomes, such as percent of adults and children who are still alive and on treatment at 12 months after initiating ART, number of adults and children currently on ARVs, and number of adults and children newly and ever enrolled in care and treatment clinics. Special efforts will be placed to track lost to follow up patients using educators and by strengthening collaboration with home-based care providers through quarterly coordination meetings. Funds will also be used for implementation of the new WHO treatment guidelines. A pilot study will be conducted at Mnazi Mmoja CTC to evaluate feasibility of identification and optimal management of HIV/HBV co-infection.

Implementing Mechanism Details

Mechanism ID: 13359	**Mechanism Name: ITECH**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 5,147,960	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
GHP-State	5,147,960

Sub Partner Name(s)

(No data provided.)

Overview Narrative

I-TECH's goal is to build the necessary HR and infrastructure capacity for training HCWs to provide quality health services, including HIV. The objectives include strengthening ZHRC system's capacity to manage in-service trainings; supporting MOHSW to increase the number of qualified HCWs; strengthening MOHSW and other partners capacity to use TrainSMART; strengthening pre-service schools to produce competent HCWs; building capacity of regional and district health teams to train HCWs in PITC; and strengthening distance education. I-TECH's goal and objectives contribute to all six goals of the Partnership Framework, with emphasis on Goal 2 with (prevention); Goal 3 (leadership, management, accountability, and governance); and Goal 5 (human resources).

Due to I-TECH's support of MOHSW at national and zonal levels, coverage of projects is national. I-TECH collaborates with MOHSW staff at the national, zonal, and regional levels in planning and implementation of its activities. M&E is done through site visits, supportive supervision, regular progress reports, and assessments in collaboration with MOHSW counterparts. This ensures local ownership and facilitates transition of programs. Transition of activities is underway in ZHRC, pre-service and PITC programs; transition plans for all programs will be included in COP 12.

While continuing its emphasis on high-impact, sustainable programs focusing on pre-service education, I-TECH will also develop innovative approaches to in-service trainings, including training staff at district level, exploring e-learning modalities, and emphasizing on-site training through supportive supervision and mentoring.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	5,047,960

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	13359		
Mechanism Name:	ITECH		
Prime Partner Name:	University of Washington		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	186,930	0

Narrative:

The TB/HIV program aims to increase the capacity of health care workers to provide quality TB/HIV care and treatment services. In FY 2012, I-TECH will disseminate the results of a TB/HIV training evaluation expected to take place in FY 2011. Based on the results, I-TECH will collaborate with NTLP, PATH, ICAP, USAID, and other partners to revise the TB/HIV training and develop refresher TOT training materials.

I-TECH will also support the MOHSW-NTLP efforts in the on-going 3Is pilot by developing and printing 500 copies of TB/HIV and 3Is Standard Operating Procedures (SOP). In collaboration with NTLP, NACP, and other TB/HIV partners, I-TECH will draft the SOP outline based on the national approved TB/HIV and 3Is guidelines and training packages. Several TWG meetings will be organized to review the outline and content of the SOP. The team will also support MOHSW to train 25 pre-existing national, regional, and district TB/HIV trainers on the TB 3Is package. I-TECH will work with NTLP to follow up the 3Is trainers to assess effectiveness of teaching skills in the delivery of the 3Is course.

In FY 2011, the project was able to develop the TB 3Is training package for health care workers and trained 20 tutors from health training institutions on the TB/HIV content and drafted TB/HIV training evaluation protocol. This project is aligned with the MOHSW policy (revised in 2007) and the Health Sector Strategic Plan III (July 2009 - June 2015), the Five-Year Partnership Framework in Support of the Tanzania National Response to HIV and AIDS (2009 - 2013), the National TB and Leprosy Program Strategic Plan (2009 - 2015), and the National TB/HIV Policy Guidelines (2007). The Policy guidelines clearly demonstrate the need to fight the dual epidemics and provide the basis for action in collaborative TB/HIV activities by the National TB and Leprosy Program (NTLP), the National AIDS Control Program (NACP), and other stakeholders to work synergistically to reduce the burden of TB/HIV co-infection by strengthening the capacity of health care workers to provide quality TB/HIV care and treatment services.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	230,000	0
Narrative:			
In FY 2012, I-TECH, in collaboration with MOHSW, medical laboratory universities, and medical laboratory health training institutions in Tanzania, will continue to strengthen laboratory training for faculty and pre-service students who have an interest in becoming laboratory tutors. These efforts will contribute to creating skilled laboratory tutor graduates who in turn will train laboratory health workers at health training institutions. I-TECH will continue to support 17 medical laboratory students (15 Bsc and two Msc) at KCMC, Bugando, IMTU and Makerere Universities. Of the 17 students, 10 BSc and two MSc students will graduate in FY 2012. I-TECH will also support two full-time tutors to teach at laboratory training institutions.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	3,980,000	0
Narrative:			
I-TECH supports MOHSW to build human resources capacity and infrastructure for HCWs to provide quality HIV services through pre-service training (PST), human resource for health scale-up (HRHS), zonal health resource centers (ZHRCs), distance learning (DL), and TrainSMART (TS) programs. I-TECH has made significant contributions in the finalization of the standardized training materials for clinical assistants and clinical officers (CA/COs), hiring of tutors to support PST scale up, strengthening ZHRCs, development of DL bridging courses for CAs to upgrade to COs, and in piloting TrainSMART in two ZHRCs.			

The program will work with MOHSW and partners to build ZHRC's capacity to coordinate, implement, monitor, and evaluate pre- and in-service training. I-TECH will work with ZHRCs to support pre-service health training institutions (HTIs) by training some tutors on teaching methods and others on training coordination and logistics. A few tutors will also be trained on supportive supervision (SS) and mentoring key ZHRC/HTI staff on leadership and management, including financial and library management. I-TECH will also support ZHRCs to conduct stakeholders and annual ZHRC coordinators meetings and, while also building their capacity in M&E. Three PC volunteers and two zonal field officers will be supported to help strengthen ZHRCs.

The pre-service program works with MOHSW to develop and strengthen pre-service curricula and build tutor capacity in classroom and clinical teaching. Support will be provided to MOHSW to develop harmonized faculty development packages. M&E activities will receive high priority to ensure quality classroom and practical teaching. In FY 2012, I-TECH will develop the curricula for upgrading AMOs/COs to a Bachelor in Clinical Medicine (BCM) and strengthen the capacity of tutors and clinical instructors in collaboration with JHPIEGO.

I-TECH will collaborate with MOHSW to develop standardized DE training materials and orient tutors to the new materials. Support will be provided to build the capacity of tutors in DE teaching and student assessment skills, whereas options to pilot e-learning materials will also be explored.

In FY 2012, TS will expand to more USG partners, regions, and districts. New users will be trained on registration forms with online and offline database versions. I-TECH will build capacity of the ZHRC staff and regional and district continuing education officers to use TS data for decision-making, while the ICT officers will be trained to provide technical support. I-TECH will also work with USG partners who train community health workers on TS. I-TECH will mentor selected RMOs and DMOs to use TS for reporting, budgeting, and participant selection.

I-TECH's HRHS program will collaborate with MOHSW and partners to develop a plan for mainstreaming up to 49 full-time tutors at nursing and CA/CO schools into the government service. CDC and I-TECH will work together, with a minimum of three pre-service training institutions, to increase their throughput by providing furniture, supplies, and student aid. I-TECH will also collaborate with MOHSW and CDC to prioritize HTIs for infrastructure development to scale-up enrollment. Support will be provided to a few I-TECH-hired tutors to earn a diploma in health personnel education at CEDHA. In addition, support will be directed to MOHSW to harmonize curricula of the three tutor training institutions (Bugando, Muhimbili, and CEDHA).

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	540,000	0

Narrative:

In collaboration with NACP, Morogoro Health Authority, and FHI, I-TECH will continue to provide technical assistance to Morogoro region on PITC in health care facilities. Morogoro region has an HIV prevalence rate of 5.1% and targets to test about 25,000 clients. Since 2008, I-TECH has trained 804 out of 2,055 HCWs in Morogoro region with a long-term objective of continuing to transition training activities to the districts. In FY 2012, I-TECH will provide financial and technical support to two districts to train 60 HCWs. Technical assistance will be provided to the remaining four districts for training HCWs that expect to get funds from the Basket Fund. I-TECH will also support the NACP on strengthening HIV couples testing and counseling (HCTC) by enhancing or developing relevant HCTC materials, including training and job aid materials. In addition, I-TECH will collaborate with NACP to provide support to the districts for on-site training of 20 HIV counselors and PITC trainers on HCTC. I-TECH expects that by the end of FY 2012, PITC services to 22,880 clients will have been provided.

I-TECH will support districts in preparing for transition and sustainability of PITC activities. Twenty district health managers will be trained on coordination and logistics as provided by I-TECH and NACP. Moreover, 20 HCWs selected by the districts will be trained on HIV/AIDS mentoring and supportive supervision. These HCWs will be used by the region and districts to support effective implementation of PITC training.

Financial support will also be provided to RHMTs and CHMTs to conduct supportive supervision to monitor the quality of services. I-TECH will support an annual review meeting where selected PITC implementers and managers will come together to share experiences and challenges. Districts will be encourged to budget for training and supportive supervision activities. In addition, I-TECH will compile PITC overview reports and share them with CDC and MOHSW. Capacity of CHMTs in PITC data management using national tools and protocols will continue to be built.

In collaboration with NACP, John Hopkins University, Stradcom, and other media groups, I-TECH will develop various targeted HIV messages. I-TECH will also support Morogoro region to participate in the commemoration of World AIDS Day.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	40,000	0

Narrative:

In its efforts to coordinate and manage trainings, ITECH has introduced a web-based tool for monitoring and reporting training activities, called TrainSMART. The tool helps to strengthen coordination and

management of in-service training. Currently, ITECH is working with MOHSW and its institutions including National Aids Control Program, National TB and Leprosy Program, RCH, and PMTCT programs as well as USG training partners (particularly Track 1 partners) and Zonal Health Resource Centers to input their training data into the system.
In FY 2011, ITECH introduced the tool to partners by assessing each partners' need, which was followed by customizing their needs into the system and training them on how to use the system. All partners were able to enter and report training information into the system as well as export the data from TrainSMART into the PEPFAR PROMIS system. Trainsmart has enabled the MOHSW to have a standardized tool to report on the national- approved HIV/AIDS in-service training.

For COP 2012, I-TECH will build the capacity of approximately 25 PMTCT staff from the POHSW and USG-funded PMTCT partners to enter data online and generate training reports using the new version of TrainSMART. I-TECH will also provide technical assistance and refresher trainings to address TrainSMART new releases, and to introduce an offline version to NACP and PMTCT. These trainings will help the vertical programs to collect and enter training data in the database at training sites, which are often in areas with limited internet access.

I-TECH will conduct "data for decision makers" capacity building on TrainSMART to 10 MOHSW vertical program staff. This capacity will be offered to selected high profile individuals at each of the vertical programs using TrainSMART. Finally, I-TECH will conduct quarterly follow up visits to the vertical programs to address any issues or difficulties encountered with the new version.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	171,030	0

Narrative:

As part of the efforts to support the decentralization of ART trainings to districts during FY 2012, I-TECH will collaborate with ZHRCs, NACP, FHI, ICAP, MDH, and other ART training implementing partners to provide technical assistance to Central and Eastern ZHRCs to conduct TOTs to 20 district-level trainers. The partners, in collaboration with the District Health Authority, will identify the trainers. In addition, to strengthen decentralization of ART training and improve the implementation of effective ART services, I-TECH will collaborate with the previously mentioned partners to provide TA to Central and Eastern Zones by training 40 health care workers on HIV health services (including ART), supportive supervision, and clinical mentoring. Trained HCWs will in turn support training, supportive supervision, and clinical mentoring activities in the districts, which will be specified in the Comprehensive Council Health Plans for each respective district/council.

To promote transition, local ownership, and sustainability, ZHRCs will take a leading role in training coordination and logistics. ZHRCs will also be encouraged to use the existing resources within their zones, including health system structures and inventory of human resources, for improved efficiency and cost effectiveness.

Implementing Mechanism Details

Mechanism ID: 13518	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13553	**Mechanism Name: FBO TA Provider**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Balm in Gilead	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 629,300	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	629,300

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Balm in Gilead (BIG) works to enhance and strengthen the capacity of national faith-based organizations (Tanzania Interfaith Partnership/TIP) to respond effectively to the impact of HIV/AIDS in Tanzania. The overall goal is to contribute to efforts to reduce HIV/AIDS transmission and help mitigate the effects of the epidemic. The program addresses key priorities identified in Tanzania that respond to emerging needs, integrating prevention with continuum of care, while monitoring and evaluating services

for quality in order to support indigenous responses, local government strategies, and community sustainability.

BIG works with FBO networks in the eight regions of Dar es Salaam, Mtwara, Lindi, Shinyanga, Mara, Dodoma, Singida, Kigoma, Iringa), and Zanzibar. The ability of FBO networks to mobilize communities with limited resources offers a critical entry point for HIV/AIDS service provision. However, effective service provision, in contrast to the ad hoc 'culture of donation' in which many religious institutions are rooted, requires a paradigm shift towards systematic project management and accountability, which is a new concept for many FBOs.

BIG responds to the challenges faced by FBO network members of both capacity building and technical assistance for TIP. Systematic organizational and leadership development is a key component of BIG's strategy. The OD model seeks to engage FBOs with effective management structures, financial and grants administration, systems and programmatic planning, implementation and reporting systems, and effective delivery of services and mobilization. BIG's exit strategy includes plans with TIP partners that monitor progressive milestones, which are reviewed and monitored annually, towards achieving sustainability.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID:	13553		
Mechanism Name:	FBO TA Provider		
Prime Partner Name:	Balm in Gilead		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	97,150	0

Narrative:

BIG will continue to provide technical guidance to Tanzania Interfaith Partnership (TIP) in implementation of community home-based care services to PLWHAs and their families in Kigoma region. BIG will also strengthen the capacity of TIP partners to provide integrated and high quality HBC services to PLWHAs from the time of diagnosis throughout continuum of care. This program is in line with the PF that guides the USG and URT's HIV/AIDS response.

To ensure client retention and referrals, BIG will strength the linkages of this program with care and treatment sites, ICAP's facility-based HBC program, and regional and council health management teams (RHMT and CHMT). This will enable tracking of clients from the community up to the facility and vice versa, building synergy within the system tolenhance quality of care to PLWHAs. The BIG will further continue with capacity building to TIP's partners in the implementation of Positive Health Dignity and Prevention (PHDP) by providing training to TOT who will go and train HBC service providers at community levels. This will go hand in hand with linking this program to other providers of PHDP supplies and commodities, including PSI's WASH products, FANTA 2 for food and nutrition support, and IMARISHA Program for income generating activities.

Balm in Gilead will provide TOT for FBO network staff in community sensitization and strategies to reduce stigmatization and marginalization of PLWHAs that include knowledge about availability of and access to services. BIG will also provide technical assistance to TIP in the designing of the training to HBC volunteers and service provision to PLWHAs, support to clinical services and referral system. In

service provision, technical assistance will strongly emphasize linkages between PLWHAs, HBC volunteers, and facility-based care.

In the monitoring of quality of care and support services, the project will use NACP tools and guidelines in the provision of community HBC. The service providers will be trained by NACP certified trainers and will use NACP's HBC training guideline to train the providers. The technical oversight will be provided to monitor HBC activities, including updating of monitoring toils to improve the performance of persons providing care and ensure uniformity, monitoring of adherence to national guidelines and service standards that include the national HBC reporting system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	97,150	0

Narrative:

Balm In Gilead (BIG) will continue to support and provide technical assistance (TA) and guidance to Tanzania Interfaith Partnership (TIP) in implementing and supporting MVC/OVCs and their households, which is aligned with the USG/URT's Partnership Framework.

The main goal for TA provision is to enable TIP to support a total of 4,000 MVCs/OVCs and families in Kigoma region (mainland) through evidence-based implementation that improves the knowledge base for the provision of effective care and support for children affected by HIV/AIDS. The target population to be supported would include, under age of 6: male 240, female 240; age 6-14: male 1200, female 1200; age15-17: male 480, female 480; and age above 18: male 80 and female 80. In addition, the program intends to support about 400 OVCs in Zanzibar.

Technical oversight will be provided to TIP to insure that the MVCs/OVCs interventions are aligned with the revised National Costed Plan of Action. Strategically, the TA to TIP-FBOs would focus on strengthening families as primary caregivers of children, supporting the capacity of communities to create protective and caring environments, building the capacity of social service systems to protect the most vulnerable, and allocating resources for children according to need in the context of HIV/AIDS.

TA in MVCs/OVCs intervention will include training of caregivers and MVCC facilitators, facilitation of MVCC capacity building, MVCs/OVCs nutrition enhancement, and household improvement.

In addition, TIP/FBO partners will be supported to ensure that program monitoring is in line with the national MVCs/OVCs M&E plan, an essential component of the National Costed Plan of Action. Trainings will be provided to local government authorities in Kigoma, TIP/FBOs, and the community on

updating and maintaining MOHSW's automated MVC/OVC data management System.

In FY 2011, the TA provider would carry out a mapping exercise and support establishment of child protection teams in MVCs/OVCs activities in the region, including training to the teams on child protection related issues that integrate appropriate monitoring tools as well as obtaining relevant training materials.

Supportive supervision to and across all implementation levels will be a key role for the TA provider to ensure effective and efficient implementation of the program. The TA provider will engage and orient TIP/FBOs and the communities to the use data as a way of making informed decisions for the beneficiaries and communities at large.

The FBO network has proved to be effective in supporting vulnerable children in their respective homes and localities, particularly in mobilizing and providing psychosocial as well as spiritual support. The TA provider plans to carry out an economic performance evaluation, which will be paramount to creating a sustainable community program. Getting every sector on board for the MVC/OVC thematic area has been a challenge, however, the current efforts by the URT advocating for the public-private partnership will bring more stakeholders closer to better understanding and supporting vulnerable groups towards becoming good active members of the society.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

The Balm in Gilead (BIG) will support the scale-up of the "Sasa Tuzungumze" (Time to Talk) intervention, an evidence based, community based, group-level behavior change intervention for couples who live among Muslim or Christian faith communities. In high prevalence areas of Africa, such as Tanzania, cohabiting couples (including married couples), make up a large proportion of the groups at risk from HIV-infection; the greatest risk for women in these unions are their husbands or regular partners.

The primary goal of the Sasa Tuzungumze intervention is to promote safer sex behaviors among married couples by improving the ability to communicate, increasing risk perceptions, encouraging male involvement, and promoting as well as providing access to HIV testing and counseling services. Attention will be paid to counseling and support to help reduce gender based violence.

BIG will support the scale-up of Sasa Tuzungumze, which will be implemented by the Tanzania Interfaith Partnership (TIP) and its partners, in three regions (Coast, Dodoma, and Kigoma). It is estimated that over 7,000 couples will be reached in the three regions with each couple attending a three day Family

Life Workshop. Key activities will include support for the training of Family Life Workshop facilitators and provide programmatic support for implementation of the workshops, including quality assurance and training of 40 additional facilitators. BIG will also work with TIP to ensure that the intervention is linked to service provision including couples HTC services.

BIG will work with Muhimbili University to conduct an outcome evaluation of the intervention, in partnership with TIP. In addition, BIG will work with TIP to support the implementation and M&E of the Families Matter Program (FMP). Tools for conducting routine monitoring of activities and summary reports will be used, while data quality will be assessed on a regular basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	135,000	0

Narrative:

The Balm In Gilead (BIG) will continue with strengthening capacity of TIP's partners in the area of community-based HIV testing and counseling (HTC), including an increased focus on couples, in Shinyanga region. The overall HIV prevalence of Shinyanga is 7.4% (8.4% females and 6.3% males (THMIS 2008), which is much higher than the national average of 5.7% (6.6% females and 4.6% males). The prevalence rate by marital status shows that in 1.2% both partners are HIV-infected, while around 4.5% the male partner is HIV-infected and around 3.5% the female partner is HIV-infected (THMIS 2008).

The program will continue using FBO networks to provide outreach and mobile HTC services where high risk groups are present, particularly those living in hard to reach areas or have no or limited facility-based HTC and services due to poor infrastructure. Balm in Gilead will provide technical support to TIP's partners to strengthen and scale up the use of churches and mosques as platforms for provision of education and HIV/AIDS services, including HTC with emphasis on couple HTC and support for discordant couples.

Technical oversight will be provided to TIP to ensure that interventions are aligned with the national guidelines, recommended approaches are strengthened, and that effective collaboration exist with the MOHSW and the National AIDS Control Program. For greater impact, TIP partners will also conduct activities that raise awareness, promote couples communication, reduce stigma, and promote HTC. Technical assistance in HTC will include linkages to MOHSW to ensure availability of HIV test kits, ensure TIP's partners adhere to standard operating procedures, that protocols for implementing HTC are applied, and facilitating linkages include referrals for HIV-infected clients to access HIV and health care, including ARV treatment for eligible patients and other social services.

BIG will assist TIP in providing close over-sight on data collection, information management, and monitoring using the approved national tools. TOT training for TIP's FBOs network will be supported to prepare couples' community mobilizers' trainings and activities. BIG will also provide technical assistance for the training of counselors to improve and upgrade skills in accordance with national guidelines and provision of refresher training for couples HTC.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	200,000	0
Narrative:			
The Balm in Gilead (BIG) will support the scale-up of the "Sasa Tuzungumze" (Time to Talk) intervention, evidence based, community based, group-level behavior change intervention for couples who live among Muslim or Christian faith communities. In high prevalence areas of Africa, such as Tanzania, cohabiting couples (including married couples), make up a large proportion of the groups at risk from HIV-infection; the greatest risk for women in these unions are their husbands or regular partners. The Sasa Tuzungumze program includes promotion of consistent and correct condom use as a key prevention component. Many of the FBO partners are willing and already involved in the implementation of this component. They also play an important role in advocating for open promotion of condom use with other religious leaders and within more traditional or conservative religious environments. In addition, special attention is being paid to working with couples living and/or working along transport corridors or hot-spots within the three target regions to address prevention issues and needs related to greater vulnerability and specific risk behaviors. Note: BIG does not provide direct services but rather provides technical assistance to an umbrella of faith based organization in the country.			

Implementing Mechanism Details

Mechanism ID: 13554	**Mechanism Name: FIND**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Foundation for Innovative New Diagnostics	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 11,852	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	11,852

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2012, Foundation for Innovative New Diagnostics (FIND) will be implementing a set of activities that aims to strengthen the quality of laboratory services in Tanzania. The recently WHO endorsed Xpert-MTB/RIF (Cepheid) real time based PCR system is a fully automated, walk-away system that requires minimal training needs and biosafety requirements for its implementation. Therefore, the aim is to use the system at the district and or sub district levels in the tiered laboratory diagnostic network. FIND will continue to facilitate the roll out of the Xpert/RIF novel rapid diagnostic tools at five additional testing sites, introduce a simple test related EQA scheme at all testing sites, and increase human resource capacity by providing trainings on Xpert/Rif.

The EQA of TB smear microscopy is the fundament of mycobacteriology laboratory services to identify patients with more advance and infectious disease forms and to monitor the efficacy of treatment. FIND aims to improve timely management and monitoring of blinded rechecking and panel testing-based EQA of AFB microscopy by a new AFB smear microscopy management software system.

Implementation of adequate biosafety measures are crucial to roll-out of novel TB diagnostics. FIND will organize a biosafety meeting specifically focusing on TB laboratory practices with hands-on and theoretical sessions. FIND's project approach involves country leadership that helps pave the way forward with discussions reviewing past policies and strategic plans that identify needs, gaps, and creation of timelines for project implementation.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	11,852

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

TB

Budget Code Information

Mechanism ID:	13554		
Mechanism Name:	FIND		
Prime Partner Name:	Foundation for Innovative New Diagnostics		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	11,852	0

Narrative:

The recently WHO endorsed Xpert-MTB/RIF system is a fully automated assay has an excellent sensitivity to detect TB and MDR-TB not only on smear positive but also on smear negative specimens, which allows the rapid testing of patients with paucibacillary TB, such as individuals with HIV. In FY 2012, FIND will support the continued roll out of the newly developed Xpert/RIF rapid molecular test and facilitate the site preparation, training of technicians, procurement of necessary equipments, and reagents for an additional five testing sites. This will be in addition to the three sites already planned for set up in FY 2011. The target will be to implement five GX4 machines at five testing sites, with the training of 10 technicians.

FIND will facilitate the implementation of a EQA panel testing method for Xpert/RIF to document proficiency after initial training, set up, and sustainability of testing quality at the end of the project. Monitoring and evaluation of results on the panels will analyze Xpert/RIF testing outputs, results, and assess impact to identify successes and challenges. FIND's exit strategy will include training local experts how to implement, monitor, and evaluate these activities. The target will be for all seven testing sites to pass panel testing.

The EQA of TB smear microscopy is the fundament of mycobacteriology laboratory services. The most accurate method of TB smear microscopy EQA is the blinded rechecking of slides of the peripheral laboratories at a higher level (district or regional) supervisory center. Timely examination of slides, accurate calculation quality indicators as well as the timely feedback of results, corrective actions, and related follow-up of laboratories is challenging. A large amount of date handling is associated to all these steps, especially if a third reading is also necessary to resolve discrepancies. FIND is proposing the implementation of a newly developed software (www.slide2check.net) that is aimed to support TB slide rechecking programs. The software system is allowing easy data management, monitoring, and reporting of all slide rechecking associated EQA activities in a rapid and user-friendly way. Training of the staff working at rechecking supervisory level will be conducted on the system. Job aids and a user manual will also be provided. The target will be to have the system piloted and finalized for local needs at 10 microscopy centers. FIND is organizing a three-day theoretical and practical workshop on TB laboratory biosafety. The TB specific curriculum that was piloted in India will provide lessons that will enable participants to learn to organize risk assessment, determine the biosafety level of their laboratories, and establish the related requirements. In addition, trainees will learn good laboratory practices to avoid aerosol generation when performing novel TB diagnostics, such as liquid cultures or DNA extraction for molecular testing, use and maintenance of safety equipment with samples containing tuberculosis, establish biosafety SOPs, and learn waste management of infectious materials with TB. At the end of the course, participants will develop the core components of a full laboratory biosafety manual that can be customized to their local needs at their testing sites. The target will be to train 15 laboratorians.

Implementing Mechanism Details

Mechanism ID: 13555	**Mechanism Name: FELTP**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Field Epidemiology Network	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 763,973	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	763,973

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Field Epidemiology Laboratory Training Program (FELTP) strengthens the capacity of the public health workforce in Tanzania to collect and use surveillance data to better manage programs, including national HIV/AIDS/TB/malaria programs, and strengthens laboratory support for surveillance, diagnosis, treatment, disease surveillance, monitoring, and HIV sc+B1 screening for blood safety. The program supports Goals 5 (HRH) and 6 (evidence-based and strategic decision-making) of the Partnership Framework strategy and is aligned with the GHI strategy focused on systems strengthening and country ownership. Activities have national coverage with primary target population being in-service health professionals who are trained in two-year masters' program and short courses. Strategies for cost efficiency include recruiting graduates of the program to provide mentorship and teaching for residents of TFELTP, supporting the equipping of the program library with key reference materials rather than supplying each trainee with personal reference materials, and recruiting local staff to the extent possible to keep personnel costs down. The transition strategy includes development of a close partnership with the MOHSW, participation of MOHSW in the biannual steering committee, participation of MOHSW in developing a graduate retention and career plan, and strengthening field sites through various partnerships, capacity building strategies and supply of essential materials such as furniture and computers. Monitoring and evaluation methods include use of EPITRACK, a software, among other methods of data collection.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	763,973

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	13555		
Mechanism Name:	FELTP		
Prime Partner Name:	African Field Epidemiology Network		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	763,973	0

Narrative:

Tanzania is faced with a challenge of inadequate human resources for health services. The lack of adequately trained personnel is often the most significant rate-limiting step in providing quality health and clinical services. In addition, there is an inadequate number of well-trained public health professionals (field epidemiologists, program managers, laboratory personnel, support staff, etc.) that have the capacity to collect and use surveillance data and manage national HIV/AIDS and other programs, as well as validate and evaluate public health programs to inform, improve, and target appropriate health interventions.

This mechanism focuses on providing training for health care professionals using two mechanisms: the two-year masters' program and the two-week short courses. Both modes of training are competency-based, focusing on performance improvement for participants in the training. The two-year training produces leaders in public health who can head government bodies and other private and public

entities, where they directly influence public health policy and action. The two-week short course empowers participants with skills to implement the policies formulated at the national level. The FELTP works closely with various departments within MOHSW, including the National Health Laboratory and programs like malaria, HIV/AIDS, TB/Leprosy, HMIS, and EPI. These provide potential field sites where trainees are posted to build their skills. Apart from CDC, FELTP has managed to secure support from various partners, including the World Bank who will give financial support to trainees on the laboratory track; the Pan Influenza Flu Group who supports strengthening FELTP training on influenza and other zoonotic diseases; PMI supports trainees' activities for malaria; and International Association of National Public Health Institutes (IANPHI) supports training activities for noncommunicable diseases. National Institute for Medical Research has provided training facilities and will enhance research skills, while Muhimbili University of Health and Allied Services will provide lecturers to teach trainees and accreditation of the two-year masters' training.

Implementing Mechanism Details

Mechanism ID: 13662	**Mechanism Name: TIBU HOMA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

African Medical and Research Foundation	Management Sciences for Health	

Overview Narrative

University Research Corporation (URC) implements "Tibu Homa," which is Swahili for "Treat Fever," in

the Lake Zone. The goal of the project is to reduce morbidity and mortality of children under-five years of age due to severe febrile illness. Through strategic linkages with other child health programs in the Lake Zone, Tibu Homa will target most vulnerable children, including those infected with HIV, with quality health services. The three main objectives of the program are to increase availability and accessibility to fundamental facility-based curative and preventive child health services; ensure sustainability of critical child health activities; and increase linkages within the community to promote healthy behaviors, thereby increasing knowledge and use of child health services.

Tibu Homa targets more than 1.3 million children under-five in Mwanza, Kagera, and Mara. The program is implemented in collaboration with the local government and aligned with national program priorities, responding to all of the Intermediate Results in the USG/T GHI strategy. The program emphasizes collaboration among partners to improve efficiencies and works with the private sector to promote corporate social responsibility. URC also helps regional and district health management teams to appropriately allocate and advocate for resources for child health. For effective monitoring and evaluation, the program trains regional and district officials in program M&E activities. An advantage for data collection and utilization is that the project M&E data management system is already linked to the national health management information system.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	20,000
Human Resources for Health	40,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID:	13662		
Mechanism Name:	TIBU HOMA		
Prime Partner Name:	University Research Corporation, LLC		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	400,000	0

Narrative:

URC is an international organization that primarily assists MOHSW in managing its national quality improvement (QI) program. Tibu Homa is a child health program that is being implemented in the Lake Zone to decrease child morbidity and mortality resulting from febrile illnesses. Through strategic program linkages with OVC and pediatric AIDS programs, Tibu Homa will target HIV-infected children health services as part of a continuum of care initiative aimed at improving the health and well-being of vulnerable children.

Tibu Homa is aligned with PEPFAR's OVC priority of enhancing program integration to maximize effectiveness, as demonstrated through collaboration with PACT and other partners to increase linkages between vulnerable households and facilities to improve health outcomes of most vulnerable children; providing technical assistance to OVC and pediatric care service providers in integrated management of childhood illnesses; and documenting best practices in health and HIV program integration and child-focused continuum of care programming. The strategies also respond to various GHI Intermediate Results, particularly of improving case management of children under five, improving health support systems, and improving early health care-seeking behaviors.

There is evidence that shows linkages between community and facility-based services are weak, resulting in inefficiencies and gaps in continuum of care services. Due to this information, program strategies are based on identified gaps in provision of continuum of care services for vulnerable children, particularly children under-five years old. Through enhanced community and facility linkages, increased

numbers of vulnerable children will be treated for malaria and other febrile illnesses, in addition to being identified for HIV testing and treatment, as needed. These interventions will result in improved health outcomes for vulnerable children, particularly for children under-five years.

Implementing Mechanism Details

Mechanism ID: 13774	**Mechanism Name: Tanzania Youth Scholars**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: International Youth Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 600,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	600,000

Sub Partner Name(s)

CAMFED	Kiota Womens Health and Development Organization	Vocational Education Training Authority

Overview Narrative

Tanzania Youth Scholars, a project implemented by IYF, will provide OVC aged 14-24 with employability and life skills to successfully transition from school to work or develop other livelihood opportunities. Working with local organizations, IYF will deliver various services ranging from informal education to small business start-up support to orphaned and vulnerable youth. The project goal will be met through three strategic objectives:

1. Providing livelihood opportunities to 3,200 OVC through scholarships for secondary education, vocational training, counseling, life skills training, internships, job placements, and business start-up assistance;
2. Building the capacity of civil society partners to manage and coordinate OVC programs through grant-making, technical support, knowledge dissemination, and networking with stakeholders; and

3. Improving the tracking and coordinated reporting of PEPFAR-funded OVC scholarships.

IYF will implement the project in 10 regions throughout the country and support 3,200 MVC and youth, particularly girls. In FY 2012, IYF will incorporate GHI strategies to focus efforts on leveraging resources from private sector partners to complement USG/T scholarship funds. With an aim to transition activities to local implementing partners, the project will strengthen partners' capacity in program management and service delivery, including resource mobilization skills and grant writing training that will be facilitated between partners and private sector stakeholders.

IYF will continuously monitor progress toward PEPFAR, country-level, and project targets. In FY 2012, IYF will also develop a tool to improve coordination of data collection and track the number of scholarships provided to OVC throughout Tanzania.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	200,000
Education	200,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Family Planning

Budget Code Information

Mechanism ID:	13774		
Mechanism Name:	Tanzania Youth Scholars		
Prime Partner Name:	International Youth Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	600,000	0

Narrative:

International Youth Foundation (IYF) implements three projects in Tanzania, all of which address education and quality of life for children and youth. IYF's Tanzania Youth Scholars Program aims to provide OVC aged 14-24 with employability and life skills to successfully transition from school to work or to develop livelihood opportunities. The project targets vulnerable youth in the 10 regions of Tanzania, providing scholarships, training, and psychosocial support with the goal of strengthening youth resilience to the effects of HIV, improved well-being, and reduced vulnerability. The project contributes to national USG/T goals for OVC by strengthening household economies in order to reduce vulnerability, particularly amongst girls. The project's life skills and psychosocial support components also contribute to the third Intermediate Result of the GHI strategy by strengthening social norms and increasing the uptake of health-seeking behaviors. By paying particular attention to girls, the project emphasizes a core principle of GHI in focusing on girls and gender equality. In addition, the project intends to support the prevention goal of the PFIP by addressing transactional sex, a key driver of HIV infection in Tanzania, through economic empowerment of vulnerable girls.

The main components of Tanzania Youth Scholars are scholarships for secondary and vocational education students and business start-up kits to increase employability, a strategy which evidence shows serves as a protective measure against HIV infection, particularly for vulnerable girls. The project will use a mix of strategies to support education of OVC, including implementing School Block Grants, a resource-exchange mechanism, and recognized best practices, in which schools and vocational centers provide waivers to identified OVC in exchange for material and equipment grants. The grants to the educational institutions help improve the quality of the school, thus also indirectly supporting non-OVC. In addition, all partners provide life skills training using evidence-based curricula, counseling, career guidance, and job placement support.

Tanzania Youth Scholars will work with three primary partners as follows:

(1) Vocational Education Training Authority (VETA), a Tanzanian government authority, will provide

three years of vocational training paired with core subjects, such as mathematics, technical drawing, entrepreneurship, communication skills, English, and computer applications; (2) Campaign for Female Education (Camfed), an international NGO, will provide scholarships and mentoring for girls secondary education to ensure school completion; and (3) Kiota Women Health and Development Organization (KIWOHEDE), a local NGO based in Dar es Salaam, will provide six months of easy-entry vocational training, such as painting, masonry, food production, hairdressing, tailoring, etc. Some youth will also be provided with business start-up support. IYF's partnership with VETA, Camfed, and KIWOHEDE will enhance the quality of local initiatives to address youth education and unemployment. IYF will strengthen the capacity of the three partners in program management and resource mobilization using Public-Private Partnerships to increase funding for vulnerable children and youth to complete their education.

Implementing Mechanism Details

Mechanism ID: 14536	**Mechanism Name: AGPAHI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ariel Glaser Pediatric AIDS Healthcare Initiative	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,412,647	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
Central GHP-State	503,108
GHP-State	909,539

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The work of Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI) was initiated under Track 1.0 funding to support comprehensive care and treatment services in Tanzania, with a focus on sustainability

and transition of responsibility to local government. Over the life of the project, AGPAHI will progressively transfer capacity to the RHMT as well as CHMTs to move toward a fully-capacitated local health management system where CHMTs conduct program management and oversight of service provision at facilities, and the RHMT performs the supportive supervision, mentoring, and management of respective CHMTs. Activities will take place at 41 sites in the Shinyanga region.

The goals and objectives of AGPAHI are in line with GHI strategy IR 1 (Increased access to quality services) as well as IR 2 (Improved health systems) while also supporting PF Goals 1 (services) and 5 (human resources).

Regular data collection, monitoring and evaluation will take place on a regular basis, with quarterly data analysis reviews. Efforts are ongoing to improve data quality, including building the capacity of service providers through onsite mentorship and supportive supervision.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14536**
Mechanism Name:	**AGPAHI**
Prime Partner Name:	**Ariel Glaser Pediatric AIDS Healthcare Initiative**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	336,450	0

Narrative:

AGPAHI will support HBHC by strengthening the provision of integrated high-quality HIV care and support aimed at extending and optimizing quality of life for PLWHIV from the time of diagnosis throughout the continuum of HIV care by strengthening leadership, management, and accountability of the CHMTs; improved human resources at CHMTs; as well as evidence-based and strategic decision-making by improved data and data utilization. AGPAHI will work with the respective districts and oversee the provision of services at 41 sites in the Shinyanga region.

AGPAHI's support to lower level health facilities and hospitals is in line with the MOHSW and PEPFAR country strategy. Active acceleration of growth will occur during this COP period in order to achieve greater reach (depth) of patients enrolled and retained on care. Cost effectiveness strategies will involve an increase in the number of patients on treatment. Policy changes, such as the 2010 WHO guidelines, will help facilitate this by increasing patients at the same sites. AGPAHI will ensure care and treatment services are brought close to the patient through outreach services and further integration into existing facilities that can provide care and support.

AGPAHI will ensure referral and tracking systems are strengthened to minimize the loss to follow-up of pre-ART clients through improving linkages between HIV care, support, treatment and prevention sites , other health facilities and the community. Activities have enhanced focus on diagnosis and management of opportunistic infections, pain and symptom management, integration with other key services (PMTCT, RCH, FP, TB etc). Activities will support and extend nutritional assessments and counseling in all supported sites. AGPAHI will integrate and finally expand Positive Prevention services in all supported facilities while providing continued support, strengthened coordination and collaboration mechanisms between partners in the operational regions and building the capacity of local government and civil society for sustainable service provision for PLWHIV.
AGPAHI will continue to support ongoing efforts to improve data quality, including building the capacity of service providers through onsite mentorship and supportive supervision. Adult care data collection, utilization, and reporting will continually be addressed and data quality audits performed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	97,150	0

Narrative:

AGPAHI will support HVTB by strengthening the provision of integrated high-quality TB/HIV activities,

which are aligned with Tanzania national policies and strategic plans for TB and HIV, as laid out in National Multi-Sectoral HIV/AIDS Framework (2008-2012) and the Health Sector HIV/AIDS Strategic Plan III (2009-2015). AGPAHI will strengthen TB/HIV integration at National, Regional, District and site levels. AGPAHI will ensuring the availability of sufficient number of trained personnel, providing regular on site mentorship and supportive supervision.

Intensified case finding of tuberculosis among PLHIV at CTC, RCH, OPD and Adult/Pediatric wards shall be strengthened using the TB screening questionnaire and work-up of TB suspects in accordance with the national diagnostic algorithm. AGPAHI will work in strengthening the TB IC measures at all units within supported health facilities. AGPAHI will support the role out of the National IPT pilot program. TB/HIV data triangulation will be conducted regularly to improve data recording and reporting at CTCs and TB clinics.

AGPAHI will continue to support and strengthen TB/HIV coordinating committees at all levels, including supportive supervision; on-the-job training and mentorship; quarterly review meetings; and interdepartmental meetings, including TB unit, CTC, lab, inpatient unit, and OPD units. The main activity during this COP year is to maintain services related to implementation of the Three I's.

AGPAHI, in collaboration with RHMT and CHMT, will continue to support ongoing efforts to improve data quality, including building the capacity of service providers through onsite mentorship and supportive supervision. TB/HIV data collection, utilization, and reporting are some of the challenges that are being addressed. Focus is on registers, CTC2 cards, and databases to be updated as well as ensuring that the existing HIV care and treatment M&E tools capture TB/HIV indicators.

A continuous effort shall be made to incorporate TB/HIV activities into the comprehensive council health plan, a strategy for sustaining the program through promoting ownership by the local entities. In addition, AGPAHI will work closely with other partners working on TB/HIV in leveraging resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	97,150	0

Narrative:

With these funds AGPAHI will support PDCS through a focus on strengthening the provision of integrated high-quality pediatric HIV care and support aimed at extending and optimizing quality of life to the target population of HIV-exposed and infected infants, children, and adolescents at the selected 41 sites in Shinyanga region.

Active acceleration of growth will occur during this COP period, achieving greater reach of children enrolled and retained in care. Cost effectiveness strategies toward scaling up will not only increase the number of sites, but will involve an increase in the number of patients. Expanded efforts to early infant diagnosis (EID) and integration with other service sites, such as RCH clinics, will help facilitate this. Activities promoting integration with routine pediatric care, nutrition services, and maternal health services include emphasizing identification of infected infants through PITC at all contact points and routine assessment of exposure status at RCH. This will be combined with the strengthening of EID services. AGPAHI will scale up cotrimoxazole (CTX) prophylaxis for HIV-exposed and infected children and adolescents, as well as diagnosis and management of tuberculosis and other opportunistic infections (OI's), palliative care, and psychosocial support. Additionally, lab diagnostics will be strengthened in collaboration with HLAB and EID funded activities.

Quality improvement activities will be implemented at the supported sites that provide pediatric care. Activities will incorporate strategies that include quality through supportive supervision, on-the-job training, and clinical mentorship. Quality improvement activities will measure performance of key indicators in order to identify strengths and develop strategies to address pediatric care challenges at the site level. Community mobilization and linkage activities to community-based care will also be undertaken. Additional activities include providing nutrition assessment, counseling and support, and kids' corners in CTC clinics.

AGPAHI will support ongoing efforts to improve data quality, including building the capacity of service providers through on-site mentorship and supportive supervision. Pediatric treatment data collection, utilization, and reporting will continually be addressed and data quality audits will be performed

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	881,897	0

Narrative:

For COP 2012, AGPAHI will support HTXS through a focus on strengthening the provision of integrated high-quality HIV ART treatment aimed at extending and optimizing quality of life for PLWHIV through the implementation of activities focused on ensuring adherence and retention of patients on treatment. HTXS activities will take place at 41 sites in Shinyanga region .

AGPAHI's support to lower level health facilities and hospitals is aligned with the MOHSW and PEPFAR country strategy. Active acceleration of growth will occur during this COP period in order to achieve greater reach of patients enrolled and retained on care. Cost effectiveness strategies towards scale up not only will increase the number of sites, but will also involve an increase in the number of patients.

Policy changes, such as the 2010 WHO guidelines, will help facilitate this by increasing patients at the same sites. In line with other COP strategies, AGPAHI will ensure care and treatment services are brought close to the patient through outreach services and further integration into existing facilities that can provide care and support. AGPAHI will conduct supportive supervision, on-the-job training and clinical mentorship. Furthermore, AGPAHI will conduct quarterly review and interdepartmental meetings, between CTC, lab, and in the community. Capacity building and providing service delivery will be of focus to assist in the transition of ART sites from international partners in the supported regions. AGPAHI will evaluate clinical outcomes and other performance data through regular supportive supervision visits, quarterly data review, and annual data quality assessments. AGPAHI aims to improve retention of patients initiated on ART by focusing on high quality HIV services at existing sites by identifying problems along with strategies that will lead to increased retention of patients on ART. Activities to mitigate above challenges will be met with supportive solutions, such as on-the-job training, on-site mentorship, advocacy, community mobilization, defaulter tracing, and updating of tools for tracking and retention, with a focus more on clinical mentorship, supportive supervision, and adherence to consolidation of in-service ART trainings in the zonal training centers. All activities will be interlinked, with referrals to and use of a comprehensive care and treatment package, including ART provision, cotrimoxazole prophylaxis, and TB screening. EGPAF will continue to support ongoing efforts to improve data quality, including building the capacity of service providers through onsite mentorship and supportive supervision. Adult treatment data collection, utilization, and reporting are continually being addressed and data quality audits performed.

Implementing Mechanism Details

Mechanism ID: 14537	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14538	**Mechanism Name: C-CE**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 500,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In the second year of this mechanism, ICAP will continue to build on its extensive experience partnering with government agencies and community-based organizations in Tanzania to support URT's efforts to ensure a unified response to TB/HIV co-infection in the pediatric population. To achieve a sustainable response, ICAP will intensify the work initiated in enhancing the stewardship and capacity of MOHSW towards an effective national response to TB/HIV co-infections among children. Furthermore, the newly established pediatric TB/HIV Center of Excellence (COE) at Mwananyamala Hospital in Dar es Salaam will serve as a resource centre to healthcare workers. Trainings will be augmented by on-going mentorship in diagnostic procedures through clinical attachments at the COE, as well as on-site mentorship and supportive supervision from ICAP. Pediatric TB diagnostic algorithms and standard operating procedures will be strengthened to ensure that all TB suspects undergo a diagnostic work up, including chest x-ray and gene Xpert investigations, where indicated.

During the second through fifth years, ICAP will support scale-up and expansion of pediatric TB/HIV services through formation of regional COEs and establishment of linkages and referral systems with a network of private and public-sector satellite health facilities in regions with high TB and HIV burdens. ICAP will mentor regional and council health management teams so that they can ultimately assume management responsibilities and can sustain and ensure achievements beyond the life of the project. Support to MKUTA (NGO of former TB clients) to provide health education and contact tracing at community levels will continue with establishment of more TB clubs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

TB

Budget Code Information

Mechanism ID:	14538		
Mechanism Name:	C-CE		
Prime Partner Name:	Columbia University Mailman School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	PDTX	500,000	0

Narrative:

Building on its highly effective working relationship with the NTLP and NACP, ICAP will engage MOHSW and provide support to strategically plan, manage, and evaluate pediatric TB/HIV diagnostics, prevention/control, and care and treatment programs. ICAP will facilitate stakeholders meetings which will be coordinated and conducted by NTLP and NACP to foster an enabling, collaborative environment and ensure a unified response to pediatric TB/HIV among MOHSW and implementing partners. ICAP will also actively participate and engage in the TWG and planning bodies to support the review and revision of existing pediatric TB/HIV guidelines, training curricula, and national policy related to TB/HIV to reflect the latest WHO guidelines.

As a means of strengthening the workforce at the MOHSW-NTLP unit, ICAP will hire a pediatrician and a

nursing officer who will coordinate pediatric TB/HIV activities. ICAP will conduct a training of trainers for pediatric TB/HIV and provide TA to develop a TB screening tool for children under six, based on ICAP's evidence-based pediatric TB/HIV screening approaches in other African countries.

ICAP will support MOHSW to conduct a systematic review of its TB and HIV recording tools to ensure that patients' forms and registers are streamlined and their clinical information accommodates the pediatric TB/HIV programs M&E. ICAP will work in strengthening TB screening and diagnosis outcomes as well as linkages to care and treatment for HIV and TB in children. ICAP will also support the regular review of pediatric TB/HIV data to inform program evaluation and planning.

In collaboration with the RHMT of Dar es Salaam City Council and the CHMT of Kinondoni Municipality, ICAP will strengthen activities at the pediatric TB/HIV COE at Mwananyamala Hospital for the provision of comprehensive services for children with TB/HIV co-infection. Collaboration with the Kinondoni Municipal Council and existing partners at Mwananyamala Hospital, including Management and Development for Health (MDH) and PATH, that provide support to Mwananyamala Hospital's care and treatment and TB programs, respectively will be enhanced to ensure ownership. The activities include infrastructure support, provision of trainings for staff followed by strong clinical mentorship support at the COE and strengthening of the M&E system for program evaluation and continuous quality improvement of the pediatric TB/HIV COE.

ICAP will collaborate with MOHSW and Kinondoni Municipality CHMT on rapid laboratory infrastructure and staff capacity assessments to establish a lab network between the COE TB laboratory and lab network within the Kinondoni Municipality. During the second through fifth years, ICAP will support scale-up and expansion of pediatric TB/HIV services through formation of regional COE and establishment of linkages and referral systems with a network of private and public-sector satellite health facilities. Healthcare workers will be trained by national trainers and will receive mentorship in diagnostic procedures and clinical skills through clinical attachments at the COE as well as on-site mentorship and supportive supervision from ICAP.

Implementing Mechanism Details

Mechanism ID: 14540	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14541	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14542	Mechanism Name: Baylor Fogarty AITRP
Funding Agency: U.S. Department of Health and Human Services/National Institutes of Health	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 150,000	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this program and the Masters of Health Services Research (MHSR) degree is to produce practically oriented health services research leaders possessing the knowledge and skills required to address current and future health services delivery challenges both nationally and internationally. As pediatric HIV service delivery issues are a PEPFAR priority, this program has an objective of answering key Tanzanian health systems issues related to pediatric HIV prevention, care, and treatment through fellowship dissertation projects.

The program addresses PF goals 5 and 6 regarding human resources and evidence-based decision making. The program will support all the regions in Tanzania over time, with two new fellows identified each year from two new regions. Program related costs are primarily associated with academic program tuition and fees, fellow stipends, and partial salary support for individuals supporting program administration and fellow mentorship. As the program matures and annual fellow recruitments, placements, and performance activities become routine, efficiencies in program administration will be

realized; thus, leading to cost efficiencies.

Increased linkages with the MOHSW at the national and regional level is intended in FY 2011 in order to place the fellows in positions relevant to their newly acquired training in the region of fellowship origin. Integration of the fellows and potentially some of the fellowship administration activities (e.g. recruitment and placement) into regional plans will be explored. Regular quarterly narrative and financial reports, semi-annual fellow grade reports, and post training fellow tracking through FIC/AITRP Career Track will support program M&E activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	150,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	14542 Baylor Fogarty AITRP U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Governance and Systems	OHSS	150,000	0
Narrative:			
The Baylor College of Medicine International Pediatric AIDS Initiative (BIPAI) receives support from the Fogarty International Center's AIDS International Training and Research Program (AITRP) for advanced level research training. This program supports health systems strengthening and advanced training in health systems research through the Makerere University School of Public Health in Kampala, Uganda. This program sponsors regional level health professionals, identified through a competitive application process, for a Masters of Health Services Research (MHSR) through the Makerere University School of Public Health in Kampala, Uganda. The goal of this two-year, masters level training is to produce practically oriented health services research leaders possessing the knowledge and skills required to address current and future health services delivery challenges locally, nationally and internationally. As the program roll out plan intends to support this training for one health professional per region over time, with a requirement that the trainee returns to the region of origin to support health systems research within the regions throughout Tanzania. As regional health facilities are tasked by MOHSW with conducting health systems research which contributes to quality improvement and enhanced regional health systems service delivery and efficiencies, this health systems strengthening program will work to support the goals of URT's MOHSW as well as the PEPFAR Partnership Framework goals for support of evidence-based programming and decision making for health. BIPAI and its local implementing organization Baylor-Tanzania focus on pediatric HIV-focused care and treatment as well as capacity building; the program requires the sponsored fellows to focus their dissertation projects on health systems issues related to pediatric HIV service delivery. This will allow for simultaneous addressing of gaps and challenges associated with pediatric HIV services delivery.			

Implementing Mechanism Details

Mechanism ID: 14543	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14544	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14545	**Mechanism Name: Dartmouth Fogarty AITRP**
Funding Agency: U.S. Department of Health and Human Services/National Institutes of Health	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goals and objectives of this project address three main areas: curriculum development, faculty development, and partner/stakeholder development. To improve curricula, a comprehensive review is underway of the all masters programs curricula of the School of Public Health and Social Sciences (SPHSS) of the Muhimbili University of Health and Allied Sciences. Other activities include developing core course curriculum vs electives, creating course timetables, and strengthening course content in public health research. Faculty capacity is enhanced through collaboration with leadership to strengthen teaching skills focused on student-centered active teaching, use of a teaching collaborative, student mentoring, and research. The project identifies and develops relationships with local researchers and strengthens links with GOT ministries and other stakeholders with interests in public health.

The immediate geographic coverage is Dar es Salaam but long-term impact will effectively cover the entire country. Target populations are SPHSS faculty but will also involve all MUHAS faculty and regions as health care professionals matriculate. The cost-effectiveness strategy engages more SPHSS faculty in the training process to assume a leadership role in new teaching methodologies. More training will be

provided using interactive technologies (e.g., video, web, CD Rom) as appropriate and when IT infrastructure is in place. Additionally, the major plan as time progresses is that the process will have been transitioned to SPHSS by giving their faculty/administrators necessary skills and training to assume "ownership" of the partnership. Monitoring and evaluation involve student focus groups, alumni surveys, faculty focus groups, employer surveys and stakeholder interviews.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	**14545 Dartmouth Fogarty AITRP U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	200,000	0
Narrative:			
One of the major activities of this collaboration involves faculty development related to teaching			

methodologies, active learning, and the role of research in public health. This represents both a structural and cultural change in the way Tanzanian faculty teach and their students learn. The implementation process is incremental and takes continued training and experience. The first step involved presenting the concepts of active learning and providing data to support the concepts; secondly, multiple small group sessions for SPHSS faculty working together with a D/BU mentor to develop the necessary skills to implement changes in the classroom. The third step involved 3 faculty visiting Dartmouth/BU for advanced sessions and meetings with US faculty and staff.

In September 2011, a new phase of faculty development that involves an innovative faculty exchange program was initiated. A SPHSS faculty member came to the U.S. to guest lecture in the Dartmouth MPH course "Social and Behavioral Determinants of Health." In 2012, D/BU faculty will go to Dar es Salaam to co-teach/lecture in SPHSS classes. The long-term plan is to expand this activity so that each of the SPHSS degree programs will have this experiential learning experience. The major structural challenges in broad terms include understanding concepts of group teaching, paucity of teaching resources, new competency requirements, modes of delivery/instructional technology, and change to learner-centered from content-centered approach.

A core-course curriculum has been established and revisions to the core course syllabi will be completed. Work on the non-core course syllabi development will begin in 2012. Additional tasks involve synchronization of timetables across core courses, continued facilitation of teaching of content through faculty exchanges, presentation of the core curriculum to the University Senate for review and approval, agreement on system structure (semester vs. module), deciding how to deliver modules, defining minimum credit for degree programs, planning for required resources and distribution, as appropriate, and development of new masters degree courses as identified in the gap analysis and strategy plan.

These are time consuming and involve face-to-face interactions requiring international travel. The major expenditures for the budget allocation involve faculty/staff salary support, travel (international and domestic), and training support materials (text books, other publications, interactive guides, lecture recoding software, and interactive case development (for video/web/CD Rom). Additionally, the major plan as time progresses will be to transition the process to the SPHSS by giving their faculty/administrators the necessary skills and training to assume "ownership" of the partnership.

Monitoring & evaluation will involve student focus groups, alumni surveys, faculty focus groups, employer surveys, and stakeholder interviews.

Implementing Mechanism Details

Mechanism ID: 14547	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14548	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14549	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14550	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14551	Mechanism Name: Kagera
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Kagera RHMT	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 168,308	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	168,308

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This grant will enable Kagera Regional Health Management Team (RHMT) to coordinate the HIV/AIDS responses and improve the coverage and quality of HIV/AIDS prevention care and treatment services in the region. The following activities will be implemented: clinical mentoring and supervision to health providers to ensure quality implementation of HIV program; improving the logistics of supply chain management for commodities like ARVs, test kits, STI medicines, laboratory reagents, and others through trainings, supervision, mentoring, and backstopping; strengthening the M&E system; and improving communication from the periphery to the central level.

The program objectives are to improve RHMT managerial, leadership, organizational, communication, and technical capacity to enable RHMT to improve capacity of district health providers. This will ensure quality planning through use of data for care and treatment programs, improved capacity of RHMT and DHMT on clinical mentoring and supervision of ART services, including drug provision and laboratory reagents supply, and enable Kagera RHMT to support community-based interventions and respond appropriately to uptake of services and retention of clients in care.

These funds will complement financial resources from URT and other partners through the basket funding mechanism. The goal and objective is in line with the PF strategy that emphasizes building and strengthening local capacity, strengthening of the health system by increasing long-term viability and sustainability while building synergies with other resources to increase efficiencies in existing programs, including Global Fund and PPPs. GHI's core principle emphasizing collaboration to maximize impact is also highlighted through the project's activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	52,200

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14551**		
Mechanism Name:	**Kagera**		
Prime Partner Name:	**Kagera RHMT**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	168,308	0
Narrative:			
Kagera region has a population of 2,641,702 with a community HIV prevalence of 3.4% (89,818 people), although programmatic HIV prevalence shows 9.2 % (243,036 people), according to 2010 VCT data. The role of the Regional Health Management Team (RHMT) is to provide supportive supervision and mentoring to the district level (Council Health Management Teams (CHMT) and facilities), coordination of HIV interventions, and monitoring and evaluation of the program. In order to improve the quality, effectiveness, efficiency, and sustainability of HIV interventions, the RHMT has to be capacitated to acquire skills in quality improvement, supportive supervision, and mentorship as stipulated by the MOHSW guidelines and facilitated to prepare a regional monitoring and evaluation plan. All five RHMTs signing agreements with the CDC are working under the same four programmatic objectives, and thus start off with the same template of recommended actvities to complete these objectives.			

In tracking and evaluating clinical outcomes and other performance data, the RHMT uses national indicators and six standards of care to monitor performance. In this regard, health facilities providing CTC services are provided with tools and registers for patient monitoring and data capturing. In addition, monthly and quarterly reports are prepared and utilized at the facility level for patient monitoring, forecasting of commodities, and planning. Furthermore, facilities submit monthly and quarterly reports to the districts where a district wide report is prepared. The district uses this information for their planning and reporting purposes at the regional level. The region, in turn, summarizes the districts' reports and submits to the national level. The RHMT uses the regional reports for planning, coordination, and evaluation as well as provide feedback to the districts on their performances during quarterly reviews and data sharing meetings. Moreover, different levels of implementation require different working and reporting tools, including ARVs, commodities, and supplies. Therefore, ensuring proper commodity management that emphasizes accurate and timely forecasting and ordering of supplies remains the milestone for prevention, treatment, and care in HIV and AIDS interventions.

Implementing Mechanism Details

Mechanism ID: 14552	**Mechanism Name: Mtwara**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mtwara RHMT	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 168,310	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	168,310

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The proposed budget will support the roles and responsibilities of the Mtwara Regional Health Management Team (RHMT) and regional medical officers (RMO) to oversee and supervise the provision of HIV/AIDS prevention, care, support, and treatment services in the region. The region occupies 16,720 km2 with a total population of 1,288,181 and an HIV prevalence of 3.6%, according to the 2010 health indicator survey.

Administratively, it is divided into six districts of Masasi, Nanyumbu, Newala, Tandahimba, Mtwara urban, and Mtwara rural; 21 divisions; 107 wards; and 651 villages. The region has a total of 181 health facilities, which includes five hospitals, 17 health centers, and 159 dispensaries. The health sector is already accepting private investment proposals, with the future goal of transforming the region's delivery of health care to be predominantly in the public-private partnership realms.

The program objectives are to improve RHMT managerial, leadership, organizational, communication, and technical capacity, enabling RHMT to improve capacity of district health providers to ensure quality planning and implementation of care and treatment programs in the region. The goal and objective is in line with the PF strategy that emphasizes building and strengthening local capacity, strengthening of the health system by increasing long-term viability and sustainability while building synergies with other resources to increase efficiencies in existing programs, including Global Fund and PPPs. GHI's core principle emphasizing collaboration to maximize impact is also highlighted through the project's activities.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HLAB	MOHSW	0	Procurement and supply of laboratory reagents and supplies
HTXD	MOHSW	0	Procurement and supply of ARVs
HTXS	MOHSW	0	Capacity building on IMAI

HVTB	MOHSW	0	TB/HIV intergration
PDTX	MOHSW	0	Capacity building on pediatric HIV/AIDS care

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	8,310
Human Resources for Health	112,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14552**		
Mechanism Name:	**Mtwara**		
Prime Partner Name:	**Mtwara RHMT**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Treatment	HTXS	168,310	0
Narrative:			
The role of the Mtwara Regional Health Manangement Team (RHMT) is to provide technical guidance, supportive supervision and mentoring to the district level (Council Health Management Teams and facilities) as well as coordination of HIV interventions and monitoring and evaluation of the program. In order to improve the quality, effectiveness, efficiency and sustainability of HIV interventions, the RHMT has to be capacitated to acquire skills in quality improvement and supportive supervision and mentorship as stipulated by the MOHSW guidelines and facilitated to prepare a regional monitoring and evaluation plan. All five RHMTs signing agreements with the CDC are working under the same four programmatic objectives, and thus start off with the same template of recommended actvities to complete these objectives. In tracking and evaluating clinical outcomes and other performance data, the RHMT uses National indicators and six standards of care to monitor performance. In this regard, health facilities providing Care and Treatment Clinic services are provided with tools and registers for patient monitoring and data capturing. In addition, monthly and quarterly reports are prepared and utilized at the facility level for patient monitoring, forecasting of commodities and planning. Furthermore, facilities submit monthly and quarterly reports to the district where a district report is prepared. The district uses this information for their planning purposes and reporting at the regional level. The region, in turn, summarizes the district's reports and submits at the national level. The RHMT uses the regional reports for planning, coordination and evaluation as well as providing feedback to the districts on their performance during quarterly reviews and data sharing meetings. Moreover, different levels of implementation require different working and reporting tools including ARVs, commodities and supplies. Therefore, ensuring proper commodity management that emphasizes accurate and timely forecasting and ordering of supplies, remains the milestone for prevention, treatment and care in HIV and AIDS interventions, thus the RHMT facilitates accurate and timely commodity management in the region. Therefore these funds will be used to improve RHMT managerial, leadership, organizational, communication and technical capacity to manage HIV programs in Kagera Region, will enable the RHMT to continue improving capacity of district health providers to ensure quality planning through use of data for care and treatment programs, will help continue improving capacity of RHMT and District Health Management Teams on clinical mentoring and supervision of ART services including drug provision and laboratory reagents supply and to enable Mtwara RHMT to support community-based interventions and respond to uptake of services and retention of clients in care.			

Implementing Mechanism Details

Mechanism ID: 14553	Mechanism Name: Mwanza
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mwanza RHMT	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 168,310	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	168,310

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Mwanza HIV/AIDS Services Improvement Project (MHASI) will focus on improving organizational capacity to effectively coordinate, manage, and supervise HIV/AIDS prevention, care and treatment, and related services within the region. This will ensure RHMT's effective supervision and monitoring of HIV/AIDS services; improving local ownership, coordination, and sustainability. MHASI will also support members of Mwanza RHMT and CHMTs from eight districts in the region to improve their capacity to coordinate and manage HIV/AIDS services.

The project will include an M&E team dedicated to ensuring that an effective information management system is established and utilized by the project and the RHMTs and CHMTs. The baseline assessment, which will be conducted at the start of the project, will be continually referred to in the monitoring of project activities. In order to become more cost efficient, MHASI will maximize established relationships with communities, districts, regional offices, HIV/AIDS implementing partners, and national stakeholders to ensure linkages and integration with other interventions and services are made.

These funds will complement financial resources from URT and other partners through the basket funding mechanism. The goal and objective is in line with the PF strategy that emphasizes building and strengthening local capacity, strengthening of the health system by increasing long-term viability and

sustainability while building synergies with other resources to increase efficiencies in existing programs, including Global Fund and PPPs. GHI's core principle emphasizing collaboration to maximize impact is also highlighted through the project's activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	82,548

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14553		
Mechanism Name:	Mwanza		
Prime Partner Name:	Mwanza RHMT		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	168,310	0
Narrative:			
Despite the critical role that URT and implementing partners have played in improving and creating a supporting system for the delivery of quality HIV/AIDS services, Mwanza region still faces several barriers which hinder a more effective response to the impact of HIV/AIDS. These include a shortage of human resources; poor management, coordination and mentoring skills by RHMTs; inadequate funding, governance, and accountability for implementation of various activities; and the absence of a proper data			

management system. To address these barriers, MHASI will focus on strengthening organizational and technical capacities of RHMTs and CHMTs to coordinate and improve all HIV/AIDS services. RHMT will continue to conduct supportive supervision and mentoring in the region in order to improve capacity of health workers and communities in adult care. All five RHMTs signing agreements with the CDC are working under the same four programmatic objectives, and thus start off with the same template of recommended actvities to complete these objectives.

Monitoring and evaluation of care and treatment services will continue to be performed regularly through analysis of CTC data and evaluation meetings. In analyzing CTC data, the goal is to learn the number of patients enrolled in care as well as lost to follow up and treatment outcomes. Meetings will continue to be conducted regularly from CTCs up to the regional levels, which will include health workers, partners, PLHAs, and communities. The information obtained in M&E will be used to identify gaps and weaknesses in service provision, which will prompt additional meetings to discuss solutions to improve the quality of services.

Mwanza region has an estimated population of 3.8 million people and an HIV prevalence of 5.7%, which is an estimated 216,000 PLHAs. Presently, the region has 65,435 people enrolled in care while 27,000 are on ARV treatment. The region currently operates 57 CTCs. However, the main challenge the RHMT faces is loss to follow up whereby about 20% of the people in care are lost. The region will continue to take measures in order to reduce this number, including early identification of missed appointments, training of lay counselors, and linking with home-based care teams for tracking clients. The region will also engage in strengthening adherence activities, such as having daily adherence sessions and educating patients and communities on ARV use and resistance through home-based care teams. These activities reduced the number of loss to follow up from 32% in 2010 to the present 20% in 2011, and will continue to improve adherence. To ensure sustainability, the RHMT will oversee that the CHMTs incorporate HIV/AIDS activities into their CCHPs.

The program objectives are to improve RHMT managerial, leadership, organizational, communication, and technical capacity to enable RHMT to improve capacity of district health providers. This will ensure quality planning through use of data for care and treatment programs, improved capacity of RHMT and DHMT on clinical mentoring and supervision of ART services, including drug provision and laboratory reagents supply, and enable Mwanza RHMT to support community-based interventions and respond appropriately to uptake of services and retention of clients in care.

Implementing Mechanism Details

Mechanism ID: 14554	**Mechanism Name: Pwani**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Pwani RHMT	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 168,310	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	168,310

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2011, CDC funded the Pwani RHMT to strengthen capacity building efforts. However, FY 2012 financial support will be directed towards strengthening HIV/AIDS care and support services. The overall goal is to provide quality HIV/AIDS services through strengthened RHMT technical guidance, monitoring, and supervision of CHMTs.

The objectives of the project are to:
(1) Improve RHMT and CHMT planning capacity in integrating HIV/AIDS activities and quality initiatives;
(2) Strengthen financial and program management of RHMT;
(3) Improve recruitment and retention of health care workers;
(4) Conduct routine supportive supervision of CHMTs;
(5) Support districts in strengthening the skills and knowledge of health care workers in quality improvement initiatives;
(6) Coordinate support to CHMTs to integrate HCT into monthly mobile clinics;
(7) Strengthen multi-sectoral leadership and coordination of community HIV/AIDS control activities;
(8) Strengthen RHMT capacity to support and facilitate CHMTs in receiving necessary commodities and supplies through the national MSD system;
(9) Facilitate utilization of newly adopted M&E tools; and
(10) Improve data quality and completeness and strengthen data use for program management.

Pwani has a population of 1,063,521 with an area of 33,539 sq km. The goal and objectives are in line with the PF strategy that emphasizes building and strengthening local capacity, strengthening of the health system by increasing long-term viability and sustainability while building synergies with other resources to increase efficiencies in existing programs, including Global Fund and PPPs. GHI's core principle emphasizing collaboration to maximize impact is also highlighted through the project's activities.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HTXS	Ministry of Health and Social Welfare	0	ARV procurement

Cross-Cutting Budget Attribution(s)

Human Resources for Health	27,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	14554		
Mechanism Name:	Pwani		
Prime Partner Name:	Pwani RHMT		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	168,310	0

Narrative:

According to the 2007-2008 Tanzania Health Indicator Survey, Pwani region is estimated to have an HIV prevalence of about 6.7% with an approximate population of 1,063,521. By December 2010, the region had a total of 26,000 patients cumulatively enrolled on care in 39 health facilities; 15,000 patients were currently on treatment; and an average of 1,000 patients were started on ART annually.

All five RHMTs signing agreements with the CDC are working under the same four programmatic objectives, and thus start off with the same template of recommended actvities to complete these objectives. Aligning its goals and objectives with those of USG/URT Partnership Framework, Pwani RHMT will work to ensure enhancement in local leadership and ownership by strengthening technical and managerial capacity. The RHMT will facilitate the allocation of financial and physical resources into the Comprehensive Council Health Plans (CCHPs) to strengthen supervisions and oversight of health services at district and health facility levels. WHO’s six pillars of health system strengthening, which includes governance and leadership, human resource, information, essential commodities, financing, and health services delivery, will be used to assess and build the capacity of the CHMTs.

Funds will also be used to map all HIV/AIDS programs and interventions in the region and create strategic partnerships and collaborations with various key players and stakeholders in order to facilitate joint planning, information sharing, monitoring, and supervision. In collaboration with the ICAP program, Pwani RHMT will carry out clinical mentorship by using a pool of regional and district mentors, which will decentralize supervision to the health center levels through a cascade system of supportive supervision. Furthermore, the capacity of the RHMT internal systems and operational procedures will be built so as to facilitate effective management, to ensure RHMT capacity to manage the acquisition and distribution of funds, and to ensure that RHMTs and CHMTs have and utilize effective strategic information system to support planning, monitoring, and evaluation of HIV/AIDS services delivery.

Implementing Mechanism Details

Mechanism ID: 14555	**Mechanism Name: Tanga**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanga RHMT	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 160,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	160,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Tanga RHMT, under the Boresha Zaidi (“Improve More”) Project, has a goal to ensure that people living with HIV/AIDS and their families receive quality and comprehensive HIV/AIDS care, support, and treatment services.

The region is situated in the North Eastern part of Tanzania, covering an area of about 27,348 square

kilometers and is divided into nine districts. There are a total of 11 hospitals, 34 health centers, and 271 dispensaries, which provide essential medical services; out of these, 49 facilities offer care and treatment services.

As part of the sustainability plan, the project will facilitate the allocation of financial and physical resources into the Comprehensive Council Health Plans (CCHPs) to strengthen supervision and oversight of health services at district and health facility levels. Capacity building for CHMTs will be done by assessing WHO's six pillars of health system strengthening, which include governance and leadership, human resources, information, essential commodities, financing, and health services delivery.

In order to improve and sustain monitoring and evaluation activities in the region, Boresha Zaidi will ensure availability of appropriate hardware and software to support strategic information, ensure presence of monitoring and evaluation teams with appropriate knowledge and skills, and to assist facilities in generating routine monitoring data and reports.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HTXS	MOHSW	0	Procurement of ARVs

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14555		
Mechanism Name:	Tanga		
Prime Partner Name:	Tanga RHMT		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	160,000	0

Narrative:

According to the 2007-2008 Tanzania Health Indicator Survey, Tanga region is estimated to have an HIV prevalence of about 4.8%. With a projected population of 2,010,480 people, it is anticipated that about 96,503 people are living with HIV. Up until June 2011, the region had a total of 37,285 patients cumulatively enrolled on care in 49 health facilities; 21,847 patients were currently on treatment and an average of 1,000 patients were initiated on ART annually.

All five RHMTs signing agreements with the CDC are working under the same four programmatic objectives, and thus start off with the same template of recommended actvities to complete these objectives. Aligning its goals and objectives with those of USG/URT Partnership Framework, Boresha Zaidi Project will work to ensure enhancement of local leadership and ownership by strengthening technical and managerial capacity. The RHMT will facilitate the allocation of financial and physical resources into the Comprehensive Council Health Plans (CCHPs) to strengthen supervisions and oversight of health services at district and health facility levels. WHO's six pillars of health system strengthening, which includes governance and leadership, human resource, information, essential commodities, financing, and health services delivery, will be used to assess and build the capacity of the CHMTs.

Funds will also be used to map all HIV/AIDS programs and interventions in the region and create strategic partnerships and collaborations with various key players and stakeholders in order to facilitate joint planning, information sharing, monitoring and supervision. In collaboration with AIDSRelief,

Boresha Zaidi will carry out clinical mentorship by using a pool of regional and district mentors, which will decentralize supervision to the health center levels through a cascade system of supportive supervision. Furthermore, the capacity of the RHMT internal systems and operational procedures will be built so as to facilitate effective management, to ensure RHMT capacity to manage the acquisition and distribution of funds, and to ensure that RHMTs and CHMTs have and utilize effective strategic information system to support planning, monitoring, and evaluation of HIV/AIDS services delivery.

Implementing Mechanism Details

Mechanism ID: 14556	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14559	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14560	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14570	**Mechanism Name: MDH**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Management development for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 15,552,695	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
Central GHP-State	6,601,762
GHP-State	8,950,933

Sub Partner Name(s)

Dar es Salaam City Council	Harvard University School of Public Health	Ilala Municipal Council
Muhimbili National Hospital		

Overview Narrative

Dar es Salaam Region is the most populated in Tanzania with 4 million people and an HIV prevalence rate of 9.7%. Since November 2004, the program has successfully enrolled over 116,000 PLHIV into comprehensive HIV care and support whereby over 76,000 have been initiated on ART. The program has been a role model in providing quality HIV counseling and testing in 50 private and public health facilities as well as providing PMTCT services to 180 reproductive and child health clinics. The Harvard PEPFAR program is now transitioning its obligations in program management and clinical services to Management and Development for Health (MDH), which is a local institution. In FY 2012, MDH's goal is to build district capacity to provide quality HIV ART services through increasing access to and maintaining patients on ART by addressing critical gaps in service coverage and strengthening capacity of the CHMTs. MDH seeks to accomplish the following objectives: (1) Maintain quality of care and treatment services within the existing 50 public and private sites in the Dar es Salaam; (2) Support districts to identify innovative and cost efficient models of care with limited resources and to identify priority areas in program support; and (3) Strengthen health systems to improve efficiency and effectiveness. MDH will build up the existing M&E system where all HIV indicators will be reported using data from the available MOH tools. Health care providers will be trained on data management and utilization for QI. MDH will use a supervision checklist to ensure data quality. For data analysis, MDH will generate, process, and set outcome indicators through the already merged clinical data and national CTC2 database as feedback to site staff, districts, and MOHSW.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	400,000

Food and Nutrition: Commodities	280,000
Food and Nutrition: Policy, Tools, and Service Delivery	20,000
Gender: Reducing Violence and Coercion	150,000
Human Resources for Health	2,341,402

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	14570		
Mechanism Name:	MDH		
Prime Partner Name:	Management development for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	431,303	0

Narrative:			
MDH will maintain and strengthen provision of integrated high-quality HIV care and support aimed at extending and optimizing the quality of life for HIV-infected clients and their families. These services will include TB screening, diagnosis prophylaxis and treatment, STI screening, including cervical cancer primary screening, psychosocial counseling, gender based violence services, and food by prescription. The ability to implement these services will be achieved through clinical mentorship of health care providers. Training and needs assessments will be undertaken and offered to new staff using both the national basic ART and refresher ART training where all the trainings have components on opportunistic infections diagnosis, treatment, and prevention. The providers will be trained to monitor and screen for the development of opportunistic infections, including TB and ART toxicity at all patients visits. In order to achieve the above, health systems will be strengthened. District laboratories will be strengthened to perform all tests as stipulated in the national guidelines, including CD4 counts and percentages, hematology, and chemistries as well as including other important OIs tests, such as cryptococcus antigen test and Toxo IgG. The comprehensive care package will also include prevention and treatment of other HIV related illnesses, including malaria and diarrhea. These will be targeted innovatively through prevention messages to the patients in health talks and provision of IEC materials, provision of insecticide treated nets (ITNs), and provision of safe drinking water. Gender based violence (GBV), which is a new component of HIV care packages, will be established in care and treatment health facilities. GBV services will include post exposure prophylaxis (PEP) provision, STI prophylaxis, provision of emergency contraception for women of reproductive age, medical treatment of injuries, trauma counseling and psychosocial support, and referral of survivors to network partners for support. Integration with other key services (PMTCT, RCHS, TB etc): Nutrition assessment, counseling and support (NACS) activities aim to optimize the quality of life of PLHIV by assessing their nutritional status and providing counseling and support according to their specific condition. NACS programs involve screening for malnutrition to identify those 'at risk' of malnutrition and those malnourished, provision of nutrition counseling to all new cases, and cases that need this service. On availability, all severely malnourished cases are treated with therapeutic food and moderately malnourished cases are supplemented with fortified blended flour. Prevention with positives has been one of the key areas in reducing the risk of transmission and re-infection among HIV positives. MDH will strengthen the provision of quality comprehensive packages of prevention with positives interventions, including strengthening the adherence and disclosure counseling, with more emphasis on making patients disclose their status to their partners, which in return, will enhance patient adherence to medication and improve the goals of ARV in general. Furthermore, sites will establish patients' psychosocial clubs for both adults and pediatrics. Risk reduction will be given more emphasis in the health talks given to patients while waiting for services.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HVTB	203,445	0
Narrative:			
According to NTLP report of 2008, Dar es Salaam is found to have the highest number of TB cases nationally (22%). MDH supports 50 health facilities in the region offering TB/HIV services, of which 17 sites offer TB/HIV services under-one-roof. This accounts for 28% of all TB/HIV under-one-roof PEFPAR supported sites. The MDH Quarterly report of April-June 2011 states a total of 36,018 patients received HIV care and, out of those, 32,893 patients (91.3% vs. target of 80%) were screened for TB symptoms. Working closely with MOHSW and NTLP, MDH was also involved in the development of a national training curriculum for the implementation of 3Is (TB Infection control, Intensified TB case finding, Isoniazid prophylaxis), while two MDH supported sites currently are involved in a phased IPT implementation. Along with the NTLP strategies of establishing mechanisms for collaboration between HIV and TB programs, of which reduce the burden of TB in PLHA and the burden of HIV among TB patients, the following activities will be implemented in FY 2012: (1) Support of collaborative TB and HIV/AIDS programs through establishing TB/HIV exchange information meetings between CTC and TB staff at the health facility level by meeting with the TB/HIV coordinators, DTLC, facility I/C and Care and Treatment Center personnel in charge; (2) Collaborate with Dar es Salaam municipalities to expand under-one-roof TB/HIV services in all MDH supported ART initiating CTCs with TB clinics; (3) Support TB infection control by collaborating with PATH and NTLP through RTLC/DTLC in provision of health education to staff and patients, in addition to displaying TB/HIV related posters; (4) Collaborate with NTLP and other partners to support the implementation of the national 3Is program through training and mentorship of HCWs on the 3Is at CTCs, PMTCT/RCH, VCT, IPD, and OPD; (5) In collaboration with municipalities, the program will continue strengthening the strategies for improving intensified TB case findings by performing on-the-job trainings, clinical mentorships, and supportive supervisions to attain a 5% target of CTC patients on anti-TB; (6) MDH will continue collaborating with NTLP in rolling out a phased IPT implementation to the identified facilities; (7) Collaborate with NTLP in training and mentorships of HCWs in the TB diagnosis of children using the newly developed pediatrics TB/HIV management guideline; (8) Support URT in the implementation of advanced TB diagnosis strategies by putting into place systems and SOPs for identification of patients who require the services and logistics for sample transportation and results; (9) Provide technical support during supervision to ensure quality of care is given to TB/HIV co-infected patients; and (10) Support and assist facilities' activities for M&E by training site staff on quality documentation and timely reporting of nationally revised TB indicators.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	219,288	0
Narrative:			

Pediatric care and support aims to extend and optimize quality of life for HIV infected clients through provision of clinical, psychological, social, and prevention services. A quarterly MDH report from June 2011 showed that the program had a pediatric enrolment of 9.3%, which is below the CDC and national targets of 15% and 20%, respectively. Geographical scale up of EID will increase from 80 to 120 (60%) sites and will be prioritized to help achieve the national target of reaching 65% of HIV exposed infants. The quantification and forecasting of DBS supplies into the district supply chain will be strengthened. MDH will support transportation of DBS samples and results. RCH staff will be trained and mentored on EID implementation, data recording, and reporting. The program will improve follow-up, retention, and referrals of HIV exposed and enrolled infants and children by promoting the use of RCH and CTC data at facility level. District CHMTs will be supported to improve coordination and linkages of HIV pediatric services for OVC, TB/HIV, and EID programs. Fears of clinicians starting children on treatment will be addressed through clinical meetings, continued medical education, mentoring, and technical supportive supervision. MDH, in collaboration with NACP, are in the process of planning a PITC mentorship program at all pediatric entry points, such as malnutrition wards, IPD, OPD, CTC, and ANC/RCH, with the aim of increasing the number of pediatrics with known HIV sero-status in the community, and thus improve pediatric enrollment in CTC. Sensitization meetings with CHMT, the health facility in charge, and site managers will be conducted with more focus on pediatrics. Advocacy of important messages to encourage breastfeeding will be promoted. The program will ensure constant HIV supplies and commodities, including availability of HIV rapid test kits, DBS kits, testing reagents, hemcue machines, and point of care/CD4 machines. ARV and non-ARV medications will be quantified and procured by the district supply chain office and the program supply chain coordinator will be assisting the district team in ensuring sites have enough back up stock. Other supplies will include recording and reporting tools, such as CTC1 and CTC2 cards, HIV exposed cards, TB scoring charts, all HIV registers, and their summary forms. These tools will be supplied from the district and, in case of shortages, the program will have a few copies as backups. Assessments and referrals to nutritional supplements, like nutty pest and plumpy nuts, to malnourished children will be made. For adolescents with HIV, the program will continue to educate teenagers on HIV preventive methods during their clinic visits. Youth will be encouraged to formulate their own support groups and to encourage one another, which will facilitate better learning. A youth-friendly clinic environment and supportive measures towards adherence issues will be created. Program staff will conduct quarterly joint technical supportive supervision of the sites with district teams and program coordinators. On-site mentoring of service providers will be performed. Community linkage services in ‘under five child survival intervention and support services,’ like pain and symptoms management, insecticide treated nets project and safe water initiatives, will be taught through on-site training and mentoring, advocacy, community mobilization, and establishment of coordinating committees.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Governance and Systems	HLAB	100,000	0

Narrative:

MDH will support HLAB through a series of mentorship and capacity building activities towards laboratory accreditation of five district labs and three municipal laboratories (Amana, Temeke, and Mwananyamala). These activities will focus on accurate forecasting, planning and budgeting for laboratory program activities; expanded coverage of laboratory testing in the geographic area; development of training activities focused on laboratory management; and quality assurance of laboratory testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,220,870	0

Narrative:

Using a district approach, MDH will support scaling up quality PMTCT services by providing TA through district PMTCT teams conducted through on the job trainings and mentorship. This will include couples counseling, counseling on FP, and infant feeding targeting 100% RCH site coverage. The program will focus on improving PMTCT effectiveness through provision of more efficacious regimens to all HIV positive women and their infants, according to new national guidelines. Clinicians at MNCH clinics will receive basic national ART training to build their capacity to initiate ART. The partner will verify that MNHC clinics have the capacity for an efficient supply chain system for ARV and OI drugs. In order to ensure that all ART eligible women are started on HAART, procurement back up reagents for CD4, hematology and chemistry tests will be readily available, enhancing timely testing, lab staging for ART eligibility and, eventually, ART initiation for all eligible pregnant women. PMTCT-ART integration with emphasis on point of care CD4 (PIMA) evaluation (once evaluated and endorsed) will support health facilities at all levels to perform clinical and lab staging for pregnant women who are eligible for ART, including hematology and chemistry tests in order to initiate 40% of all HIV positive pregnant women on ART within RCH. Cotrimoxazole prophylaxis will be used for managing and preventing OIs and follow up on mother-infant pairs. The program will conduct ART, PMTCT, and adherence trainings and mentorship to RCH staff on providing ART and more efficacious regimens for ineligible women; provide guidelines and SOPs to facilitate implementation of revised WHO PMTCT guidelines; and support transport logistics of laboratory samples and PMTCT commodities to and from the RCH facilities. The partner will conduct a PMTCT program evaluation of the ART initiation and patient retention in the PMTCT-ART integration model. In order to increase access, the program will link with EngenderHealth and seek their experience to improve the integration of FP and HIV at ANC, delivery, and postnatal periods as well as in FANC services. The program will identify gaps in maternal health services and support procurement of essential equipment, such as hemocue and blood pressure machines, weighing scales, and delivery beds. Coordination with Jhpeigo will complement an EmOC package through

capacity building of RCH staff, and back up commodities for quality delivery of EmOC. Minor renovations of ANCs and labor wards will also be done, as needed. HCW will improve the engagement of men in RCH services by providing invitation cards to women for their partners, encourage the formation of support groups for males and mothers (through work with Mothers to Mothers), and rely on religious and community leaders for community sensitization on strengthening family-centered approach RCH services. The program will support various initiatives to promote health seeking behaviors for reproductive services through mass communication, use of cell phone SMS, and IEC and BCC materials to inform and remind communities of the importance of attending health facilities for RCH and other health issues. The program will build capacity of CHMTs to take leadership in the coordination and supervision of PMTCT services. The district teams will mobilize women and partners within their communities to access PMTCT services, with particular focus on WHO prongs 2-4.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	12,482,789	0

Narrative:

MDH's main objectives will be to utilize existing strengths to support the provision of quality ART services to reach more people who are in need of ARV drugs, improve ART M&E systems, ensure availability of ARV drugs and drugs for OI prophylaxis and treatment, establish efficient systems within the management of the supply chain for ARV and other drug procurements, and ensure strong laboratory services and infrastructure are established. MDH will provide oversight and technical support to the MDH district medical officers to provide ongoing technical support to clinicians in all care and treatment clinics of Temeke district through frequent supportive supervision and mentorship visits. Provision of OI prophylaxis and provision of PEP services will also be implemented. In order to continue capacity building and service delivery, MDH will conduct various trainings focusing on clinical mentorship and supportive supervision. The district approach model will be used to conduct on-site supervision to the sites supported by the program, which will be done by the MDH district teams who work hand in hand with the respective council health management teams (CHMTs), according to the national supportive supervision and mentoring guidelines. The supported clinics will be assisted technically to implement M&E using the national patient monitoring tool, i.e. CTC2 database both in paper based and electronic forms. A strong monitoring and evaluation program is critical and will be incorporated from the beginning. District-level capacity will be developed so that district personnel can use the data collected for program quality improvement activities at the sites and local, decentralized decision-making can be made. MDH, using its existing technical capacity on quality improvement, will ensure that all sites will be improved based on standardized measures of quality in technical service provision. All sites will have quality improvement plans and active quality improvement teams regularly reviewing the core indicators and developing quality improvement projects to address the gap identified in quality of care provided. In

order to support and improve the retention of patients, health education for patients will be given daily during visits and pairing of nurse counselors to patients will be emphasized. The tracking system will be strengthened to allow patients to be seen by the same clinician/counselor during their follow-up clinic visits, thus improving communication, openness, and trust between the patients and health providers. This will improve adherence as a whole. MDH also supports shared disclosure and adherence counseling, which will improve the overall clinical outcome. MDH will build districts' capacity in program management through a joint assessment of ART service needs. Conducted together with the CHMT, MDH will help to identify district strengths and limitations in health programs and systems. The district officials will be kept informed about the progress of the program through regular feedback meetings, thereby keeping them engaged on an ongoing basis. In order to build broader support for ART services, MDH will use influential figures to conduct intensive community sensitization and promotion of activities, which will help build demand for these services. MDH will also support district capacity in the maintenance of quality HIV care and treatment within the existing public and private sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	895,000	0

Narrative:

Currently, 7% of patients enrolled in Dar es Salaam who on ART are children < 15 years of age. Up to 80 (40%) of RCH sites in the region implement EID with about 60% of children born to mothers living with HIV being tested for HIV using DNA PCR. There are no health facilities that concentrate on pediatric HIV care and treatment; rather all supported sites have a special day dedicated for pediatric services. The program has a member in the pediatrics care and treatment TWG and has taken and active role in reviewing the national guidelines on the management of pediatric HIV/AIDS. The program has also embarked on the creation of pediatric friendly clinics. In FY 2012, the following activities are to be implemented: (1) Consolidate implementation of the revised WHO pediatric ART guidelines; scaling up pediatric enrollment in ART to 2,163 new children; (2) Increase identification and diagnosis of HIV in children through expanding EID and PITC coverage, while creating linkages with CTCs, RCH, TB/TB-HIV clinics, OPDs, and IPDs;
(3) Conduct comprehensive pediatric HIV care and treatment trainings. The program will identify and develop mentors in pediatric HIV care to deploy them to facilities to mentor and standardize quality of pediatric HIV care, eligibility assessments, and ART initiation; (4) Implement mentorship activities on new pediatric WHO guidelines for ART, whereby all children below two years of age will be initiated on ART. Furthermore, regular mentorship will be done with a focus on management of OI infections in children, including diagnosis and management of TB. All HIV exposed children will receive cotrimoxazole to prevent OI infections. The program will also use these funds to build capacity of site and district pharmacists in quantification and ordering of pediatric ARV formulas to ensure a constant

supply; (5) Consolidate implementation of QI projects on pediatric HIV care to ensure high quality of care is maintained; (6) Develop counselor-mentors on pediatric counseling, adherence, disclosure, and nutritional issues with the goal of deploying them to sites to transfer their knowledge and skill set, help standardize care, and assist with difficult cases; (7) Work closely with the DMOs/DACs/RCH to make use of the existing national tools to conduct supervision and M&E activities. The program will make use of the existing district teams to pair up with CHMTs and provide technical support to the districts in coordinating these activities. (8) Work with DMOs/DACs/RCH Coordinators/district pharmacists/district lab coordinators to ensure that all district CD4 FACS Caliber machines (which are located in all three district labs), zonal viral load machines, and DNA PCR machines at MNH lab work smoothly to process CD4, VL, and DNA-PCR tests, respectively for enrolled and exposed children. Availability of reagents and other commodities to support sample collection and processing will be ensured at all times, while the flow of investigation samples and results to and from the sites to the labs will be ran efficiently; and (9) Develop adolescent support groups while engaging DACs/RCH Coordinators to recognize, support, and encourage adolescent support groups by providing health education and incorporating them into PwP activities.

Implementing Mechanism Details

Mechanism ID: 14573	**Mechanism Name: NACP Follow-on**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National AIDS Control Program Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,236,060	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,236,060

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Cooperative Agreement with the National AIDS Control Program (NACP) covers six components, namely: strategic information, HIV testing and counseling (HTC), home-based care (HBC), HIV care and treatment, HIV/TB, prevention of mother to child transmission of HIV, information, education, and communication (IEC), and male circumcision (MC). The goal of NACP's agreement is to provide strategic leadership and management over the entire Tanzanian national AIDS program. To achieve this, NACP collaborates with multisectoral organizations in a variety of settings, including: developing and implementing comprehensive, quality HIV care and treatment strategies in public, private and community based settings, and providing quality HTC and HBC services to PLHIV and their families. NACP also aims to improve coordination and quality of IEC in support of increased demand, uptake and adherence to effective biomedical interventions and services, including MC. NACP strengthens the collaboration betweeen TB and HIV programs at national levels, to improve the quality of care and treatment for PLHIV with both diseases. In line with the Partnership Framework and the Global Health Initiative, NACP works to expand PMTCT coverage by increasing the percentage of HIV positive pregnant women who receive ARVs while improving child survival among HIV exposed and infected children. NACP, which covers all regions in Tanzania, will also strengthen its own capacity to coordinate the health sector in the implementation of strategic information objectives.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	756,932

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Military Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	14573		
Mechanism Name:	NACP Follow-on		
Prime Partner Name:	National AIDS Control Program Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0
Narrative:			
MOHSW, through NACP, is mandated to develop policy guidelines and to coordinate, monitor, and evaluate the implementation of home-based care (HBC) services in the country. Over the past 15 years, MOHSW has witnessed major successes in provision of HBC services through its implementing partners, including scaling up of HBC services from eight pilot districts in 1996 to 133 in 2010 with improved coordination capacity at NACP. NACP intends to use these funds to ensure provision of comprehensive and quality care at all levels and harmonization of HBC implementation in the country. NACP will continue to coordinate partners through bi-annual national level coordination meetings for HBC stakeholders and monthly meetings with national level HBC stakeholders. NACP will also provide guidance in the implementation of HBC services through the development of different strategies, including writing an HBC strategic plan, identifying and disseminating best practices, revision of			

guidelines, SOPs and training materials for HBC, and conducting comprehensive supportive supervision of regions, districts, and non-governmental implementing partners. With the scale up and need for sustainability of HBC services, local government involvement needs to be prioritized. Therefore, NACP intends to promote ownership of HBC services by working with the local governments and mentoring them through annual planning meetings with regional HBC/AIDS coordinators, annual feedback meetings, conducting and providing comprehensive supportive supervision, and monitoring and evaluating HBC services in the country. To ensure comprehensive quality service provision, tools for supportive supervision and mentoring service providers in HBC/PHDP will be developed and rolled out in all regions. Through supportive supervision, MOHSW will monitor the implementation of HBC services, identify opportunities and constraints in provision of HBC services, and monitor HBC data management at all levels. Planned activities include building capacity of regions to conduct supportive supervision and mentorship; conducting eight supportive supervision visits per year; and working in collaboration with the Global Fund, supply chain management system, and local government authorities to ensure availability of HBC kits and commodities for the districts. These activities aim to promote access and utilization of affordable and essential interventions and commodities, while improving the quality of HBC services for the general public, PLHIV, providers, and other vulnerable populations. These goals are aligned with PEPFAR and the Partnership Framework. Implementation of these activities requires the availability of adequate human resource personnel. In view of this, NACP will also use the funds to support one program officer.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

MOHSW has adopted the WHO TB/HIV collaborative policy guidelines, which addresses TB and HIV jointly. The policy guidelines clearly demonstrate the need to fight the dual epidemics and provide the basis for action in collaborative TB/HIV activities by the National TB and Leprosy Program (NTLP), the National AIDS Control Program (NACP), and other stakeholders to work synergistically to reduce the burden of TB/HIV co-infection. This project is in line with MOHSW's revised health policy (2007), the Health Sector Strategic Plan III (July 2009-June 2015), the Five-Year Partnership Framework in support of the Tanzania national response to HIV/AIDS (2009 - 2013), National TB and Leprosy Program Strategic Plan 2009 to 2015, and National TB/HIV Policy Guidelines 2007. NACP will use the allocated funds to ensure coordination of all TB/HIV activities and implementing partners. Specifically, they will organize and conduct a bi-annual national TB/HIV coordinating committee, quarterly national TB/HIV technical working group meetings, and conduct joint supportive supervision on TB/HIV activities in collaboration with the NTLP and implementing partners. The funds will also be used to build capacity of RHMTs and CHMTs in implementation and monitoring of collaborative TB/HIV activities. NACP will

ensure RHMT and CHMT include TB/HIV activities in their Comprehensive Council Health Plan (CCHP) for sustainability and ownership. The program has already adopted the revised Partnership Framework and PEPFAR II indicators. In addition, an M&E plan and tools have been updated to incorporate revised indicators. The indicators will be reported quarterly at district, regional, and national levels. One of the objectives of collaborative TB/HIV treatment is to reduce the incidence of TB disease among people living with HIV/AIDS (PLHIV). The WHO recommends the national programs and partners implement the 3I's to reduce TB disease among PLHIV. NACP, in collaboration with other partners, will continue scaling up of the 3I's beyond pilot sites and will print and distribute TB screening tools among care and treatment sites. NACP will also continue collaborating with the NTLP in the phased implementation of IPT as part of HIV care and treatment packages and subsequent countrywide scale up. NACP will ensure the incorporation of pediatric TB into all the TB/HIV activities while observing gender mainstreaming. The funds will also be used to enhance the capacity of frontline health care providers, including radiology and laboratory technicians, in the implementation and incorporation of the 3 I's into comprehensive HIV supportive supervision and mentorship checklists.

This fund will also be used to support two staff members to include a TB/HIV program officer and a planning officer. The following guidelines and tools for implementation of collaborative TB/HIV activities were produced: National Policy Guidelines for Collaborative TB/HIV Activities, collaborative TB/HIV activities training manual, 3I's training manual, 3I's M&E tools, TB infection control guidelines, pediatric TB/HIV guidelines, a revised TB diagnostic algorithm, revised M&E tools to include TB/HIV variables, TB/HIV job aids, and a strategic approach for 3I's phased implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The funding will assist NACP in strengthening existing systems that produce data through routine reporting, surveys, evaluations, and surveillance. In routine reporting, various HIV health sector stakeholders will be capacitated through trainings and refresher trainings on revision of recording and reporting tools, good practices in data management, data use, and analytical skills. At the national level, programmers will be empowered in various scarce skills areas, such as monitoring and evaluation methods, costing studies, triangulation, research ethics and, thus, be capable to evaluate health sector HIV interventions. Special surveys are to be undertaken by NACP to better understand the HIV prevalence and trends in the general and key populations, including FSW, MSM, IDUs, and mobile populations, such as truck drivers and traders. Evaluation and comparison on utility of PMTCT data to data collected in ANC sentinel surveillance will be conducted using these funds to better understand what method technically suits the country's needs. Under surveillance, funds received will prepare logistics to

conduct ANC sentinel surveillance as well as the HIV Drug Resistance Threshold Survey. These will entail procurement and distribution of supplies for field work and laboratory, training of data collectors, testing and retesting of samples collected, analysis, and report writing of data captured. The funds given will be used to set innovative ways that will document best practices in M&E at all levels of implementation, for example fora of meetings involving HIV health sector stakeholders. The anticipation of these fora is to create a culture in data use for implementers and decision makers. For coordination purposes, the funds obtained will be used to host technical working group meetings under the epidemiology unit, namely MARPs and HIVDR Technical Working Groups, M&E steering committee, research as well as M&E subcommittees. The allocated funds will also be used to hire new staff and maintain 10 staff that is under CDC support. From the activities emanating from the program, a number of reports will be produced using CDC funds, specifically implementation of HIV care and treatment services, surveillance reports, and any special survey report conducted. Same funds will be used to disseminate the reports locally and internationally whenever necessary for knowledge and experience sharing. For FY 2012, support received will be used to procure supplies and maintain personnel involved in HIVDR monitoring surveys at three sites and any key population survey selected by the MARPs Technical Working Group. A study tour will be conducted to understand how a data hub works in countries known to have good data use systems for planning and decision-making. Evidence To Action Data Hub will be done using these funds to assist the program towards formulating information management and sharing policy guidelines to systematically link M&E systems of vertical programs to the HMIS system within the MOHSW. This task will be done in collaboration with the MOHSW so as to ensure all program needs are met. Support received will as well be used in printing of recording and reporting tools for HIV care and treatment services, home-based care, and any other intervention when needs arise. Preventive maintenance of existing ICT infrastructure will also be addressed.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	0	0
Narrative:			
Through the National AIDS Control Program, MOHSW will continue to coordinate male circumcision (MC) services for HIV prevention. NACP will support and facilitate quarterly MC technical working group meetings to share updates and provide guidance for implementation of MC services in the country. In addition, NACP staff will conduct supervision visits, as well as annual external quality assurance (EQA) visits to MC service sites in the country. Possibilities to support additional staff to assist with oversight and technical guidance for this rapidly expanding service are also under discussion. Funds can be used to support a potential additional clinical position within the MOHSW central level and/or at the regional level.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVAB	0	0

Narrative:

The Information Education and Communication (IEC) Unit at MOHSW and the National AIDS Control Program (NACP), coordinates and oversees all HIV communications efforts carried out under or by the health sector and its stakeholders on Tanzania Mainland. The IEC unit supports other programs within NACP and MOHSW with design, production, review, and/or printing of materials that support delayed sexual debut or abstinence and faithfulness among youth in and out of school. While NACP is not direct implementer of activities, they work very closely to coordinate and ensure quality delivery of activities such as the Families Matter program, conditional cash transfers and interventions that aim at changing gender norms. The IEC unit also receives and provides technical inputs, guidance, and approvals for IEC interventions and materials developed by a wide range of stakeholders in the country. To this effect, capacity building for this unit supports improving M&E and quality assurance and standards for IEC and behavior change communication (BCC) interventions and materials. Under this Cooperative Agreement, quarterly IEC subcommittee meetings will be conducted. In addition, coordination meetings with implementing partners to share experiences on the implementation of IEC/BCC activities and relevant evaluations of activities will be carried out twice a year. NACP will conduct supervision visits to oversee IEC/BCC activities in various regions across the country. The IEC unit will continue to maintain four staff, including an IEC officer, an information officer, a librarian, and an administrative assistant. The IEC unit staff will attend different short courses to build capacity and further improve efficiency and effectiveness of the unit. To ensure a variety and up-to-date HIV/AIDS information is available at NACP, the library information system will be up-graded and maintained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Though COP 2012 funding for HTC, the NACP Counseling and Social Support Unit (CSSU) that coordinates and oversees HIV testing and counseling (HTC) services, will improve its ability to coordinate the expansion of HTC, including provider-initiated and home-based HTC; proactively reach out to the underserved key population; and focus on identifying larger numbers of HIV-infected patients in need of care and treatment-eligible patients. Strategies to achieve these goals include the expansion of provider-initiated testing and counseling (PITC), advocacy with higher level officials in regards to an expanded role for lay counselors, and home-based HTC in selected high prevalence areas. Major emphasis next year will include, in collaboration with the MOHSW PMTCT program, the roll-out and strengthening of couples HTC services. The funding will also allow closer collaboration between the MOHSW, NACP, and partners in delivering quality confidential HTC services, while increasing linkages

with services such as PMTCT (e.g. for couples HTC), family planning, voluntary medical male circumcision(VMMC), and TB and sexually transmitted infection (STI). The funds will enable the unit to continue supporting and oversee the planning, monitoring, and implementation of confidential HTC services in Tanzania with the collaboration with the PEPFAR team, UN agencies, other donors and stakeholders, and regional health authorities, and in collaboration with other HTC partners , maintaining and expanding HTC services integrated with home -based care programs in selected high prevalence districts, as well as advocating with higher officials in regards to an expanded role for lay counselors. This funding will also enable the NACP to develop/adapt relevant curricula and tools for couples HTC roll-out in line with the comprehensive HTC guidelines , coordinate HTC services through conducting quarterly technical working group meetings on HTC, and strengthen and expand existing confidential HTC services, including establishing and strengthening of Couples HTC in as many HTC sites as possible. The funding will also be used to roll out the implementation of the new comprehensive HTC guidelines, disseminate paper-based monitoring tools, and develop and pre-test IEC messages to expand awareness and increase demand and uptake of HTC. NACP will also look into conducting supportive supervision and follow-up for HTC service sites. The funds will be used to establish HTC accreditation and quality improvement systems for HTC including the development and implementation of a plan for further roll-out of HTC Quality Assurance to all established HTC sites in collaboration with the MOHSW Diagnostic Unit and laboratory staff. For strengthening the capacity of CSSU HTC staff , COP 2012 will be used to maintain two staff and exploring the creation of an additional position. Support received will enable the unit staff to strengthen their managerial skills through study tours, program management and other short courses.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

The Information Education and Communication (IEC) Unit at the Ministry of Health & Social Welfare (MOHSW) National AIDS Control Program (NACP) Coordinates and oversees all HIV communications efforts carried out under or by the health sector and its stakeholders on Tanzania mainland. The IEC unit supports other programs within NACP and the MOHSW with design, production, review and/or printing of materials that support demand creation, increased uptake and adherence. Examples include but are not limited to promotion of Male Circumcision (MC) and HIV Testing & Counseling (HTC) services, support for Positive Health Dignity and Prevention (PHDP), support for ART adherence and retention and others. The unit also receives, and provides technical inputs, guidance and approvals for IEC interventions and materials developed by a wide rage of stakeholders in the country. To this effect, capacity building for this unit supports improving monitoring and evaluation, and quality assurance and standards for IEC and Behavior Change Communication (BCC) interventions and materials. Under this

Cooperative Agreement, quarterly IEC subcommittee meetings will be conducted. In addition to that, coordination meetings with implementing partners to share experiences on the implementation of IEC/BCC activities and relevant evaluations of IEC/BCC activities will be carried out twice a year. To ensure a variety and up-to-date HIV and AIDS information is available at the National AIDS Control Program, the library information system will be up-graded and maintained. In addition to the above, For COP 2012, NACP through the IEC Unit plans to coordinate different condom promotion and distribution activities that target and strengthen the demand for and access to free public health sector condoms beyond the health facilities where they are normally placed. To implement this, the National AIDS Control Program will coordinate meetings and activities carried out by the condom committee of the Ministry of Health and Social Welfare. The committee will be charged with the responsibility of advising on the various strategies to either increase and/or improve the availability, access and utilization of condoms for HIV prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,139,282	0

Narrative:

COP 2012 funds will be used to enhance program planning at the local level and promote ownership for planning at the regional and district levels by strengthening the capacity of authorities. This activity will begin with 10 districts that have no or only a few PMTCT activities incorporated into their CCHPs. The respective regional and district planners will be oriented on how to use the Essential PMTCT and Pediatric Planning Package. Refresher trainings to HCWs on PMTCT will be conducted as part of a strategy to roll out the new WHO guidelines. MOHSW will also coordinate these trainings, in collaboration with regionalized implementing partners, as well as TOT trainings. Service provider trainings on comprehensive PMTCT course will be oriented towards gap filling. Establishment of new HEID sites will continue with the aim of reaching all sites that provide PMTCT services. Two types of trainings will take place. The first will be a comprehensive training for participants who have not yet received PMTCT and EID trainings. The second will be the modular training on EID for those who have already undergone PMTCT training. To address critical challenges which include sample transportations, shortage of trained HCWs and longer turnaround time, increasing the number of health facilities providing EID services is a crucial step in realizing universal coverage. The program plans to support a series of meetings that will incorporate PMTCT into the HIV home-based care guidelines to addresses weaknesses in the community component, such as (1) An unsystematic community network to support health, leading to increased LTFU of HIV infected mothers and their exposed infant; (2) Cultural issues and taboos; (3) Limited male involvement; and (4) Limited community and family support for women, especially those living with HIV. The PMTCT program will also facilitate and hold annual sub-committee and secretariat meetings, while the eMTCT national task team and its sub teams will meet on a quarterly basis. The

program will support bi-annual zonal meetings in each of eight RCH zones, with the aim of sharing experiences, achievements, challenges, and resolutions related to RCH service implementation, including PMTCT/HEID. Bi-annual supportive supervision and mentoring visits from the central level to regions and districts to follow up on the progress of PMTCT service provision will be conducted. These visits will complement those done regularly at district and facility levels by the respective local health authorities. The comprehensive supportive supervision and mentoring tool of HIV/AIDS health services will be used when conducting these visits. However, periodic data quality assessments will be conducted in poorly performing and reporting sites in order to ascertain availability of quality program data and proper utilization of the data at the lower levels. This will also include printing and distribution of PMTCT guidelines, training materials, and M&E tools. Lastly, support will include payment for office expenses, including stationery, electricity bills, fuel and car maintenance, telephone, fax, staff mobile phone, air time, and two wireless mobile internet modems. It will also cater to maintaining the existing 15 national PMTCT staff within the PMTCT offices. Furthermore, the funds will support national PMTCT program staff to attend short courses, meetings and international conferences.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

Implementing partners supporting care and treatment services have contributed greatly in the success of the National AIDS Control Program (NACP). This program, as the coordinating organ of the MOHSW in HIV and health interventions, will continue to coordinate partners through bi-annual progress meetings on implementation of HIV care and treatment services; provide guidance in the implementation of services through development of different strategic documents, such as the Health Sector HIV/AIDS Strategic Plan II, guidelines for the management of HIV/AIDS, and conducting comprehensive HIV/AIDS supportive supervision to health facilities and the regions to oversee the implementation of the care and treatment services. With the scale up and need for sustainability of care and treatment services, local government involvement needs to be prioritized. NACP intends to capacitate local governments and promote ownership of HIV/AIDS care and treatment by working together on planning and budgeting of the care and treatment services; providing funding to Lindi and Shinyanga regions for the implementation of HIV care and treatment for supportive supervision, mentorship, and monitoring of HIV care and treatment services. The government of Tanzania has adapted the latest WHO treatment guidelines (2009). The revised national guideline will be printed and disseminated by the end of 2011. The implementation of the new guideline requires updating and reviewing the training package according to the new guideline and orienting health care workers on the new treatment guidelines. Integration of care and treatment services will increase accessibility, availability, and utilization of ART services, as well as improve retention of patients. Activities related to this component include building capacity of the health

care workers on provision of care and treatment services among those working in PMTCT and TB clinics and providing mentorship and supportive supervision to the health care workers in those clinics. NACP will continue to work in collaboration with the Medical Stores Department, the supply chain management system, and local government authorities to ensure availability of these medicines and commodities to the CTCs. Furthermore, to capture adverse drug reactions of the most commonly used antiretroviral medicines, NACP and TFDA will collaborate to ensure pharmacy vigilance is implemented in most of the health facilities with HIV care and treatment services. Strengthening the capacity of the health care workers in managing ARVs and other HIV commodities through mentorship programs and ensuring a system for tracking of adverse drug reactions for HIV is being instituted in the care and treatment clinics through ADR form distribution. To ensure quality HIV service provision, tools for supportive supervision and mentoring health care workers on clinical and program management for HIV have been developed and rolled out in few regions. Upcoming activities include building capacity of regions to conduct supportive supervision and mentorship along with working with Tanzania Food and Nutrition Center to ensure incorporation of nutrition counseling and mentoring for PLHIVs on care and treatment programs. Implementation of these activities requires the availability of adequate human resource personnel. In view of this, NACP will also use the funds to support four additional staff: a training officer, office support staff, and two drivers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	96,778	0

Narrative:

NACP will use these funds to support two pediatric HIV/AIDS stakeholders meetings and supportive supervision and mentoring groups to selected regions. In addition, orientation for RHMT, CHMT, and facilities will be conducted on updated pediatric training materials, including emphasizing integration of services and printing and dissemination of IEC material and job aids. NACP, as the coordinating organ in HIV health interventions, will continue to coordinate partners through bi-annual progress meetings on implementation of pediatric HIV care and treatment services. Through these progress meetings, implementing partners get opportunities to share their experiences, while MOHSW takes this opportunity to disseminate guidance on implementation of services through the different developed strategic documents. Implementing partners' support for care and treatment services has contributed greatly in the success of the program. MOHSW, through NACP and working in collaboration the with Pediatric Association of Tanzania (PAT), intends to capacitate local governments in the implementation of supportive supervision, mentorship, and monitoring of pediatric HIV/AIDS care and treatment services. Activities related to this component include building capacity in provision of care and treatment services among health care workers in RCH (FP and EPI), PMTCT, and TB clinics and providing mentorship and supportive supervision. The emphasis will also be on promoting integration of care and treatment

services within other services, thus increasing accessibility, availability, early identification of infected infants, and utilization of ART services as well as improving retention of children on care. This is important in improving quality and access to services, thus reducing child morbidity and mortality associated with HIV infections. NACP will work in collaboration with Tanzania Food and Nutrition Center to ensure integration of nutrition aspects into the care and treatment program and mentoring on the management of HIV infected children. They will also work to build capacity of HCW in managing severe acute malnutrition of children as well as increase knowledge around availability, prescribing, counseling, and using ready to use therapeutic foods (RUTF). The national guidelines for management of HIV/AIDS has been revised in response to new WHO ART recommendations and other evidence based interventions. This necessitated a review and updated version of the national pediatric training package. MOHSW, through NACP, will use funds for the orientation and dissemination of the updated 2011 National Pediatric Training Packages and guidelines to RHMTs, CHMTs, and facility health care workers. With the scale up and need for sustainability of care and treatment services, local government involvement will be the key issue which needs to be given priority. There is a huge discrepancy between the estimated number of children living with HIV and those who access HIV care and treatment services. This could be due to lack of community awareness of pediatric HIV, stigma, or low competency among health care workers in managing infected children. The IEC materials and job aids will raise awareness and demand of services, thus improving access to the available services.

Implementing Mechanism Details

Mechanism ID: 14653	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14680	**Mechanism Name: LIFE Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 9,107,821	**Total Mechanism Pipeline: N/A**

Funding Source	Funding Amount
GHP-State	9,107,821

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The LIFE program is a five-year intervention awarded December 2011. It aims to provide comprehensive and sustainable PMTCT and community-based HIV/AIDS services in four regions: Tabora, Mwanza, Pwani, and Zanzibar. The program contributes to Partnership Framework Goal 1, which ensures service maintenance and scale-up by mitigating the effects of HIV/AIDS disease. The program focuses on strengthening linkages between facility and community-based services for PLHIV as well as expands PMTCT services facilities and communities to reach HIV-free survival in Tanzania as outlined in the national PMTCT strategy. For community-based services, the program provides PLHIV with a care and support package, as per the URT guidance. For COP 2012, the program will increase focus on quality of life for PLHIV by rolling out new Positive Health, Dignity and Prevention (PHDP) interventions and expanding nutritional assessment and counseling (NACS) amongst program beneficiaries.

In line with the GHI Strategy, the program ensures PLHIV access care across the continuum, particularly maternal, newborn and child health, as well as family planning and reproductive health services. Finally, at the community level, the program promotes health-seeking behaviors, particularly targeting women and girls through innovative and appropriate strategies.

The program builds capacity of local governments to improve planning, management and coordination of care and treatment activities to achieve sustainability and country ownership by the end of the project.

In addition, the program includes technical assistance to improve existing government M&E systems at various levels to ensure data quality and data use for decision-making.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14680		
Mechanism Name:	LIFE Program		
Prime Partner Name:	Elizabeth Glaser Pediatric AIDS Foundation		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	2,990,991	0

Narrative:

The LIFE program provides comprehensive clinical and community care to adults and children living with HIV/AIDS in the four regions of Tabora, Mwanza, Pwani, and Zanzibar. Building on a previous intervention, the program continues to support partners by providing HBC services through the networks of community home-based care providers who have been trained using a newly revised training curriculum finalized with support from USG/T in FY11.

Services are tailored to the stage and general outlook of the disease. Services include community based palliative care, provision of the PHDP package, linkages to and provisions of safe drinking water options, sanitation services, and household food security, and economic strengthening. These community based activities are linked to facility based care and support services.

The program supports strengthened linkages between facilities and communities through improved service provision by Community home-based care providers (CHBCPs). Through the program, the role of CHBCPs is expanded to assist in linking facility services to the community by acting as community agents for care and treatment, PMTCT, TB/HIV, pediatric HIV, and family planning. The program trains CHBCPs and provides them with effective tools to track clients lost to follow up and drop-outs from CT and PMTCT clinics, referring traced clients back to the facilities. CHBCPs are also trained to support PLHIV clients receiving TB treatment.

As ART clients in Tanzania become healthier and require less palliative care, the program supports CHBCPs to increase health promotion activities, such as nutritional assessment and counseling, lay counseling for home counseling and testing, and plans for them to conduct home testing for HIV (once approved by MOHSW).   To achieve this range of services and gain program efficiencies, the program capitalizes on community and facility referrals and linkages, civil society organizations (CSOs), faith based organizations (FBO), and services provided by non-government organizations (NGOs).   To ensure sustainability and transition to local organizations and local government, the project is implemented using government guidelines and existing structures.   Technical assistance to service providers is provided to ensure that involved partners practice and implement improved administrative, financial, and technical efficiencies over the lifetime of the project.   Sub grantees and local government receive TA in the areas of M&E, measuring quality improvement, and project management.

At the service delivery point, the program provides support to CHBCPs to enable them to carry out their roles effectively.   This support ranges from centrally procuring HBC kits and production of IEC material to training and capacity development.   Throughout the program, innovative approaches will be used to enhance program integration, secure other financing schemes, and seek opportunities that already exist locally in order to leverage resources that support the long-term sustainability of community activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	6,116,830	0

Narrative:

The LIFE program expands PMTCT services, particularly to women of reproductive age and their families in the four target regions.   Cost efficiencies will be achieved by progressively decreasing sub grants to district councils and local partners and advocating for increased funding of program activities from URT's own resources.   The program focuses on sustainability with the ultimate goal of transitioning all program activities, utilizing URT as the primary transition partner and recipient of capacity-building efforts.   The base funding will mainly be used to increase quality of services related to mother and child health.   This program will maintain the targets that have already been met.

In Tanzania, the decision to regionalize partners working in PMTCT took place in 2007.   Since then, a fairly standardized package of services is implemented throughout the country by multiple partners in their respective regions.   By the end of the program, the project will scale-up PMTCT services to cover 98% of the facilities providing RCH services in Tabora, Mwanza, Pwani, and Zanzibar.   In support of the USAID Policy Framework,   the target local governments will be provided with grants to support services that include, but are not limited to, HIV testing (in ANC and labor and delivery as well as at the FP clinic),

partner testing, counseling on infant feeding options, strengthening of counseling on FP methods to HIV+ mothers during postpartum visits, referrals to care and treatment, clinical staging of the HIV+ pregnant women at the RCH clinic by the PMTCT service providers with linkages to CTC, roll-out of more efficacious regimen to facilities with the capacities, provision of ART prophylaxis to HIV+ pregnant women who are not eligible for ART, provision of Cotrimoxazole to all eligible pregnant women and exposed infants, PMTCT outreach services in hard to reach areas, and quarterly supportive supervision by the RHMT to ensure quality of services. In collaboration with MOHSW, bi-annual supportive supervision will also be done in all regions. Psychosocial support groups will be formed in collaboration with the local government structures and community home-based providers in order to increase adherence and retention to care. The program ensures the availability of HIV test kits will be procured to fill gaps and an adequate supply of drugs will be provided for a more efficacious regimen based on needs. Printing and distribution of IEC materials and job aids is also supported. The program provides technical assistance to districts and service providers to strengthen M&E in PMTCT and ensure guidelines and M&E tools are available. Service providers are trained to fill out the PMTCT monitoring tools and engage in Data Quality Assurance activities to improve the data collection systems. The program also strengthens and facilitates CHMT annual review meetings, support the formation and integration of regional PMTCT task forces into reproductive and child health, facilitate regional quarterly partners meetings, and strengthen linkages and referrals.

Implementing Mechanism Details

Mechanism ID: 14682	**Mechanism Name: Tunajali II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Deloitte Consulting Limited	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The TUNAJALI II program, signed in FY12, builds on the achievement of its predecessor program TUNAJALI to scale-up comprehensive and sustainable clinical and community-based HIV/AIDS services in the following four regions: Iringa, Morogoro, Dodoma, and Singida. TUNAJALI II will achieve the following results by the end of the project period: (1) Improved leadership and management capacity of local governments for quality HIV services delivery; (2) Improved capacity of CSOs for HIV and AIDS service delivery; (3) Increased revenues and resources available for integrated HIV and AIDS care; (4) Improved access to quality, integrated and comprehensive HIV care and treatment services; and (5) Improved woman & girl child responsive HIV treatment, Care and Support.

The program contributes to PF Goal 1 that refers to service maintenance and scale up and supports activities at both facility as well as community levels. Facility based-care and support services include provision of counseling and testing services, palliative care, TB/HIV screening and treatment services, management of opportunistic infections, cervical cancer screening, family planning and reproductive health services, provision of insecticide treated nets, malaria prophylaxis, Positive Health Dignity and Prevention (PHDP) services, and nutritional assessment counseling services (NACS).

TUNAJALI II builds local capacity and ensures sustainability by working through existing local organization and government systems and establishing and strengthening referral networks and linkages to civil society organizations (CSO), faith-based networks, and services provided by non- governmental organizations (NGO).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14682		
Mechanism Name:	Tunajali II		
Prime Partner Name:	Deloitte Consulting Limited		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

In Tanzania, HBHC partners implement a standard package of care activities. TUNAJALI II will be implemented in Morogoro, Iringa, Dodoma, and Singida regions. It will combine two components of care packages; first being clinical care and second community home-based care.

With COP 2012 funds, TUNAJALI II will continue to support partners providing HBC services through the network of community home-based care providers who are already trained using the revised curriculum. In line with the reviewed home-based care guidelines, initial assessments will be done to ascertain the number of existing CHBCP and the coverage of the services. Those trained using new curriculum will be taken aboard while those trained using old curriculum will be provided with refresher training.

Services to patients will be tailored as to the stage and general outlook of the disease. Tailored services include community based palliative care, provision of PHDP package, linkage to and provision of safe drinking water options and sanitation services, linkage to and provision of household food security, and economic strengthening activities. These community based activities and CHBCP activities will be linked to facility based care and support services. CHBCPs will play a bigger role in linking the facility services to the community by acting as community agents for care and treatments, PMTCT, TB/HIV, Pediatric HIV and Family planning. In the community CHBCPs will link with the facility to track loss to follow up and drop outs from CT clinics and PMTCT and refer them back to the facilities. They will also monitor patients on DOTS treatment for TB. CHBCPs will increasingly carry out health promotion activities like nutritional assessment and counseling, lay counseling for home counseling and testing and

when the MOH issues permission, conduct home testing for HIV. To achieve this range of services and gain program efficiencies, the program will capitalize on the community and facility referral and linkages, civil society organizations (CSOs), faith based organizations (FBO), and services provided by non-governmental organizations (NGOs). To ensure sustainability and transition to local organization and local government TUNAJALI II will be implemented using the government guidelines and existing structures.

TA will be provided to ensure that partners involved in implementing this project practice improved administrative, financial and technical efficiencies over the time of the project. TA will be provided to sub grantee and local government in the areas of M&E, quality improvement measure, project management etc. At the service delivery point support will be provided to CHBCPs to enable them carry out their roles effectively. this support will range from centrally procured HBC kits, IEC materials and trainings. Innovative approaches will be used through program integration, use of other financing schemes and other opportunities existing locally to leverage resources to support the community activities for a long term sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

In Tanzania, particular partners working in TB implement a standard package of services throughout the country. This follow-on TB/HIV program will contribute to supporting national efforts to strengthen collaborative TB/HIV activities, focusing on the regions of Iringa, Morogoro, Dodoma, and Singida. COP 2012 funds will be used to support active TB case finding and screening among PLHIV. Activities will include supporting the scale up of intensified TB case finding, infection control (IC), and the provision of isoniazid preventive therapy (IPT). The program will support the initiative to increase the number of health facilities providing IPT, while also effectively practicing infection control activities.

Strategically selected TB clinics will be refurbished or receive minor renovations in order to alter the clinics into one-stop shops (for both TB and ART), which will help increase the proportion of TB/HIV patients starting on ART. The program will also support the integration of the 3I's activities into PMTCT, VCT, and pediatrics clinics based in the focus regions. Other partners and initiatives will be sought to strengthen laboratory services to improve TB diagnosis and programmatic management of MDR-TB. Special focus will be geared to design and implement activities aimed at mainstreaming gender in TB services provision.

The program will strengthen M&E in TB/HIV by ensuring national guidelines and M&E tools are available,

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improving data collection systems, and training service providers on filling out care and treatment monitoring tools. CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of TB services.

Program integration, use of other financing schemes, and other opportunities existing locally will be explored in order to leverage resources to support community activities on a long term basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

With COP 2012 funds, TUNAJALI II will play a key role in improving the health and well-being of children within the four regions of Iringa, Morogoro, Dodoma, and Singida, as the program implements a standard package of care interventions. The care program will enhance and strengthen linkages between facility and community-based services by integrating nutrition assessments counseling and support (NACS), offering counseling and support across care programs, and promoting integration of OVC, maternal newborn and child health (MNCH), PMTCT, and pediatric AIDS interventions to children infected by HIV.

Specifically, the program will enhance the roles of community care providers in promoting a more integrated community response. The program will build on the successful results of the community care/MCH Community Health Workers training.

Through enhanced community services, the program will strengthen the continuum of care for HIV-affected children from birth through adolescence. Focus will be in the provision of cotrimoxazole prophylaxis to eligible children, linking and integrating cotrimoxazole provision with MNCH services, and improved documentation on child health cards. In a collaborative effort with the OVC program, child protections issues will be addressed as the program seeks to pilot and scale up the community-based child protection model. Working with the OVC program, the follow-on program will strategically intensify interventions to improve the well-being of girls.

To contribute to program sustainability, the program will build the capacity and strengthen the skills of community and facility-based care providers through human resource for health (HRH) activities in the focus regions, while also addressing food security and nutrition issues for children living with HIV/AIDS and OVC.

The program will strengthen M&E in care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and

treatment monitoring tools. CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

In Tanzania, the decision to regionalize partners working in PMTCT took place in 2007. Since then, a fairly standardized package of services is implemented throughout the country by multiple partners in their respective regions. The TUNAJALI II will continue to support PMTCT services within the four regions of Iringa, Morogoro, Dodoma, and Singida. The target population includes men, women of reproductive age, and their families. The base funding will be used to increase quality of PMTCT services related to both the mother and her child to achieve and maintain strategic high geographical PMTCT coverage.

The goal will be to scale-up PMTCT services to cover 90% of the facilities providing RCH services in the focus regions. It will support services that include HIV testing (in ANC and labor and delivery as well as at the FP clinic), partner testing, counseling on infant feeding options, strengthening of counseling on FP methods to HIV+ mothers during postpartum visits, referrals to care and treatment, clinical staging of the HIV+ pregnant women at the RCH clinic by the PMTCT service providers with linkages to CTC, roll-out of more efficacious regimen to facilities with the capacities, provision of ART prophylaxis to HIV+ pregnant women who are not eligible for ART, provision of Cotrimoxazole to all eligible pregnant women and exposed infants, PMTCT outreach services in hard to reach areas, and quarterly supportive supervision by the RHMT to ensure quality of services.

In collaboration with local government authorities, bi-annual supportive supervision will also be carried out in the focus regions. To increase adherence and retention to care, collaboration with community support groups to form psychosocial support groups will be a key activity. This program will also ensure the availability of HIV test kits by procurement to fill gaps, ensure adequate supply of drugs for more efficacious regimen based on needs and support printing and distribution of IEC materials and job aids.

TA will be provided to strengthen M&E in PMTCT and will ensure guidelines and M&E tools are available. Service providers will be trained to fill out the PMTCT monitoring tools and engage in Data Quality Assurance activities to improve the data collection systems. The program will strengthen and facilitate CHMT annual review meetings, support the formation and integration of regional PMTCT task forces into reproductive and child health, facilitate regional quarterly partners meetings, and strengthen linkages and

referrals.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	0	0
Narrative:			

In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. This follow-on program will continue to support adult ART services within the four regions of Iringa, Morogoro, Dodoma, and Singida. The target population includes men, women, and their families.

The program will take a district approach to work jointly with district and regional health management teams to plan, implement, and monitor ART programs. Activities for the program will include increasing the number of pregnant women who are initiated on treatment, improving linkages and referrals between HIV program areas, strengthening support groups in facilities and communities, improving health seeking behaviors, integrating family planning methods in HIV/AIDS care and treatment services, and introducing point of care CD4 testing (PIMA).

TUNAJALI II supports the URT's initiative of adopting the latest WHO recommendations and roll out implementation of the guidelines in a phased approach. The program supports initiation of ART for all HIV positive pregnant women with CD4 counts below 350. In addition, irrespective of CD4 counts, all TB patients co-infected with HIV, all HIV positive children below the age of 24 months, and all patients with clinical stage 3 and 4 will be initiated on ART through the program. Patients identified in need of treatment from feeder systems (such as PMTCT, TB/HIV clinics, PITC, and EID) will be accommodated, while treatment support for HIV-infected pregnant women to reduce maternal mortality and prevent HIV-transmission to the baby will be prioritized. Point of care CD4 tests at ANC will be deployed, once endorsed (PIMA currently being in the final evaluation phase) , and ARV services will be integrated into TB and ANC clinics. Through their regions and districts, providers will be supported to build their capacity through refresher training and mentoring.

The program strengthens M&E in care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. CHMT annual review meetings are facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Treatment	PDTX	0	0
Narrative:			
In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. The TUNAJALI II will continue to support adult ART services within the four regions of Iringa, Morogoro, Dodoma, and Singida. Activities will focus on improving the quality of services being provided to children infected with HIV, with a specific focus on scaling up early diagnosis and treatment through Early Infant Diagnosis (EID). Focus on provider initiated testing and counseling (PITC) for older children in all pediatrics entry points, including MCH, pediatrics wards, malnutrition rehabilitation wards, care and treatment clinics, and OPD. The program will strengthen follow-up and linkages to treatment. The revised PITC and PMTCT guidelines will be utilized, while early identification of HIV exposure will be prioritized. Adoption of WHO guidelines, including earlier treatment for infected children below two years, will be incorporated into the program. Onsite mentoring, training, and resources to health care providers will be supported to improve their capacity and competency in the implementation of pediatric care and treatment interventions. Links to PMTCT and pediatric HIV care and treatment will initiate efforts to scale up comprehensive PMTCT and pediatrics HIV care, treatment, and support services. The program will promote the provision of pediatrics care and treatment services at RCH sites, which includes early identification of HIV status and infection, and follow up of HIV exposed infants. The program will strengthen M&E in care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.			

Implementing Mechanism Details

Mechanism ID: 14685	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14687	**TBD: Yes**

REDACTED

Implementing Mechanism Details

Mechanism ID: 14689	**Mechanism Name: Pastoral Activities & Services for People with AIDS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pastoral Activities & Services for People with AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,592,009	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	3,592,009

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This program will support activities providing comprehensive and sustainable clinical and community based HIV/AIDS services. Local institutions and entities will be supported to scale up, expand, and integrate HIV/AIDS care services into the two regions of Dar es Salaam and Pwani.

With COp 2012 funds, special emphasis will be placed on ensuring that adults and children living with HIV/AIDS benefit from a comprehensive package of HIV and health-related interventions. The project is aligned with the first goal of the PF focusing on service maintenance and scale up, which reflects both the facility and community level activities that will take place under this program.

Facility-based care and support services will include provision of counseling and testing services, palliative care, TB/HIV screening and treatment services, management of opportunistic infections, including cotrimoxazole prophylaxis, cervical cancer screening, family planning and reproductive health services, provision of insecticide treated nets, malaria prophylaxis, Positive Health, Dignity and Prevention (PHDP) services, and nutritional assessment counseling and services (NACS).

Community-based services will include provision of non-facility based care, such as provision of PHDP package, community-based palliative care, and linkages to and provision of safe drinking water options, sanitation services, household food safety, and economic strengthening activities.

To achieve this array of services and gain program efficiencies, this program will utilize the existing local organization and government systems by establishing and strengthening referral networks and linkages to civil society organizations (CSO), faith-based networks, and services provided by non-government organizations (NGOs).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
TB
Family Planning

Budget Code Information

Mechanism ID:	**14689**
Mechanism Name:	**Pastoral Activities & Services for People with AIDS**
Prime Partner Name:	**Pastoral Activities & Services for People with AIDS**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	716,000	0

Narrative:

In Tanzania, HBHC partners implement a standard package of care activities. This program will provide comprehensive clinical care and support in Arusha and Manyara regions. It will combine two components of care packages; first being clinical care and second community home-based care.

With COP 2012 funds, PASADA will continue to support HBC services through the network of community home-based care providers who are already trained using the revised curriculum. In line with the reviewed home-based care guidelines, initial assessments will be done to ascertain the number of existing CHBCP and the coverage of the services. Those trained using new curriculum will be taken aboard while those trained using old curriculum will be provided with refresher training.

Services to patients will be tailored as to the stage and general outlook of the disease. Tailored services include community based palliative care, provision of PHDP package, linkage to and provision of safe drinking water options and sanitation services, linkage to and provision of household food security, and economic strengthening activities. These community based activities and CHBCP activities will be linked to facility based care and support services. CHBCPs will play a bigger role in linking the facility services to the community by acting as community agents for care and treatments, PMTCT, TB/HIV, Pediatric HIV and Family planning. In the community CHBCPs will link with the facility to track loss to follow up and drop outs from CT clinics and PMTCT and refer them back to the facilities. They will also monitor patients on DOTS treatment for TB. CHBCPs will increasingly carry out health promotion activities like nutritional assessment and counseling, lay counseling for home counseling and testing and when the MOH issues permission, conduct home testing for HIV. To achieve this range of services and gain program efficiencies, the program will capitalize on the community and facility referral and linkages, civil society organizations (CSOs), faith based organizations (FBO), and services provided by non-governmental organizations (NGOs). To ensure sustainability and transition to local organization and local government the Selian supported program will be implemented using the government guidelines and existing structures.

PASADA will sought TA from partners such as EGPAF, PATHFINDER and MDH who areinvolved in implementing this similar activities to support to improve quality of service and efficiencies over the time of the project. TA will also be sought in the areas of M&E, quality improvement measure, project management etc. At the service delivery point support will be provided to CHBCPs to enable communities carry out their roles effectively. Selian will access centrally procured HBC kits, IEC materials and trainings. Innovative approaches will be used through program integration, use of other

financing schemes and other opportunities existing locally to leverage resources to support the community activities for a long term sustainability.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	450,000	0

Narrative:

The program will focus on building the capacity of local community structures, especially local councils and CBOs, to respond directly to the needs of children and their families. This program will implement its activities through district and lower local government authorities, while OVC and youth services will be provided by CBOs who utilize community volunteers. Its efforts will also highlight a core principle of the GHI strategy by leveraging other efforts as demonstrated by the local governments contributing significant financial resources to some of the MVC services. At the same time, this program will encourage other development partners to share staff skills and costs of training volunteers (e.g. peer educators and para social workers). After the initial training and capacity building of partners and volunteers, the cost of delivering services will significantly decrease over time.

The program will continue to train a network of community volunteers (para social workers, mama mkubwas or “big mothers”, peer educators, and community justice facilitators) to sustainably provide care to OVC households. Local government leaders are involved in all stages and processes through meetings and trainings, by mobilizing communities to participate in the project activities, offering support supervision, and monitoring the work of local partners and their activities within the respective communities.

As a right to all identified children and within the government policy framework to care and protect children's social welfare and future, the program will ensure that every identified and registered child has a birth certificate issued by the regional governments and a community health insurance fund card so that children can access free health care at any of the government health facilities. All children under five will be taken to health centers for vaccinations in the event this had not been done previously.

This program will provide a comprehensive package of direct services to OVC households. Caregivers grouped in 10-15 households will benefit from economic strengthening and income generating support, as well as food security and nutrition education. Children with emotional problems will be given psychosocial support and protection against any risk of sexual and/or physical abuse. Health care and treatment services will be mapped to ensure all children in need of health services are properly referred to and linked with service providers. In addition, children who have dropped out of schools will be supported to return to school, while adolescents will be organized in groups to receive HIV prevention

and life skills training.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	150,000	0

Narrative:

The TB/HIV program of PASADA will contribute to national efforts to strengthen collaborative TB/HIV activities, focusing on two regions: Dar es salaam and Pwani. COP 2012 funds will be used to support active TB case finding and screening among PLHIV. Activities will include supporting the scale up of intensified TB case finding, infection control (IC), and the provision of isoniazid preventive therapy (IPT). The program will support the initiative to increase the number of health facilities providing IPT, while also effectively practicing infection control activities.

Strategically selected TB clinics will be refurbished or receive minor renovations in order to alter the clinics into one-stop shops (for both TB and ART), which will help increase the proportion of TB/HIV patients starting on ART. The program will also support the integration of the 3I's activities into PMTCT, VCT, and pediatrics clinics based in the focus regions. Other partners and initiatives will be sought to strengthen laboratory services to improve TB diagnosis and programmatic management of MDR-TB. Special focus will be geared to design and implement activities aimed at mainstreaming gender in TB services provision.

The program will strengthen M&E in TB/HIV by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of TB services.

Program integration, use of other financing schemes, and other opportunities existing locally will be explored in order to leverage resources to support community activities on a long term basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	39,000	0

Narrative:

PASADA will play a key role in improving the health and well-being of children within the two regions of Dar es salaam and Pwani, as the program implements a standard package of care interventions. The care program will enhance and strengthen linkages between facility and community-based services by integrating nutrition assessments counseling and support (NACS), offering counseling and support across care programs, and promoting integration of OVC, maternal newborn and child health (MNCH),

PMTCT, and pediatric AIDS interventions to children infected by HIV.

Specifically, the program will enhance the roles of community care providers in promoting a more integrated community response. The program will build on the successful results of the community care/MCH Community Health Workers training.

Through enhanced community services, the program will strengthen the continuum of care for HIV-affected children from birth through adolescence. Focus will be in the provision of cotrimoxazole prophylaxis to eligible children, linking and integrating cotrimoxazole provision with MNCH services, and improved documentation on child health cards. In a collaborative effort with the OVC program, child protections issues will be addressed as the program seeks to pilot and scale up the community-based child protection model. Working with the OVC program, the follow-on program will strategically intensify interventions to improve the well-being of girls.

To contribute to program sustainability, the program will build the capacity and strengthen the skills of community and facility-based care providers through human resource for health (HRH) activities in the focus regions, while also addressing food security and nutrition issues for children living with HIV/AIDS and OVC.

The program will strengthen M&E in care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. PASADA will particpate in CHMT annual review meetings and provide support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	290,000	0

Narrative:

This program will use the strategy of using mobile VCT services to increase the number of people testing for HIV. In previous years, this strategy brought the monthly number of people tested from approximately 1,500 to over 6,000. Furthermore, in an attempt to identify more HIV+ children in need of services, door-to-door counseling and testing will also be initiated. Close collaboration with other program services will continue, as will regular supervision of all VCT sites, in order to guarantee quality of service and the availability of supportive counseling for all clients in need. PLHA will also be trained and involved in all of the program activities.

Private community based health facilities will be sensitized about the need for provider initiated testing and counseling (PITC). A special training for teenagers, called “Teens in Action,” will also be conducted to promote HIV testing among young people.

Care for counselors will continue through various anti-burnout strategies, including review retreats, in-service training, upgrade courses, and supervision. VCT volunteers will be provided with on-site trainings as a way of capacity building and sustained motivation. This program will also pay particular attention to monitoring and evaluation, as well as quality data collection and management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	328,509	0

Narrative:

The PASADA PMTCT program will continue to support PMTCT services sites in two regions: Dar es aalaam and Pwani. The target population includes men and women of reproductive age and their families. The base funding will be used to increase quality of PMTCT services related to both the mother and her child to achieve and maintain strategic high geographical PMTCT coverage.

The base funding will especially be used to increase quality of services related to mother and child health in a program reached by a ongoing PMTCT project . In addition, it will maintain the targets that have been met, and will try to even go beyond.

The program will scale-up PMTCT services to cover 98% of the facilities providing RCH services in focused facilities in Coast and Dar Es Salaam. PASADA will support services that include but are not limited to: HIV testing (in ANC, L&D), partner testing, counseling on infant feeding options (IF), strengthening counseling on FP methods to HIV+ mothers during postpartum visits, offering HIV testing at the FP clinic, offering referrals to care and treatment, clinical staging of the HIV+ pregnant women at the RCH clinic by the PMTCT service providers with linkages to CTC, rolling out of more efficacious regimen to facilities with the capacities, provision of ART prophylaxis to HIV+ pregnant women who are not eligible for ART, provision of Cotrimoxazole to all eligible pregnant women and exposed infants, conduct PMTCT outreach services in hard to reach areas and normadic populations, quarterly supportive supervision together with the RHMT to ensure quality of services. Selian will ensure the availability of HIV test kits by linking with MSD and SCMS, ensure adequate supply of drugs for more efficacious regimen based on needs and support printing and distribution of IEC materials and job aids.

TA will be sought from MDH and ICAP to strengthen M&E in PMTCT and will ensure guidelines and M&E tools are available, improve data collection systems, and train service providers on filling of the PMTCT

monitoring tools, including Data Quality Assurance activities. The program will strengthen and participate in CHMT annual review meetings, the formation and integration of regional PMTCT task forces into Reproductive and child health, support regional quarterly partners meetings and strengthen linkages and referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,462,500	0

Narrative:

In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. The PASADA program will continue to support adult ART services in Dar Es Salaam and Pwani The target population includes men, women, and their families.

The program will support the ART serices in several CTC clinics it currently support, and ensure it implements and monitor a comprehensive ART program. Activities for the program will include supporting initiating, refill and outreach sites, increasing the number of pregnant women and HIV+ TB patients who are initiated on treatment, improving linkages and referrals between HIV program areas, strengthening support groups in facilities and communities, improving health seeking behaviors, integrating family planning methods in HIV/AIDS care and treatment services, and introducing point of care CD4 testing (PIMA).

PASADA will supports and implement the URT's initiative of adopting the latest WHO recommendations and roll out implementation of the guidelines in a phased approach. The program supports initiation of ART for all HIV positive pregnant women with CD4 counts below 350. In addition, irrespective of CD4 counts, all TB patients co-infected with HIV, all HIV positive children below the age of 24 months, and all patients with clinical stage 3 and 4 will be initiated on ART through the program. Patients identified in need of treatment from feeder systems (such as PMTCT, TB/HIV clinics, PITC, and EID) will be accommodated, while treatment support for HIV-infected pregnant women to reduce maternal mortality and prevent HIV-transmission to the baby will be prioritized. Point of care CD4 tests at ANC will be deployed, once endorsed (PIMA currently being in the final evaluation phase) , and ARV services will be integrated into TB and ANC clinics. Through their regions and districts, providers will be supported to build their capacity through refresher training and mentoring.

The program will sought TA from ICAP and MDH and strengthens M&E in care and treatment by ensuring national guidelines and M&E tools are available, used, and improving data collection systems, and training service providers on filling out care and treatment monitoring tools. Selian will participate in CHMT annual review meetings are facilitated and strengthened, while support of activities in the focus

districts and regions will be aimed at strengthening coordination of care and treatment services.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	PDTX	156,000	0

Narrative:

In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. The PASADA program will continue to support adult ART services in Pwani and Dar Es Salaam

Activities will focus on improving the quality of services being provided to children infected with HIV, with a specific focus on scaling up early diagnosis and treatment through Early Infant Diagnosis (EID). Focus on provider initiated testing and counseling (PITC) for older children in all pediatrics entry points, including MCH, pediatrics wards, malnutrition rehabilitation wards, care and treatment clinics, and OPD.

The program will strengthen follow-up and linkages to treatment. The revised PITC and PMTCT guidelines will be utilized, while early identification of HIV exposure will be prioritized. Adoption of WHO guidelines, including earlier treatment for infected children below two years, will be incorporated into the program. Onsite mentoring, training, and resources to health care providers will be supported to improve their capacity and competency in the implementation of pediatric care and treatment interventions. Links to PMTCT and pediatric HIV care and treatment will initiate efforts to scale up comprehensive PMTCT and pediatrics HIV care, treatment, and support services. The program will promote the provision of pediatrics care and treatment services at RCH sites, which includes early identification of HIV status and infection, and follow up of HIV exposed infants.

The program wil sought TA from ICAP and MDH Relief to strengthen M&E in pediatric care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. PASADA will participate CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Implementing Mechanism Details

Mechanism ID: 14690	**Mechanism Name: Selian Lutheran Hospital Follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Selian Lutheran Hospital, Tanzania	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,874,657	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,874,657

Sub Partner Name(s)

(No data provided.)

Overview Narrative

With COP 2012, Selian will be providing comprehensive and sustainable clinical and community based HIV/AIDS services. This program will support local institutions and entities to scale up, expand and integrate HIV/AIDS care services in the two regions of Arusha and Manyara. Special emphasis will be placed on ensuring that adults and children living with HIV/AIDS benefit from a comprehensive package of HIV and health – related interventions.

In line with PF Goal on service maintenance and scale up, activities at both facility and community levels will be involved. Facility based care and support services will include counseling and testing services, palliative care, TB/HIV screening and treatment services; management of opportunistic infections including Cotrimoxazole prophylaxis, cervical cancer screening, family planning and reproductive health services, provision of insecticide treated nets, malaria prophylaxis, Positive Health, Dignity and Prevention (PHDP) services and nutritional assessment counseling and services (NACS). Community-based services will include the provision of the PHDP package, community-based palliative care, linkages to and provision of safe drinking water options and sanitation services, and linkages to and provision of household food safety and economic strengthening.

To achieve this array of services and gain program efficiencies, Selian will rely on the existing local organization and government system to establish and strengthen referral networks and linkages to civil society organizations (CSO), faith-based networks, and services provided by non- Government Organizations (NGO).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	14690		
Mechanism Name:	Selian Lutheran Hospital Follow-on		
Prime Partner Name:	Selian Lutheran Hospital, Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	483,000	0
Narrative:			
In Tanzania, HBHC partners implement a standard package of care activities. This program will provide comprehensive clinical care and support in Arusha and Manyara regions. It will combine two components of care packages; first being clinical care and second community home-based care. With COP 2012 funds, Selian will continue to support HBC services through the network of community			

home-based care providers who are already trained using the revised curriculum. In line with the reviewed home-based care guidelines, initial assessments will be done to ascertain the number of existing CHBCP and the coverage of the services. Those trained using new curriculum will be taken aboard while those trained using old curriculum will be provided with refresher training.

Services to patients will be tailored as to the stage and general outlook of the disease. Tailored services include community based palliative care, provision of PHDP package, linkage to and provision of safe drinking water options and sanitation services, linkage to and provision of household food security, and economic strengthening activities. These community based activities and CHBCP activities will be linked to facility based care and support services. CHBCPs will play a bigger role in linking the facility services to the community by acting as community agents for care and treatments, PMTCT, TB/HIV, Pediatric HIV and Family planning. In the community CHBCPs will link with the facility to track loss to follow up and drop outs from CT clinics and PMTCT and refer them back to the facilities. They will also monitor patients on DOTS treatment for TB. CHBCPs will increasingly carry out health promotion activities like nutritional assessment and counseling, lay counseling for home counseling and testing and when the MOH issues permission, conduct home testing for HIV. To achieve this range of services and gain program efficiencies, the program will capitalize on the community and facility referral and linkages, civil society organizations (CSOs), faith based organizations (FBO), and services provided by non-governmental organizations (NGOs). To ensure sustainability and transition to local organization and local government the Selian supported program will be implemented using the government guidelines and existing structures.

Selian will sought TA from partners such as EGPAF, PATHFINDER who areinvolved in implementing this similar activities to support to improve quality of service and efficiencies over the time of the project. TA will also be sought in the areas of M&E, quality improvement measure, project management etc. At the service delivery point support will be provided to CHBCPs to enable communities carry out their roles effectively. Selian will access centrally procured HBC kits, IEC materials and trainings. Innovative approaches will be used through program integration, use of other financing schemes and other opportunities existing locally to leverage resources to support the community activities for a long term sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	150,000	0

Narrative:

The program will focus on building the capacity of local community structures, especially local CBOs, to respond directly to the needs of children and their families. This program will implement its activities

through district and lower local government authorities, while OVC and youth services will be provided by CBOs who utilize community volunteers. Its efforts will also highlight a core principle of the GHI strategy by leveraging other efforts as demonstrated by the local governments contributing significant financial resources to some of the MVC services. At the same time, this program will encourage other implenmeting partners to share staff skills and costs of training volunteers (e.g. peer educators and para social workers). After the initial training and capacity building of partners and volunteers, the cost of delivering services will significantly decrease over time.

The program will continue to train a network of community volunteers (para social workers, mama mkubwas or “big mothers”, peer educators, and community justice facilitators) to sustainably provide care to OVC households. Local government leaders are involved in all stages and processes through meetings and trainings, by mobilizing communities to participate in the project activities, offering support supervision, and monitoring the work of local partners and their activities within the respective communities.

As a right to all identified children and within the government policy framework to care and protect children's social welfare and future, the program will ensure that every identified and registered child has a birth certificate issued by the regional governments and a community health insurance fund card so that children can access free health care at any of the government health facilities. All children under five will be taken to health centers for vaccinations in the event this had not been done previously.

This program will provide a comprehensive package of direct services to OVC households. Caregivers grouped in 10-15 households will benefit from economic strengthening and income generating support, as well as food security and nutrition education. Children with emotional problems will be given psychosocial support and protection against any risk of sexual and/or physical abuse. Health care and treatment services will be mapped to ensure all children in need of health services are properly referred to and linked with service providers. In addition, children who have dropped out of schools will be supported to return to school, while adolescents will be organized in groups to receive HIV prevention and life skills training.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	17,000	0

Narrative:

With COP 2012 funds, this follow-on program will play a key role in improving the health and well-being of children in Arusha and Manyara, as the program implements a standard package of care interventions. The care program will enhance and strengthen linkages between facility and community-based services

by integrating nutrition assessments counseling and support (NACS), offering counseling and support across care programs, and promoting integration of OVC, maternal newborn and child health (MNCH), PMTCT, and pediatric AIDS interventions to children infected by HIV.

Specifically, the program will enhance the roles of community care providers in promoting a more integrated community response. The program will build on the successful results of the community care/MCH Community Health Workers training.

Through enhanced community services, the program will strengthen the continuum of care for HIV-affected children from birth through adolescence. Focus will be in the provision of cotrimoxazole prophylaxis to eligible children, linking and integrating cotrimoxazole provision with MNCH services, and improved documentation on child health cards. In a collaborative effort with the OVC program, child protections issues will be addressed as the program seeks to pilot and scale up the community-based child protection model. Working with the OVC program, the follow-on program will strategically intensify interventions to improve the well-being of girls.

To contribute to program sustainability, the program will build the capacity and strengthen the skills of community and facility-based care providers through human resource for health (HRH) activities in the focus regions, while also addressing food security and nutrition issues for children living with HIV/AIDS and OVC.

The program will strengthen M&E in care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	263,000	0

Narrative:

This program will adopt the strategy of using mobile VCT services to increase the number of people testing for the HIV virus. This strategy in previous years brought the number of people tested monthly from about 1,500 to over 6,000. In an attempt to identify more HIV+ children in need of services, door-to-door counseling and testing will also be initiated. Close collaboration with other program services will continue, as will regular supervision of all VCT sites, in order to guarantee quality of service and the availability of supportive counseling for all clients in need. PLHIV will be trained and involved in all these

activities. Private community based health facilities will be sensitized on the need for Provider Initiated Testing and Counseling. A special training for teenagers will also be done to promote HIV testing among young people.

Care for counselors will continue through various anti-burnout strategies including review retreats, in-service training, upgrading courses and supervision. VCT volunteers will be provided with onsite training as a way of building their capacity and maintaining motivation. This program will also pay particular attention to monitoring and evaluation and quality data collection and management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	256,157	0

Narrative:

In Tanzania, the USG team had decided to regionalize partners working in PMTCT. Consequently, a fairly standardized package of services is implemented throughout the country by multiple partners in their respective regions. This program will continue support for PMTCT services in Arusha and Manyara. The target populations include women of reproductive age and their families. Cost efficiencies will be achieved by decreasing cost inactivities such as centralized, introducing mentoring and and advocating for increased funding of program activities from the GoT's own resources. The prgram will focuses on sustainability and the ultimate goal is support program with local government. The GoT will be the primary transition partner and recipient of capacity-building efforts.

The base funding will especially be used to increase quality of services related to mother and child health in a program reached by a ongoing PMTCT project . In addition, it will maintain the targets that have been met, and will try to even go beyond.

The program will scale-up PMTCT services to cover 98% of the facilities providing RCH services in focused facilities in Arusha and Mnanyara. Selian will support services that include but are not limited to: HIV testing (in ANC, L&D), partner testing, counseling on infant feeding options (IF), strengthening counseling on FP methods to HIV+ mothers during postpartum visits, offering HIV testing at the FP clinic, offering referrals to care and treatment, clinical staging of the HIV+ pregnant women at the RCH clinic by the PMTCT service providers with linkages to CTC, rolling out of more efficacious regimen to facilities with the capacities, provision of ART prophylaxis to HIV+ pregnant women who are not eligible for ART, provision of Cotrimoxazole to all eligible pregnant women and exposed infants, conduct PMTCT outreach services in hard to reach areas and normadic populations, quarterly supportive supervision together with the RHMT to ensure quality of services. Selian will ensure the availability of HIV test kits by linking with MSD and SCMS, ensure adequate supply of drugs for more efficacious regimen based on needs and

support printing and distribution of IEC materials and job aids.

TA will be sought from EGPAF and AIDS RElief to strengthen M&E in PMTCT and will ensure guidelines and M&E tools are available, improve data collection systems, and train service providers on filling of the PMTCT monitoring tools, including Data Quality Assurance activities. The program will strengthen and participate in CHMT annual review meetings, the formation and integration of regional PMTCT task forces into Reproductive and child health, support regional quarterly partners meetings and strengthen linkages and referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	637,500	0

Narrative:

In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. The Selian program will continue to support adult ART services in Arusha and Manyara. The target population includes men, women, and their families.

The program will support the ART serices in several CTC clinics it currently support, and ensure it implements and monitor a comprehensive ART program. Activities for the program will include supporting initiating, refill and outreach sites, increasing the number of pregnant women and HIV+ TB patients who are initiated on treatment, improving linkages and referrals between HIV program areas, strengthening support groups in facilities and communities, improving health seeking behaviors, integrating family planning methods in HIV/AIDS care and treatment services, and introducing point of care CD4 testing (PIMA).

Selian will supports and implement the URT's initiative of adopting the latest WHO recommendations and roll out implementation of the guidelines in a phased approach. The program supports initiation of ART for all HIV positive pregnant women with CD4 counts below 350. In addition, irrespective of CD4 counts, all TB patients co-infected with HIV, all HIV positive children below the age of 24 months, and all patients with clinical stage 3 and 4 will be initiated on ART through the program. Patients identified in need of treatment from feeder systems (such as PMTCT, TB/HIV clinics, PITC, and EID) will be accommodated, while treatment support for HIV-infected pregnant women to reduce maternal mortality and prevent HIV-transmission to the baby will be prioritized. Point of care CD4 tests at ANC will be deployed, once endorsed (PIMA currently being in the final evaluation phase) , and ARV services will be integrated into TB and ANC clinics. Through their regions and districts, providers will be supported to build their capacity through refresher training and mentoring.

The program will sought TA from EGPAF and AIDSRelief and strengthens M&E in care and treatment by ensuring national guidelines and M&E tools are available, used, and improving data collection systems, and training service providers on filling out care and treatment monitoring tools. Selian will participate in CHMT annual review meetings are facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	PDTX	68,000	0
Narrative:			

In Tanzania, treatment partners implement a standard package of services throughout the country in their respective regions. The Selian program will continue to support adult ART services in Arusha and Manyara.

Activities will focus on improving the quality of services being provided to children infected with HIV, with a specific focus on scaling up early diagnosis and treatment through Early Infant Diagnosis (EID). Focus on provider initiated testing and counseling (PITC) for older children in all pediatrics entry points, including MCH, pediatrics wards, malnutrition rehabilitation wards, care and treatment clinics, and OPD.

The program will strengthen follow-up and linkages to treatment. The revised PITC and PMTCT guidelines will be utilized, while early identification of HIV exposure will be prioritized. Adoption of WHO guidelines, including earlier treatment for infected children below two years, will be incorporated into the program. Onsite mentoring, training, and resources to health care providers will be supported to improve their capacity and competency in the implementation of pediatric care and treatment interventions. Links to PMTCT and pediatric HIV care and treatment will initiate efforts to scale up comprehensive PMTCT and pediatrics HIV care, treatment, and support services. The program will promote the provision of pediatrics care and treatment services at RCH sites, which includes early identification of HIV status and infection, and follow up of HIV exposed infants.

The program wil sought TA from EGPAF and AIDS Relief to strengthen M&E in pediatric care and treatment by ensuring national guidelines and M&E tools are available, improving data collection systems, and training service providers on filling out care and treatment monitoring tools. Selian will participate CHMT annual review meetings will be facilitated and strengthened, while support of activities in the focus districts and regions will be aimed at strengthening coordination of care and treatment services.

Implementing Mechanism Details

Mechanism ID: 14691	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14692	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14693	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14694	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14695	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14696	Mechanism Name: Tanzania Social Action Fund
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: TASAF/WB	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 450,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	450,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

World Bank (WB) is working with URT to implement the national safety net program through Tanzania Social Action Fund (TASAF). For the past 15 years, several safety net programs have been implemented, including community-based conditional cash transfer (CB-CCT), food insecure (FI) households, and provision of social infrastructures to service-poor (SP) communities.

TASAF III has been designed on the CB-CCT pilot project evaluation findings and a WB study on national assessment of the safety nets systems for vulnerable populations. The objective of TASAF III is "to enable poor households increase incomes and opportunities while improving consumption." The project is aligned with the PEPFAR priorities of enhancing multi-sectorial response to HIV/AIDS, while also contributing to GHI's system strengthening goal.

TASAF III strategy is to strengthen institutions and communities' technical and organizational capacity to mobilize coordinated services for targeted PLHIV, poor, and vulnerable households. In addition, the capacity of local government structures to deliver and monitor community programs and social services delivery systems will be enhanced.

To ensure sustainability, TASAF III will work within existing structures, contribute to economic empowerment through reduction of poverty, integrate economic strengthening activities, and promote livelihood activities to reinforce families' long-term caring capacities.

A comprehensive M&E plan for the program will be developed. A national database system, including a unified registry of beneficiaries, will be developed to capture data at all healthcare facilities. A baseline survey and several studies will be undertaken to document the impact of the project and contribute to an evidence-base approach to learning.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	14696		
Mechanism Name:	Tanzania Social Action Fund		
Prime Partner Name:	TASAF/WB		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	150,000	0
Narrative:			
(Please see HKID budget code narrative as both areas share the same goals and objectives) In FY 2012 USG/T will change its strategic approach to address the needs of PLHIV. The approach will be tailored to develop specific non-bedridden and bedridden PLHIV services packages. Both of the packages will comprise livelihood and economic strengthening support, as well as linkages to other economic supporting opportunities. The TASAF III program will support this strategic shift by improving livelihoods for vulnerable PLHIV. Support of the program contributes to the USG/T's HBC priorities of contributing to household economic sustainability, care, and support of PLHIV households.			

USG/T funds will specifically support the TASAF III national database system development to ensure that the database includes PLHIV. To ensure comprehensive information is captured, database tools that specify various economic status and illnesses will be developed. This will enable PLHIV and their dependents to resume normal activities and receive community support. In order to monitor that PLHIV are recorded within the system, routine checks, verification exercises, and assessments will be built in to the system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	300,000	0

Narrative:

The World Bank is coordinating URT efforts to develop the national social safety net program through the Tanzania Social Action Fund (TASAF). The project, TASAF III, will engage a multi-sectoral team that includes various URT agencies. The Government is providing nearly $30 million toward the program and plans to roll out TASAF III nationwide as part of its efforts to reduce poverty and improve the lives of the poor. TASAF III will target people living under the basic needs poverty line, which is currently 33.6% of the population. USG/T support to the program contributes to the PEPFAR OVC priorities of developing sustainability and local ownership of the OVC response. The government expects to achieve the objective by implementing the following four components:

1. Provide cash transfers linked to participation in public works and adherence to co-responsibilities;
2. Support community-driven interventions that enhance livelihoods and increase incomes through community savings and investments, as well as specific livelihood enhancing seed grants to facilitate asset building;
3. Target infrastructure development (education, health, water) to enable service poor communities to realize the objectives of the safety net;
4. Capacity building at the community, LGA, regional, and national levels to ensure adequate program implementation.

USG/T will support the development of a national database system to capture information about the social safety net program beneficiaries, which will include socioeconomic and demographic profile information. The database will also track services and support provided through the program. Information from the database will assist URT policy makers to monitor program implementation, demonstrate impact, and plan for program scale-up and management. Most importantly, the database will be linked with the national OVC database to ensure coordination of OVC service delivery and provide evidence on appropriate interventions for OVC households. The linkages will also ensure that

vulnerable children households are incorporated into government social safety structures in order to access services in a sustainable way.

Implementing Mechanism Details

Mechanism ID: 14697	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14698	**Mechanism Name: National Capacity Building**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

According to the 2010 Tanzania Demographic and Health Survey (TDHS), an estimated 353,685 (4.7%) children in mainland Tanzania are acutely malnourished; of which 85,334 (1.1%) are severely acutely malnourished (SAM). Regional disparities in the prevalence of acute malnutrition in Tanzania exist within the Arusha region, which has the highest prevalence of acute malnutrition (9.5%) (DHS, 2010). If left untreated, up to half of children with SAM will die.

This activity will contribute to URT's efforts in reducing under-five mortality resulting from severe acute undernourishment. The activity is in line with the first goal of the PF of service maintenance and

scale-up, as well as the GHI goal to supporting URT's national health and development goals of reducing maternal, neonatal, and childhood deaths through increased access to quality comprehensive services for women and newborns. In addition, GHI stresses the improved quality of primary prevention of childhood illness and case management of children under-five, which is addressed in this activity.

The UNICEF program covers 18 model hospitals, which work in 19 districts within 12 regions of Tanzania. These hospitals are typically higher-level facilities that can adequately manage referral cases.

For sustainability and cost efficiencies, UNICEF will promote local ownership of programs by URT within the community structures. This includes building the capacity of district councils to provide essential nutrition services, along with promoting and supporting availability of essential nutrition supplies locally.

Key nutrition indicators will be monitored using national systems, particularly the care and treatment database.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HKID	Tanzania Food and Nutrition Centre	50000	Nutrition suplies needs assessment, procurement &quantification

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	14698		
Mechanism Name:	National Capacity Building		
Prime Partner Name:	United Nations Children's Fund		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0

Narrative:

UNICEF will use these funds to support the national integrated management of acute malnutrition (IMAM) as a wraparound activity with other donors that seek to benefit people living with HIV/AIDS and other clinically malnourished under-five children, including orphans and vulnerable children.

Training support will be provided to healthcare professionals on management of severe acute malnutrition, as well as integration on nutrition assessment and counseling. These trainings will allow healthcare professionals to offer a comprehensive set of clinical nutrition package. These funds will also support USAID/UNICEF's joint participation in the national dialogues and review processes, which bring attention and actions to the new nutrition recommendations that benefit under-five children and women, particularly those of vulnerable groups such as HIV-positive women.

UNICEF will work with selected private sector partners that can bring business solutions to nutritional problems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	200,000	0
Narrative:			
The goal of this activity is to elevate the importance of child protection in Tanzania and reduce violence against children. These funds will be used to provide capacity building activities and support to local governments strengthen and expand child protection UNICEF will work with Save the Children and local government councils to model and collect data on community-initiated child protection entities, such as safe schools, one-stop center, child protection units, children's councils, child police desks, and using existing traditional community structures. Four district councils will be selected to replicate the child protection system model. In addition, selected district councils in Temeke and Mwanza will pilot child protection one-stop centers. Technical assistance to URT's Department of Social Welfare will focus on integrating child protection issues in the revised MVC National Costed Plan of Action (NACP). By strengthening the national social welfare strategy and the data management system (DMS) the social workforce and data collection at district councils will dramatically improve. Although this is a new mechanism, UNICEF has the comparative advantage of having already worked directly with the government structures, enabling a more efficient process for the USG to further the goal of protecting children in Tanzania.			

Implementing Mechanism Details

Mechanism ID: 14699	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14701	**Mechanism Name: DELIVER Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 2,450,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,450,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

JSI Deliver is collaborating with Supply Chain Management systems to develop pre-service training for health commodities and to develop a central logistics data repository leveraging technical expertise and resources across projects to further both PF and GHI goals. Partnering with MSD on infrastructure development and ERP projects with funding contributions from both PEPFAR and Global Fund, has provided an opportunity to strengthen collaboration and increase funding efficiencies while giving MSD the opportunity for leadership and ownership in project development and system strengthening. JSI Deliver Performance Management Plan (PMP) for monitoring and evaluation focuses on continuous improvement of product availability; strengthening of logistics data collection and analysis capability within the MOHSW; improved capacity of MSD to manage and deliver health commodities; improved data availability to support central level decision making; and strengthening of commodity management capacity at health facilities. This funding will be specifically used to fund the Electronic Logistics Management Information System (e-LMIS). e-LMIS is the second phase of the Medical Stores Department (MSD) Enterprise Resource Program (ERP) development and implementation which USAID supported through JSI SCMS and JSI Deliver. This project directly relates to PF Goal 4 to support the URT in "strengthening a functional, prioritized, transparent, and timely logistics and supplies procurement system", as well as to GHI goal IR2 for improved health systems.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HTXD	Medical Stores Department	250000	This partner supports Medical Stores Department which is part of the MOHSW. Support is provided for the procurement of commodities and for technical assistance with supply chain. Global Fund also provides grants to MSD. Deliver and MSD coordinate much o

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	14701		
Mechanism Name:	DELIVER Project		
Prime Partner Name:	John Snow, Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Governance and Systems	OHSS	2,450,000	0
Narrative:			
JSI Deliver TO #4 will use COP 2012 funding toward the Electronic Logistics Management Information System (e-LMIS). e-LMIS is the second phase of the Enterprise Resource Program (ERP) development and implementation of the Medical Stores Department (MSD), which USAID supported through JSI SCMS and JSI Deliver. The e-LMIS is an electronic ordering and management system which is designed to replace the existing paper ordering system. Health facilities will be able to process their commodities orders through the electronic system linkd to the MSD ERP system through a web based connection. The transition to the electronic system will increase ordering efficiencies by reducing mistakes from manual addition and transcription errors at various stages in the ordering process. e-LMIS will also diminsh ordering lead times by allowing for electronic transfer of orders through the internet instead of physical transmissions through the post. This project intentionally focuses on all commodities within the supply system to create efficiencies within the supply chain ordering and distribution system, resulting in spill-over effects and benefits for the entire health system.			

Implementing Mechanism Details

Mechanism ID: 14702	TBD: Yes
REDACTED	

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		140,100			140,100
ICASS		880,000			880,000
Institutional Contractors		1,702,200			1,702,200
Management Meetings/Professional Developement		119,700			119,700
Non-ICASS Administrative Costs		556,700			556,700
Staff Program Travel		143,300			143,300
USG Staff Salaries and Benefits		1,278,120			1,278,120
Total	**0**	**4,820,120**	**0**	**0**	**4,820,120**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount

Computers/IT Services		GHP-State		140,100
ICASS		GHP-State		880,000
Management Meetings/Professional Developement		GHP-State		119,700
Non-ICASS Administrative Costs		GHP-State		556,700

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		49,000			49,000
ICASS		504,000			504,000
Management Meetings/Professional Developement		40,740			40,740
Non-ICASS Administrative Costs		300,000			300,000
Staff Program Travel		205,000			205,000
USG Staff Salaries and Benefits		1,841,494			1,841,494
Total	**0**	**2,940,234**	**0**	**0**	**2,940,234**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		49,000
ICASS		GHP-State		504,000
Management		GHP-State		40,740

Meetings/Professional Developement				
Non-ICASS Administrative Costs		GHP-State	These costs are associated with field office. Utilities $150,000, Vehicle Maintenance $23,000, Equipment $50,000, Security Guard Services $18,000, Equipment Maintenance Insurance $11,000, Generator Fuel $8,000, and Office Space $40,000.	300,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing		100,000			100,000
Computers/IT Services		845,200			845,200
ICASS		890,000			890,000
Institutional Contractors		3,608,716			3,608,716
Management Meetings/Professional Developement		180,000			180,000
Non-ICASS Administrative Costs		471,636			471,636

Staff Program Travel		859,541			859,541
USG Staff Salaries and Benefits	3,683,000	867,743			4,550,743
Total	**3,683,000**	**7,822,836**	**0**	**0**	**11,505,836**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		100,000
Computers/IT Services		GHP-State		845,200
ICASS		GHP-State		890,000
Management Meetings/Professional Developement		GHP-State		180,000
Non-ICASS Administrative Costs		GHP-State	$27,861 Transport and Courier Services; $82,000 Communication (telephone, fax, internet, teleworks); $72,000 utilities; $85,000 Office Maintenance; $89,775 Office Supplies; $10,000 Furniture; $105,000 Contractuals (consultancy service, contracts)	471,636

U.S. Department of Health and Human Services/Office of Global Health Affairs

Agency Cost of	GAP	GHP-State	GHP-USAID	Central	Cost of Doing

Doing Business				GHP-State	Business Category Total
Capital Security Cost Sharing		20,000			20,000
ICASS		73,000			73,000
Management Meetings/Professional Developement		15,000			15,000
Non-ICASS Administrative Costs		152,000			152,000
Staff Program Travel		60,000			60,000
USG Staff Salaries and Benefits		165,760			165,760
Total	**0**	**485,760**	**0**	**0**	**485,760**

U.S. Department of Health and Human Services/Office of Global Health Affairs Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		20,000
ICASS		GHP-State		73,000
Management Meetings/Professional Developement		GHP-State		15,000
Non-ICASS Administrative Costs		GHP-State		152,000

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT		0			0

Services					
ICASS		65,000			65,000
Management Meetings/Professional Developement		0			0
Non-ICASS Administrative Costs		0			0
Staff Program Travel		0			0
USG Staff Salaries and Benefits		0			0
Total	**0**	**65,000**	**0**	**0**	**65,000**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		0
ICASS		GHP-State		65,000
Management Meetings/Professional Developement		GHP-State		0
Non-ICASS Administrative Costs		GHP-State		0

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		11,300			11,300
Non-ICASS Administrative Costs		112,800			112,800

Peace Corps Volunteer Costs		1,440,100			1,440,100
Staff Program Travel		16,500			16,500
USG Staff Salaries and Benefits		291,100			291,100
Total	**0**	**1,871,800**	**0**	**0**	**1,871,800**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		11,300
Non-ICASS Administrative Costs		GHP-State		112,800