Tanzania

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

I. Country Context

Since 2004, PEPFAR Tanzania has been working closely with the United Republic of Tanzania and other donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, to respond to the HIV epidemic. PEPFAR/T, the GFATM and the URT share a symbiotic relationship in Tanzania. While PEPFAR/T predominantly focuses on services and system strengthening, GFATM is responsible for commodity procurement and some systems strengthening, and the URT provides policy framework, infrastructure, systems, and personnel. Deficits in resources, governance, and health systems continue to complicate Tanzania's ability to adequately respond to HIV/AIDS. As a result, Tanzania's health programs, especially for HIV, 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/T (74%) and the GFATM (16%). In addition, the country grapples with weak health infrastructure, shortages of health and social workers, high levels of stigma, cumbersome government procurement systems, weak management and strategic planning, and poor accountability.

According to the 2011 UNAIDS Report on the Global AIDS Epidemic, adult HIV prevalence in the country is estimated at 5.8% and an estimated 1.6 million Tanzanians are living with HIV of which 1.3 million are OVC. An estimated 84,000 AIDS related deaths occur in Tanzanian each year. According to the 2007-08 Tanzania HIV and AIDS and Malaria Indicator Survey, the impact of the epidemic varies significantly by region, with the highest prevalence region (Iringa) estimated at 15.7%, and the lowest estimated (Zanzibar) at 0.6%, and with a significant difference in the prevalence between urban (9%) and rural (5%) areas. The data also reveal significant sex differentials in HIV prevalence, with male prevalence at 5%, and female prevalence at 7%. A new THMIS was conducted in 2011-2012 and is due to be released in late March 2013. Despite a generalized epidemic, key populations 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 people who inject drugs (2007) and 31.4% among sex workers (2010), while unpublished data for men who have sex with men in Dar es Salaam indicates prevalence over 30% (2012).

PEPFAR support to Tanzania has enabled a dramatic increase in the number of adults and children accessing ART, with 364,000 individuals receiving treatment in FY2012. Also during FY2012, a total of 3,370,000 individuals received HIV testing and counseling, 1,100,000 pregnant women were tested and counseled through PMTCT services, 526,000 OVC received support, and 152,000 VMMC took place.

In addition to PEPFAR/T and GFATM, a few other bilateral donors provide some assistance for HIV. PEPFAR/T representatives actively participate in several groups that bring government, donors, and civil society together, including the Tanzanian National Coordinating Mechanism, the Joint Technical Working Group on HIV and AIDS, DPG-AIDS and DPG-Health on which USAID/Tanzania serves as co-chair. Throughout the last year, PEPFAR/T has collaborated extensively with the GFATM and URT to navigate global and local transitions at the GFATM, particularly ensuring that the GFATM Round 8 HIV grant renewal was finalized to secure a steady supply of all commodities, including ARVs, rapid test kits and lab supplies.

Despite systems challenges and leadership turnover, the country has made progress in defining a policy and strategy framework to guide stakeholders in the HIV response. Key documents include the National Multi-Sectoral Framework on HIV and AIDS (2008-2012), Health Sector HIV Strategic Plan III (2009-2015), and Zanzibar National HIV Strategic Plan II (2011-2016), of which the former two are currently undergoing revision. The Tanzania Partnership Framework (2009-2013) defines the roles and responsibilities of the URT and PEPFAR/T in addressing HIV, is aligned with these key national documents, and will be updated during 2013 to reflect the new NMSF III.

II. PEPFAR focus in FY2013

Through the FY2013 COP, PEPFAR/T continues to support achievement of the six PF goals (Service Delivery and Scale Up; Prevention; Leadership, Management, Accountability, and Governance; Sustainable and Secure Drug and Commodity Supply; Human Resources; and Evidence-based and Strategic Decision Making) while promoting greater capacity among Tanzanian actors in all sectors to manage and support the national response to HIV. Gender is a cross-cutting consideration in the Partnership Framework, and PEPFAR/T continues to recognize the importance of gender-differentiated strategies to achieve PF goals.

In FY2013, implementation of the PF goals will closely correspond to the newly released *PEPFAR Blueprint: Creating an AIDS-free Generation* (*Blueprint*) by strategically prioritizing high-impact interventions, including adopting PMTCT Option B+, scaling up both adult and pediatric treatment coverage under the 2010 WHO ART Guidelines, and increasing access to and uptake of VMMC, HTC, and condoms. PEPFAR/T has targeted the populations at greatest risk for HIV that fall under the Road Maps for Smart Investment and Shared Responsibility and is furthering efforts to increase shared responsibility.

PEPFAR/T is working in collaboration with URT to meet aggressive ART treatment goals and other

PEPFAR targets. Despite substantial challenges with commodities in FY2012, PEPFAR/T and government partners reached 98% of the FY2012 USG target for individuals on ART. To build on this momentum, PEPFAR/T has prioritized implementation of the recommendations of the joint TDY visit in October 2012 from the Adult Treatment, PMTCT, SI, and Pediatric Treatment Technical Working Groups conducted in conjunction with the OGAC/Multilateral Diplomacy section and the Fund Portfolio Manager from the GFATM. PEPFAR/T credits this visit with spurring the URT to make decisions on several key policy items that have impeded rapid program scale-up and expansion, including:

1. Full adoption of the 2010 WHO ART Guidelines by the URT,
2. Advancement of plans to implement PMTCT Option B+ ,
3. Signature of the second phase of the GFATM Round 8 HIV grant, which provides a majority of HIV commodities to the national program,
4. Decision by the URT to utilize the Voluntary Pooled Procurement mechanism, and
5. Negotiation of replacement test kits after the recall of SD Bioline HIV-1/2 3.0.

These five important developments will help to ensure that Tanzania can continue to aggressively accelerate treatment and achieve related targets through FY2013 and FY2014. PEPFAR/T has strategically adjusted its portfolio toward the AIDS-free Generation (AfG) target areas. The signing of the Round 8 HIV grant and the imminent implementation of VPP will eliminate many of the impediments to efficient program implementation and allow for efficient and secure commodity flows. Lastly, PEPFAR/T is working to improve linkages and referrals along the continuum of the HIV response to increase the likelihood that newly identified PLHIV are initiated into care and decrease loss to follow up.

Increased funding in AfG target areas (treatment services, PMTCT, HTC and VMMC) represent major funding shifts in the FY2013 COP. PEPFAR/T has also programmed funding in the FY2013 COP to fill forecasted gaps in commodities that exist based on the currently approved GFATM grant and that may occur as the country enrolls and transitions into the VPP. The consequent decreases in areas outside of the AfG target areas have pushed the respective portfolios to focus on high impact, efficient interventions in high burden/high prevalence populations and areas.

While VPP will minimize supply chain disruptions in the long run, the FY2013 COP partially covers the funding gap until this mechanism becomes completely operational. PEPFAR/T expects to use this entire allocation to respond to shortfalls; thus, there should be no carry over pipeline for procurement that would affect the country burn rate.

The interagency pipeline review of PEPFAR funds was a helpful exercise that increased attention to country, agency, and partner pipelines, with quarterly analyses that are now routine. PEPFAR agencies are increasing monthly burn rates to reduce pipelines and scale up to reach AfG targets. Pipeline

analyses are also integral to Operational Plan Update actions. Agencies are diligent in identifying program areas and partners with "excessive" amounts or amounts that would not be utilized in a timely fashion. This increased sensitivity will lead to consistent reprogramming actions that have the end goal of increasing the country burn rate. Because of the delayed arrival of FY2012 COP funding to country, in the past several months, PEPFAR/T has been forced to require several key partners to significantly slow down their implementation as pipeline funds are exhausted. Once FY2012 COP funds are obligated, PEPFAR/T will support partners to return to previous expenditure rates to avoid longer-term impact on results. The team will also continue to conduct regular financial reviews, including future Expenditure Analyses, to enable PEPFAR to continue to receive maximum value for its investments. This year's EA did not receive adequate participation (80% of partners and an unknown proportion of the overall portfolio) to enable comprehensive conclusions about country investments across the portfolio, but PEPFAR/T expects next year to have reliable results for COP planning as long as findings are provided to the country team early enough in the COP planning cycle.

Meeting the AfG targets will require strong government systems that are efficiently implementing GFATM grants, adopting necessary policy changes, and utilizing data effectively to make informed decisions on the epidemic. To that end, PEPFAR/T will continue to provide assistance to the URT to improve its management, technical, and financial capabilities. This includes working with Medical Stores Department on timely and efficient forecasting, procurement, warehousing and distribution of commodities to developing strategies that better link multiple, disparate national information systems. Both COP and central funds will contribute to this critical systems strengthening. The new Global Fund Collaboration Initiative will work with government agencies engaged in GFATM grant implementation, including better defining their roles, improving management capacities within those agencies, and enhancing collaboration between those agencies and PEPFAR/T.

III. Progress and Future

PF/PFIP Monitoring

PEPFAR/T uses the Partnership Framework Implementation Plan as a guiding document for all technical interventions and systems and capacity development priorities. Engagement with the URT has increased with the addition of routine PFIP reviews between PEPFAR/T and URT counterparts. These meetings, chaired by the Permanent Secretary of the Prime Minister’s Office, allow PEPFAR/T to update the URT on implementation of the six PF Goals. PEPFAR/T also uses these opportunities to discuss critical policy issues with government colleagues. Lastly, they provide a forum for discussion of URT priorities, needs, and gaps across technical areas and supplement on-going participation in national Technical Working Groups as well as DPG-AIDS.

Country ownership

Political ownership and stewardship have been demonstrated recently as the country prepares the evaluation of two national strategic documents and the development of their successor strategies: the NMSF III (currently being circulated for comments) and the HSHSP II (currently under review). However, coordination between these two documents and between the agencies leading their development, TACAIDS and MOHSW respectively, has been a challenge, and one that PEPFAR/T is actively trying to address by advocating for the alignment of the two strategies.

PEPFAR/T targets increasing institutional and community ownership in the FY2013 COP with renewed investment in public-private partnerships, private sector engagement, indigenous implementing partners, organizational support to community networks and groups, and capacity building of national and sub-national government institutions.

Technical and financial capability to manage the national HIV response still varies widely by program area, but PEPFAR/T has taken initial steps to identify specific areas and timelines in the new PF that can transition to national responsibility. The program staff presented these suggestions at the most recent PFIP review meeting in February 2013. Lastly, accountability may be expected to rise in the mid-term future, as the Ministry of Finance and Economic Affairs prepares to launch a pay-for-performance plan that entails financial awards for high ratings on GFATM grant performance, as determined by the GFATM.

Trajectory for FY2014 and beyond

FY2013 is a crucial year for the relationship between the URT and PEPFAR/T, as key strategy documents are renewed. The formation of the two critical national documents is timely for the renegotiation of the terms of the new PF. It is expected that the UNAIDS Investment Framework, the *Blueprint*, and the epidemiologic data from the new THMIS will have a central role in all three documents.

The partnership between PEPFAR/T and the GFATM has improved over the last year. Three major factors include: organizational transitions at the GFATM, a new Fund Portfolio Manager dedicated to Tanzania and Zanzibar, and the GFATM and PEPFAR/T collaboration to resolve the crisis surrounding the WHO de-listing of the SD Bioline HIV-1/2 3.0. The next PF will account for this welcome, strengthened relationship and the impact of the GFATM on program implementation over the subsequent five years. The potential for greater stewardship, ownership, and responsibility by national agencies is very promising for the future, given the organizational changes that will result from the VPP adoption, the Global Fund Collaboration Initiative, and the new PF.

IV. Program Overview

Clinical Services

As of September 2012, PEPFAR/T directly supported 364,243 people on ARVs, and 46% of PLHIV with clinical care services. Using the outdated CD4 criteria (<200), 59% of HIV positive patients who were eligible for ART were currently on treatment. The program also supports 4,366 facilities with PMTCT services, an increase of 690 facilities since FY2010, and 976 facilities with care and treatment services, an increase of 247 care and treatment centers since FY2011. PEPFAR/T partners implement a variety of clinical services including diagnosis, prevention and management of opportunistic infections, PITC, PMTCT, EID and pediatric care and treatment, cervical cancer screening and referrals, TB screening, and PHDP interventions. Moreover, PEPFAR/T care and treatment partners support the integration of family planning services at CTCs and HIV care and treatment within reproductive and child health clinics.

Adult ART

The ART strategy in the FY2013 COP focuses on increased identification of PLHIV, increased linkages along the prevention, care, and treatment continuum, timely ART initiation, maintenance of patients on ART with quality clinical services, and retention of patients in care and treatment. PEPFAR/T has initiated collaboration among ART, HTC and HBC partners to strengthen linkages to and retention of patients in care and treatment services. These collaborations are essential to achieve the AfG targets, which include increasing the number of patients currently receiving ART to 449,000 by September 2013.

PEPFAR/T will support the URT in its efforts to scale-up treatment services and maximize efficiencies by focusing on the availability of quality services and commodities, and strengthening systems to link patients in need of care and treatment services who are identified in “feeder systems” such as HTC, PMTCT, TB/HIV clinics, provider initiated testing and counseling or EID. In addition, to accommodate the full adoption of the new National ART guidelines, PEPFAR/T is advocating for an increase in clinic days at facilities, comprehensive reviews of adult and pediatric pre-ART patient charts to determine ART eligibility, CD4 testing when indicated and enhanced efforts to conduct outreach services for both adults and children. PEPFAR/T is also working in close collaboration with headquarters TWGs, the URT and WHO to simplify ART regimens.

Pediatric ART

Despite intensified efforts to collaborate between program areas to link those who know their status to a CTC and to link patients in care to ART, PEPFAR/T has been challenged with identifying, enrolling and retaining children in care and treatment. A major goal for the FY2013 COP is to increase increasing enrollment and retention. PEPFAR/T will continue to expand pediatric ART services in parallel with adult ART services. In addition, PEPFAR/T aims to expand pediatric ART services to 80% of all facilities offering PMTCT. Strategies to improve EID services include improving the logistics of DBS delivery through scaled up use of SMS-based printer systems and courier systems, and ensuring the receipt of

results to mothers through a collaborative tracking system that includes community-based and facility-based providers.

PEPFAR/T expects that the percentage of children out of all patients who are tested through PITC will increase substantially. This will be achieved through strengthening testing for children of index CTC clients and testing of inpatient and outpatients clients, such as in RCH and under-5 clinics. In addition, trainings and onsite mentoring will improve provider skills and confidence of healthcare providers in pediatric ART. Finally, improving demand creation through advocacy and community mobilization will increase the number of children attending the clinic for enrollment and care services. Quality improvement initiatives, with a specific focus on pediatrics, will also be implemented to address gaps around identification, linkages and retention to care and treatment services.

TB/HIV

PEPFAR/T will continue to support the National TB Program and work toward stronger TB/HIV integration and collaboration with a focus on QI and expanded coverage. Of particular interest, PEPFAR/T will work with the URT to adopt the revised National HIV/TB guidelines and scale up the 3Is in high burden CTCs in order to ensure intensive case finding through continued screening for TB among PLHIV and initiate all TB/HIV co-infected patients on ART. To accomplish this, priorities include addressing PITC in children and adults where TB is suspected and improving the linkages between CTCs and TB clinics to increase the proportion of TB/HIV clients receiving ART. To enhance diagnosis, PEPFAR/T also plans to supplement its current support of eight Gene Xpert machines with eight to fifteen additional machines, particularly in high volume, high TB/HIV burden district hospitals. Since 2012, all identified TB/HIV co-infected patients in Tanzania are offered ART regardless of CD4 count or WHO clinical stage.

PMTCT

The PMTCT strategy for the FY2013 COP focuses on preparing mainland Tanzania for the rollout of Option B+ and continuing to support Zanzibar with implementation of Option B+, which began in December 2012. PEPFAR/T is working closely with the MOHSW to strategize and implement the regional rollout of Option B+ by reviewing policies on M&E for ART and PMTCT integration, logistics, training, defining the minimum package of services, and organizing community roll-out. Costing estimates completed in collaboration with the MOHSW and GFATM, quantification of drug needs, and budget re-allocations to implement Option B+ have already taken place. PEPFAR/T will continue to work with the URT to assess infrastructure, human resources, and commodities impact on the capacity to absorb rapid increases of HIV+ women, families, and eventually other ART clients.

While preparing for Option B+, PEPFAR/T will continue scaling up PMTCT services to 100% of all facilities offering RCH services, with a goal of providing prophylaxis/treatment to 95% of all HIV positive

pregnant women identified. PEPFAR/T will improve HTC capacity with training and sensitization of RCH nurses, healthcare workers, and pregnant women themselves. Additional efforts will be made to scale up community-based initiatives, including mother peer support groups, male involvement, and follow-up of mother-infant pairs in the community to ensure timely delivery of DBS results to the mother and to provide outreach services. There will also be a continued emphasis on integration of family planning and reproductive health services with PMTCT to provide a comprehensive package of care. Couples counseling, gender-based violence prevention, detection and care, and PHDP activities will be supported. QI will also focus on PMTCT and MCH services and strengthened service integration and linkage of PMTCT and CTC services.

Laboratories

PEPFAR/T will continue to support the MOHSW in laboratory management and accreditation, diagnostics, logistics and procurement, and pre-service training. Activities build upon on-going activities in systems strengthening of the laboratory service at the national, zonal, and district levels.

Community Services

Despite increasing numbers of PLHIV on ART, there are still high rates of LTFU with up to 26% of CTC clients no longer being reported in the system, as well as late enrollment, in some cases with very low CD4 counts, and delays in ART initiation due to lack of regular monitoring and late diagnosis. The goal of the community care service portfolio is to ensure improved access to quality community health and social services for PLHIV, people affected by HIV and other vulnerable populations. PEPFAR/T has supported the URT to deliver health and social services to improve the quality of life of PLHIV and OVC through development of a standard of care package of services, guidelines and policies, and by strengthening community and civil society to provide quality care. In the past, the community care package for PLHIV was primarily palliative care for bed-ridden patients. With more PLHIV receiving ART and living longer, the portfolio is currently undergoing critical strategic changes to address essential care and support services to better respond to the changing needs of PLHIV and households affected by AIDS. These strategic changes include health promotion and linkages to social services as HIV becomes a chronic illness. As children infected with the virus at birth grow into adolescence, a new set of guidance is needed to address disclosure, adherence, and reproductive health and life skills for this growing population.

Assuring linkages in the continuum of care, from the point of diagnosis through enrollment, staging, pre-ART care, and ART initiation is driving strategic changes in the portfolio. Intentional efforts are underway to further refine community-based care and support services in order to focus on household economic strengthening, PHDP interventions, and nutritional assessment counseling and support, along with proactive tracking and reconnection of clients who fall out of the care continuum.

Home Based Care

Emerging program data indicates that HBC providers support less palliative care and more health promotion and linkages to social services, as HIV becomes a chronic rather than terminal illness for their clients. HBC will play a critical role in contributing to AfG targets by reducing loss to follow up of pre-ART and ART clients through supporting linkages and retention, improving care for non-ART patients and ensuring timely initiation of ART. The program will focus on scale-up in high prevalence areas, create efficiencies wherever possible, and leverage the clinical and HTC programs to support joint linkage and retention strategies. PEPFAR/T will also support potentially significant strategic changes at the national level as HIV/AIDS becomes a chronic condition through expanded access to treatment. HBC providers are decreasingly providing palliative care and increasingly providing more health promotion services and linkages to health facilities. Standardizing the role of CHWs and updating national guidelines to better address discharging patients from HBC to self-care will be a major priority.

Orphans and Vulnerable Children

The strategic focus of the OVC portfolio has shifted from an individual child to a family-based care-centered approach, conforming to the new PEPFAR OVC guidance. Responding to recent program data which indicate that more than 50% of OVC are adolescents, the portfolio will also strengthen linkages of OVC into youth-friendly, sexual and reproductive health services in addition to HIV/AIDS care. OVC programs will continue to integrate child protection strategies and respond to violence against children. Provision of critical and sustainable services to address child needs and scale-up in areas with heightened HIV prevalence will contribute to roll out of the new National Costed Most Vulnerable Children Plan of Action (2013-2017). A rigorous impact evaluation is planned to establish evidence-based strategic interventions and stable community systems that impact vulnerable populations at large. Two new procurements focus on capacity building of the social and health structures at the community level, which will enhance implementation of the MVC Plan of Action.

PEPFAR/T expects higher quality service provision for OVCs by focusing on interventions to address critical HR gaps in social work, including expanding trainings for the para-social worker cadre, providing tuition support for social welfare graduates, and collaborating with PMO-RALG to ensure that LGAs plan for and retain the social welfare workforce. More than10% of the budget will support M&E for OVC programs.

Positive Health Dignity and Prevention

Through collaboration with the URT, guidance for integration of PHDP support in HIV services at the community level has been developed. In the FY2013 COP, this community-focused PHDP guidance will be rolled out to ensure comprehensive, holistic health promotion in addition to prevention for PLHIV. PHDP guidance for facility-based care providers will be finalized in 2013.

Prevention

PEPFAR/T continues to support high impact, evidence-based HIV prevention services and increase the adoption of protective social and gender norms and behaviors in an effort to reduce HIV incidence. This combination approach, which includes behavioral, biomedical, and structural interventions, balances its focus between general population, key populations, and other at-risk sub-population interventions. This strategy will enable the prevention portfolio to better create demand for other components of the HIV continuum of response and more effectively address the needs of program beneficiaries.

Testing and Counseling

The HTC portfolio continues to grow, reflecting its centrality to contributing to AfG targets. In an effort to support PEPFAR/T's goal of increasing the number of people on ART, the HTC portfolio will heighten its focus on PITC as a priority modality while adopting a high-yield approach to HTC by strategically working in regions with high HIV prevalence, key populations and other large at-risk sub-populations. PEPFAR/T will focus on improving linkages and coordination with other program area activities; strengthening referral systems to care and CTCs; supporting a conducive policy framework and guidelines to institutionalize and scale-up the use of lay counselors and testers; enhancing use of HTC data for decision-making at all levels; and coordinating commodities to ensure adequate and timely supply of rapid HIV test kits. The HTC portfolio will introduce a program that reshapes the provision of mobile HTC to be targeted by geographic area and by population (including efforts to promote male uptake of testing); this program will be complemented by community-based behavioral and structural interventions.

Biomedical Prevention

The VMMC program will continue to scale up services and implement innovative methods to attract older men to services. PEPFAR/T will work with the URT on the integration of VMMC services within existing activities at static facilities, improve costing and modeling data for determining VMMC impact, involve private sector and faith-based supported facilities in the national program, assess feasibility and acceptability of neonatal circumcision services, and conduct a randomized control trial on methods for reaching older men. A new program addresses engagement of the private sector in providing VMMC services.

Methadone assisted therapy remains a key component of the response for PWID, and will be expanded into new areas with high concentrations of PWID. Additional data will be gathered on PWID to better understand the epidemic as well as provide appropriate interventions.

Funding for the injection safety/infection prevention and control and the injecting/non-injecting drug use portfolios were reduced from previous years. The IS/IPC program will concentrate on increasing URT

ownership, improving integration with other facility-based programs, and enhancing resource mobilization from other donors in order for PEPFAR/T to pass on full ownership to the URT. The blood safety program is focusing on strengthening systems for blood collection, screening, and distribution, also with the vision of gradual transition to the URT.

Sexual Prevention and Key Populations

A strategic decision to shift funding from HVAB and HVOP to evidence-based prevention programs, including VMMC and HTC, and HIV treatment as prevention activities, led to a dramatic change in the sexual prevention portfolio for the FY2013 COP, and a significant reduction in funding as compared to the FY2011 COP. Resources will be prioritized for targeted and evidence-based interventions for populations at greatest risk, including improving the availability and uptake of HIV services for key populations; linking PLHIV with community-based care and support interventions; and addressing stigma, discrimination, and legal barriers to ensure key populations' access to services. PEPFAR/T will expand focus on key populations, multiple and concurrent partnerships, transactional and inter-generational sex, and harmful social and gender norms. Efforts will also focus on developing an enabling environment to diminish vulnerability among adolescent and young girls, including GBV prevention. Condom promotion remains a core intervention, specifically targeting high-risk venues and key populations. A new procurement strategically integrates four previous awards into one large project that will provide a combination of gender-differentiated, community-based interventions in high prevalence areas.

System Strengthening

Tanzania's health sector has made significant progress in addressing health systems challenges that were hindering progress on several key health indicators. However, the country is still facing many of the challenges common to low-income countries with high disease burdens. PEPFAR/T continues to support the URT in ensuring that systems and capacity exist to sustainably deliver and continuously improve health services that are high quality, equitable, efficient and evidence-based.

Human Resources for Health

Adequate, skilled HRH remains a major challenge for the health sector in general, and for HIV in particular. With an approximately 65% vacancy rate for positions in the public sector according to the recent MOHSW-Joint Annual Sector Review, the shortfall in health workers threatens to impede efforts to scale up and maintain care and treatment services.

While PEPFAR/T will continue to help boost the quality and production of HCWs through support of scholarships, faculty training, curriculum development, and scaling up of distance education efforts, increasing attention will be given to making investments that can be sustained by the URT. For instance, emphasis will be given to supporting the URT to develop and maintain a harmonized curriculum

development process and train curriculum development professionals within the MOHSW and health training institutions. The PEPFAR/T team will support the MOHSW in understanding the current cost of producing health care workers and assess how the process could be more efficiently managed. The aim is to address HRH production in a holistic manner by engaging the URT in broader workforce planning discussions. PEPFAR/T will work directly with both local government and national ministries to ensure that necessary cadres are deployed and retained in underserved areas.

Additionally, the Program Strengthening and Community Care interagency teams will collaborate to raise the profile of CHWs by advocating professionalization of this historically neglected cadre to ensure that they and the social welfare workforce are fully integrated into the HRH strategic plan. PEPFAR/T will support in-service training for the new treatment guidelines and AfG priority areas, supportive supervision, mentorship and clinical attachments, QI, and information systems. Promotion of task-shifting/sharing and organizational development of professional organizations will intensify in the FY2013 COP.

Sector leadership, management, accountability, and governance

PEPFAR/T will continue to build leadership capacity and skills of local government authorities to promote decentralization, and strengthen coordination between central, regional, and district levels. Building upon the work accomplished in the previous year, a holistic approach to organizational development and institutional strengthening will be used to assess capacity across all management areas in relation to performance of core activities. At the lower level, the focus will be on improving financial management, accountability, and budgeting. PEPFAR/T will continue to utilize various management tools, like Plan Rep III for planning purposes, Integrated Financial Management Software, and the Local Government Human Resource Information System for tracking HRH, to focus on bottom up planning, data use for decision making, and implementation tracking. In addition, PEPFAR/T will support the creation of a Private Public Health Partnership Forum to discuss health policy issues, mobilize private sector resources, and improve health service delivery, including care and treatment services through both public and private sectors. PEPFAR/T will support the development of the health care financing strategy, which will include a strategy for increasing domestic sources of financing.

Evidence based and strategic decision-making

PEPFAR/T is supporting integration of data systems across health programs and donors by providing technical support to key government departments and aligning investments with multi-donor initiatives like the MOHSW M&E Strengthening Initiative. In health information systems, PEPFAR/T will continue to invest in the URT's HIV Patient Monitoring System and provide technical support to the MOHSW efforts to use DHIS as a national data warehouse. Investments in information system planning, technology infrastructure and GIS capabilities will collectively improve access to information and use of evidence. In M&E, PEPFAR/T will support a continuing evolution of indicators and tools to support the generation of

quality evidence emphasizing the use of data at all levels. For surveys and surveillance, PEPFAR/T is supporting ANC surveillance, ANC/PMTCT comparison, targeted surveillance of key populations, Integrated Disease Surveillance and Response, Sample Vital Registration with Verbal Autopsy and national surveys including DHS preparation, THMIS dissemination, Service Provision Assessment and support to the Bureau of Statistics. PEPFAR Records and Organization Management Information System and USG specific data verification activities will also continue.

Implementation Science

With the phasing out of the PHE mechanisms and broadening of the spectrum of implementation science, the Implementation Science interagency technical team has been restructured. It will play a larger role ensuring that PEPFAR-funded research and evaluations in-country are well coordinated, more widely accessible and consistent with the national research agenda. These new roles include coordinating comprehensive in-country reviews of Impact Evaluations proposed for the COP. PEPFAR/T is also developing a mechanism to capture key information about critical implementation science activities in an effort to better coordinate the research portfolio.

Supply chain

PEPFAR/T has worked tirelessly over the last year with the GFATM and the URT to solidify Phase II of the Round 8 HIV grant, which was signed on December 1, 2012 and which provides the country with most HIV-related commodities. PEPFAR/T program staff as well as senior management intend to assist vigilantly in preparing the country to adopt and adapt to the VPP mechanism for HIV and malaria commodities. Because of concerns that VPP implementation may take some months and commodity gaps are know, PEPFAR/T will monitor its progress and address any potential stock outs by using prior COP funds, FY2013 COP funds and/or the Emergency Commodity Fund. Furthermore, in the FY2013 COP, PEPFAR/T renews its commitment to strengthen the entire public health supply chain system, starting at the central level of MSD, to improve the availability of health commodities at all public health facilities. Support for developments in HR, infrastructure, and technology-based systems will supplement TA to strengthen and unify M&E systems. The design and implementation of the electronic Logistics Management Information Systems for all health commodities will improve access, management and use of data for decision-making, further contributing to commodities security.

V. GHI, Program Integration, Central Initiatives, and other considerations

PEPFAR/T works collaboratively with and leverages health and non-health investments to better integrate programs between HIV, maternal and child health, family planning, TB, and malaria. An example of this integration is the redesign of the comprehensive PHDP package of services. In addition to cotrimoxazole and condoms provided by PEPFAR and the GFATM, contents include other family planning commodities

from GFATM and USAID family planning; bed nets from the President's Malaria Initiative and GFATM; NACS through the GFATM; and water purification items through PSI, among other items.

GHI Strategy

The Global Health Initiative focus areas remain a priority for PEPFAR/T, and are realized through many of the activities mentioned above. Promoting ART initiation among pregnant women, improving linkages and referrals between HIV program areas, strengthening PLHIV support groups, integrating family planning into HIV and AIDS care and treatment services fall squarely under IR1, “increased access to quality integrated services with focus on maternal, newborn, and child health, family planning, and reproductive health.” Since the health systems priorities for the HIV/AIDS response, such as a secure supply chain system and a skilled health and social labor force, apply to health services in general, PEPFAR-funded program strengthening strengthens all health systems and thereby contributes to IR2, “improved health systems to strengthen the delivery of health care services.” PEPFAR/T will contribute to IR3, “improved adoption of healthy behaviors including healthcare-seeking behavior,” by supporting early uptake of preventive health services; increasing access to preventive and curative services for women and adolescent girls; strengthening the legal and regulatory environment in support of gender equity; and building country capacity for effective social and behavior change communications activities.

Central Initiatives

Tanzania is fortunate to receive funding for several central initiatives, all of which complement country programming through the COP and bolster PEPFAR/T efforts under the PF.

Global Fund Collaboration Initiative activities are being implemented through the Grant Management Solutions Project under USAID. The initiative will build upon activities of the previous year to foster a better environment of collaboration between PEPFAR/T, the URT, and GFATM. The initiative will provide TA to capacitate the Principal Recipient (MOFEA) and Sub Recipients within the URT to respond ably to GFATM requests and requirements. This will not only lead to the improved ability to avoid commodity shortages due to weak management, but also allow for increased collaboration, planning, forecasting, and implementation between PEPFAR/T programs and GFATM grants.

Tanzania received $7 million for the second year of programming under the three-year *GBV Initiative.* Priorities for the FY2013 COP include training adequate numbers of providers in the new, national GBV clinical curriculum and standardizing tools for effective service delivery and oversight. In GBV prevention, partners will continue to implement coordinated interventions along the continuum of the ecological model to maximize impact. New this year, PEPFAR/T will roll out GBV prevention and response services in a fourth region (Mara) and provide support to laboratory systems for forensic evidence collection.

PEPFAR/T submitted a successful proposal in November 2012 to apply $1.5M from *Together for Girls* to activities in the operational plan developed by the Multi-Sectoral Task Force, based on results of the 2009 Violence Against Children study. UNICEF is the implementing partner of the three-year project, which falls in line with both the GBV Initiative and the USG child protection portfolio.

Through a central initiative, PEPFAR/T was awarded in January 2013 $16,796,144 to help fulfill the proposed FY2013 target for VMMC as well as conduct an additional 76,000 procedures. These funds will be instrumental in rapidly scaling the VMMC program in the priority regions, and dramatically increases the likelihood of attaining saturation levels in a reduced timeframe in a select number of areas.

The USG has been actively supporting UNAIDS' leadership of the Secretariat for the *Pink Ribbon Red Ribbon* Alliance in Tanzania, and will continue to be engaged in planning and implementing this important initiative.

PEPFAR/T received approval in FY2012 for $7,875,000 for *NACS integration* into multiple program areas. As part of the NACS integration into PMTCT, Tanzania has formed a steering committee for the partnership for HIV free-survival (PHFS), led by the URT, with the participation of multilateral development partners along with PEPFAR/T. Multiple PEPFAR/T partners will be implementing activities in the selected regions of Iringa and Shinyanga. Stakeholders are currently reviewing a draft document identifying PHFS intervention areas in accordance with the newly released postnatal care guide and Option B+ roll-out plan. The document will be finalized for the multi-country PHFS launch meeting in South Africa in March 2013. To accelerate the integration of nutrition care, economic strengthening, livelihoods, and food security in HIV community care programming, multiple PEPFAR/T partners and consortia are implementing activities that strengthen services in and capacity building for the continuum of care to promote referrals and linkages between community and facility care. Activities will also include integration of basic nutrition, economic strengthening, and food security information into the training curriculum for social welfare assistants and para-social workers, and will be implemented in synergy with Feed the Future community nutrition activities in Morogoro and Dodoma, where the two programs overlap.

Through prior year central *PHE* funds, PEPFAR/T is engaged in eight rigorous evaluations. In 2013, the findings from three of these studies will be widely disseminated; evaluation areas include PITC modalities; disclosure, sexual behavior, FP uptake, and clinical outcomes within a clinic-based PHDP intervention; and drug resistance among adults on ART in Tanzania. Five other studies are in progress, including an appreciative inquiry intervention with adults on ART; optimal models of HIV care approaches; and three economic evaluations that include costing studies of ART and PMTCT and a cost-effectiveness study of HTC modalities. Additionally, PEPFAR/T won a FY2011 CDC Implementation Science grant for a

randomized controlled trial to increase uptake of VMMC among older men. Lastly, an impact evaluation of PEPFAR-supported economic strengthening initiatives is being proposed.

The *Medical Education Partnership Initiative* (MEPI) program is a five-year $10 million grant funded through HRSA and implemented at the Kilimanjaro Christian Medical Centre `in partnership with Duke University. The project aims to train future generations of graduates to become leaders in health care academics, research and policy within Tanzania. Enrollment has increased from 120 to 158 students, and faculty capacity has improved through performance evaluations and faculty satisfaction initiatives. KCMC further addresses retention of both students and faculty establishing training opportunities at community sites, offering student career counseling, and developing a career-tracking database.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	1,300,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	06	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	230,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	84,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	120,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	150,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	1,862,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for			

			number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	96,000	2011	WHO			
Number of people living with HIV/AIDS	1,600,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	1,300,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	00	2011	WHO			
Women 15+ living with HIV	760,000	2011	AIDS Info, UNAIDS, 2013			

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 Percent 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	P1.2.D	P1.2.D Number and percent of

	support services, dependent on available resources		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 of 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
		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 and horizontal flow of information and use of data by HIV and AIDS, health, and social service sectors	P6.2.N	P6.2.N Percentage of health facilities with HIV 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

How is the USG providing support for Global Fund grant proposal development?
Approximately $2 million in central funding from the Country Collaboration Initiative (CCI) is planned for Tanzania to build capacity of the URT to be able to respond to the new funding cycle, in collaboration with PEPFAR and other donors, although not specifically for grant proposal development. The Grant Management Solutions (GMS) project has been selected to identify technical assistance needs, including those relevant to Global Fund grant proposal development. The Global Fund Liaison position as well as technical staff for commodities, treatment, prevention, PMTCT and Labs will also assist Tanzania in technical components of grant proposal development.

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

If yes, please indicate which round and how this may impact USG programming. Please also

describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).

HIV grants from Rounds 1, 3, and 4 are currently in closure. The HIV/HSS grant from R9 is approaching the end of Phase 1 and is currently preparing for Phase 2 negotiations. Round 4 for Condom Procurement for the Social Marketing Sector comes to an end in December 2013. USG is providing technical support to the process through the routine work of the Technical Working Groups (TWGs) of the Technical Committee Sector Wide Approach SWAp (TC-SWAp). The Global Fund Liaison is also working with the government's HSS team on the proposal renewal.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

No

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
	APHFTA - PPP		Association of Private Health Facilities of Tanzania, Bienmoyo Foundation, PharmAccess International	55,000	55,000	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.
	BIPAI-PPP		Baylor University, Bristol-Myers Squibb Foundation, The Abbott Fund	22,500,000	22,500,000	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.
	CIDR - PPP		Biolands Ltd., Elton John AIDS Foundation, International de Developpement et de Recherche	729,000	729,000	The Centre for International Development and Research (CIDR) is a French NGO that successfully established an insurance

			(Centre for International Development and Research)			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.
	CME - PPP		Africare, Tanzania Chamber of Minerals and Industry, African Barrick Gold	114,000	114,000	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.
2012 APR	Health Facility Accreditation		PharmAccess International, Vodacom	547,000		Health Facility Accreditation is a partnership with CDC Foundation and PharmAccess to provide support to the MOHSW Quality Assurance Directorate, continue to

						develop an accreditation program. The Health Sector Strategic Plan III (2009 – 2015) includes a goal for the establishment of a system for accreditation of health services. The Accreditation PPP will build upon current work being done by the MOHSW and PharmAccess through the Stepwise Certification towards Accreditation program. Stepwise Certification towards Accreditation is a process based on standardized cycles of assessment and QI efforts. The program aims at providing a path

						along which health facilities will be graded before they are fully granted eligibility to become accredited, based on international standards. Through accreditation, the MOHSW seeks to improve the quality of service delivery while providing the public with a transparent system of quantifiable indicators measuring the quality of care.
2011 APR	Madaktari-PPP		Cornell University, Madaktari Africa	850,000	850,000	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	12204:P4H	Johnson and Johnson, PharmAccess International, mHealth Alliance, Deloitte Consulting Tanzania Limited, DEUTSCHE	4,043,000	1,825,000	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

			GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT (GIZ) GMBH, KfW Bankengruppe, Khanga Rue Media			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.
	Touch-PPP	9681:Single eligibility FOA	Touch Foundation, Bristol-Myers Squibb Foundation, McKinsey & Company, The Abbott Fund	6,505,000	6,510,000	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 (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.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	2010 Female Sex Worker Study Mainland Tanzania	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing	11/01/2012
Surveillance	2010 Zanzibar ANC Sentinel Surveillance	AIDS/HIV Case Surveillance	Pregnant Women	Data Review	03/01/2013

Surveillance	2011 ANC Surveillance - Mainland Tanzania	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation	01/01/2014
Survey	2011 Female Sex Worker Study - Zanzibar	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing	09/01/2013
Survey	2011 FSW Study in Zanzibar	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing	11/01/2012
Survey	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	11/01/2012
Survey	2011 HIV DR Threshold Study	HIV Drug Resistance	Pregnant Women	Implementation	12/01/2014
Survey	2011 MSM Study	Population-based Behavioral Surveys	Men who have Sex with Men	Publishing	11/01/2012
Survey	2011 Tanzania HIV Malaria Indicator Survey	Population-based Behavioral Surveys	General Population	Publishing	12/01/2012
Survey	2011 Tanzania HIV, Malaria Indicator Survey	Population-based Behavioral Surveys	General Population	Publishing	03/01/2013
Surveillance	2012 ANC Surveillance - Zanzibar	Sentinel Surveillance (e.g. ANC	Pregnant Women	Development	12/01/2013

		Surveys)			
Surveillance	2012 ANC Surveillance Zanzibar	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Development	05/01/2013
Survey	2012 HIV DR Monitoring	HIV Drug Resistance	General Population	Development	12/01/2014
Surveillance	2012 HIV Drug Monitoring	HIV Drug Resistance	General Population	Development	05/01/2014
Survey	2012 Injection Drug User Study Mainland Tanzania	Population-based Behavioral Surveys	Injecting Drug Users	Planning	05/01/2013
Survey	2012 Injection Drug Users Mapping Mainland Tanzania	Population-based Behavioral Surveys	Injecting Drug Users	Development	05/01/2013
Survey	2012 Men having Sex With Men Study - Mainland	Population-based Behavioral Surveys	Men who have Sex with Men	Data Review	12/01/2013
Survey	2012 Men who have Sex with Men Mapping Mainland Tanzania	Population-based Behavioral Surveys	Men who have Sex with Men	Planning	05/01/2013
Survey	2012 Men who have Sex with Men- Zanzibar	Behavioral Surveillance among MARPS	Men who have Sex with Men	Publishing	09/01/2013
Survey	2012 MSM Study Mainland	Population-based Behavioral Surveys	Men who have Sex with Men	Data Review	05/01/2013
Surveillance	ANC/PMTCT Comparison Study - Mainland	Sentinel Surveillance	Pregnant Women	Development	12/01/2014

		(e.g. ANC Surveys)			
Surveillance	ANC/PMTCT Comparison Study - Zanzibar	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Data Review	12/01/2015
Survey	ANC/PMTCT Comparison Study Mainland Tanzania	Evaluation of ANC and PMTCT transition	General Population	Development	12/01/2012
Surveillance	Biological and Behavioral Surveillance (Dar Es Salaam)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Data Review	09/01/2012
Surveillance	Biological and Behavioral Surveillance (Unguja and Pemba - Zanzibar)	Behavioral Surveillance among MARPS	Injecting Drug Users	Publishing	12/01/2012
Surveillance	Biological and Behavioral Surveillance (Unguja and Pemba - Zanzibar) 2	Population-based Behavioral Surveys	Men who have Sex with Men	Development	05/01/2013
Surveillance	Biological and Behavioral Surveillance (Unguja and Pemba)	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development	03/01/2013
Surveillance	HIV Drug Resistance Monitoring	HIV Drug Resistance	General Population	Development	06/01/2014
Surveillance	Mortality Data Surveillance	HIV-mortality surveillance	General Population	Implementation	09/01/2012
Surveillance	Sample Vital Verbal Autopsy - Mainland Tanzania	HIV-mortality surveillance	General Population	Implementation	09/01/2014
Surveillance	Sample Vital Verbal Autopsy Mainland Tanzania	HIV-mortality surveillance	General Population	Implementation	09/01/2013
Survey	Tanzania Demographic and	Population-ba	General	Publishing	12/01/2012

	Health Survey Population-based Behavioral Surveys	sed Behavioral Surveys	Population		
Survey	Tanzania HIV/AIDS Malaria Indicator Survey (2011-12) THMIS	Population-based Behavioral Surveys	General Population	Publishing	12/01/2012

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		24,197,416		**24,197,416**
HHS/CDC	7,307,878	129,471,014		**136,778,892**
HHS/HRSA		7,912,474		**7,912,474**
HHS/NIH		500,000		**500,000**
HHS/OGHA		438,760		**438,760**
PC		2,300,000		**2,300,000**
State		71,000		**71,000**
State/AF		1,217,500		**1,217,500**
USAID		174,561,642		**174,561,642**
Total	**7,307,878**	**340,669,806**	**0**	**347,977,684**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	DOD	HHS/CDC	HHS/HRSA	HHS/NIH	PC	State/AF	USAID	AllOther	
CIRC	2,668,595	5,172,396					14,311,321		**22,152,312**
HBHC	2,324,108	7,489,858	245,000				14,357,199		**24,416,165**
HKID	150,000	3,046,870	900,000			0	26,219,803		**30,316,673**

HLAB	655,135	5,801,950	330,000				1,007,316		**7,794,401**
HMBL		5,138,211							**5,138,211**
HMIN		1,058,047							**1,058,047**
HTXD		19,349					15,207,566		**15,226,915**
HTXS	7,672,125	52,994,359	171,030			400,000	29,539,589		**90,777,103**
HVAB	366,162	427,640					1,277,459		**2,071,261**
HVCT	1,584,135	5,465,682	691,444				8,617,671		**16,358,932**
HVMS	749,406	4,458,921			2,240,000		4,132,198	509,760	**12,090,285**
HVOP	1,346,162	3,590,833			60,000		14,022,414		**19,019,409**
HVSI	142,567	6,309,282					2,094,726		**8,546,575**
HVTB	775,000	4,893,455	250,000				3,273,783		**9,192,238**
IDUP		2,510,811	0						**2,510,811**
MTCT	3,645,804	16,629,289	1,140,000			50,000	21,851,967		**43,317,060**
OHSS		4,427,597	4,185,000	500,000		767,500	13,830,738		**23,710,835**
PDCS	286,000	2,160,045					1,081,595		**3,527,640**
PDTX	1,832,217	5,184,297					3,736,297		**10,752,811**
	24,197,416	**136,778,892**	**7,912,474**	**500,000**	**2,300,000**	**1,217,500**	**174,561,642**	**509,760**	**347,977,684**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

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	Ongoing		
Narrative	MOHSW/NACP identified need for review, update & consolidation of several VCT guidelines and SOPs 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	Stakeholders: MOHSW/NACP; CDC; WHO; AMREF; local partners. TWG established. Challenges: 1) Harmonizing policies into one; 2) unresolved policy issues (eg. HRH - lay counselors; # of professionals and skills level); approval and registration process;	Stakeholders as under Stage 2; extensive consultations. Challenges: 1) Legal/ regulatory contradictions; 2) unresolved policy issues (eg. task shifting; licensing; approval and registration - procurement)	Comprehensive guidelines are still in draft format. They include finger-prick testing guidelines; age of consent; issues related to confidentiality; discordant couples counseling, and key populations. The new guidelines will almost certainly be used/adapted for Zanzibar.		

	% men (adults) tested compared to coverage target of 85-90%); unknown status leading to unmet need for ART	procurement; equity); 4) weak health system (eg. HCT services/ # of sites)				
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 others, in 2005 WHO	MOHSW established TWG; TA from HPI. Key stakeholders: USAID / partners; UN family; ministries and agencies (MoJCA,	HPI initiated drafting (7/10), working closely w/GBV TWG led by MOHSW. Larger group of stakeholders reviewed policy and	Management guidelines adopted/ signed by MOHSW; printed in English launched 12/11; translated into Kiswahili	PEPFAR supporting competency-based clinical training curriculum to enable GBV services per management guidelines,	PEPFAR Tathmini GBV evaluation (2012-1015) will examine, among other outcomes, efficacy of clinical response to

	study, 2008 HPI GBV policy scan, and 2010 DHS DV module. 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).	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.	provided feedback. Challenges: Conflicting views, interests, and definition of GBV due to diversity (cultural, ethnic, religious, gender). Inadequate internalization of GBV as a problem.	1/12	expected completion March 2013. Deliverables: lit review, TOT manual, trainers manual, participant manual, job aides. Pilot TOT and participant training completed late 2012; PEPFAR partners to receive further training Q3 FY 2013 Challenges: weak health system; poor multisectoral coordination; funding	GBV in Mbeya region
Completion Date						
Narrative						

Policy Area: Gender						
Policy: National Plan of Action for the Prevention and Eradication of Violence against Women and Children (2001-2015)						
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	M&E plan completed; needs to be operationalized

	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	olicy: 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 management 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 multisectoral stakeholders 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). Internalization of GBV as a problem		develop training package (estimated completion early 2013) and regional stakeholder orientation package (completed June 2012) Challenges: Mandate required beyond health sector; 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	1980 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 members 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, WILDAF, and Washing & Kee University). 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: VAC-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	NA	Ongoing	
Narrative	2010 DHS DV module and 2010 VAC Survey raised awareness of magnitude of GBV and VAC problem in Tanzania. In Justice sector, survivors do not receive appropriate treatment in police	UNICEF has supported the Police Partners Coordination Group to identify gaps in the response to VAC and GBV in the police force and coordinate donor/partner support. PEPFAR partners participate.	By end 2012, developed Guidelines for establishment of GCDs and SOPs for police to respond to GBV and child abuse. UNICEF led process with police and PEPFAR partners participated	N/A since these are operational polices	Development of Training Manual on VAC/GBV for police (expected final by Feb 2013) in order to operationalize the SOPs and appropriately staff the GCDs. Inspector General of Police has declared	

	stations due to lack of trained personnel and SOPs. Police Gender and Child Desks (GCD) have been instituted to address special needs of GBV/VAC survivors but there have been no standards to guide the GCDs	Challenges: lack of funding; lack of capacity of police to respond appropriatel y to GBV/VAC a training issue but also a social/norm s issue; effective coordination with other sectors			intention to implement GCDs in every police station. Mapping of GCDs undertaken to identify current footprint and create plans for expansion; mapping to be shared with MOHSW, other stakeholder s	
Completion Date						
Narrative						

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	Completed (Mid-Term)
Narrative	Process and challenges: With health sector	MOHSW developed strategy w/ many partners	Completed in 2008	Endorsed in 2008.	HRH continue to be major challenge, particularly	he mid-term evaluation of HRHSP completed Feb. 2012.

	reform in 1990s, this 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;	(eg. WHO, Capacity 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			related to harmonization of production, financing, deployment, and retention in most needy areas. Task shifting study results expected this quarter and advocacy/policy work needs to move forward. Donor/implementing partner coordination, including GF, is important for ensuring most efficient/effective resource utilitization.	SP still highly relevant; garnered strong support despite funding and implementation challenges, especially at LGA level. Not all objectives realized. Workshop to begin development of new HRH SP planned for Feb. 2013.

	infrastructure, etc.					
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Human Resources for Health 5-Year Development Plan (2012-17) HR/MOH, Zanzibar						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Ongoing		Completed 2012	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		The HRH Plan was completed in 2012 through support from WHO. Multiple stakeholders and MOHSW participated in process.	The Plan is awaiting final endorsement by the Minister of Health.		The previous plan was evaluated but there was no official report. The background Section of the new SP talks a bit about the evaluation and findings.

	in intial stages.					
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: National Human Resource (HR) Policy (MOHSW)						
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 reforms in 1994. Challenges include(d) rentention and deployment of health professionals, continous education, incentive schemes, task shifting, and other. Health	This policy is important for systematic development of HRH strategic plans. HRH 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,	A situation analysis about the HR Policy Guidelines was presented mid-2012 to the HRH TWG. A draft paper has been drafted but needs futher TA to strengthen it. It has not been circulated. Current status of draft is unknown but this subject			

	Network secretariat was established to coordinate initiatives like PHCP and the HRHSP 2008-2013	including Intraheath and other CAs	should be on the HRH TWG agenda in early 2013 in order to reach a decision on next steps.			
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 Date	Ongoing	Ongoing	Completede	Passed 2010	Ongoing	
Narrative	he Act provides for training, registration, enrollment and practice of nursing and midwifery. Challenges: Act has not been amended despite the fact that	Acts as barrier to overcome shortage of nurses; prohibits conferring of doctors' rights to nurses and imposes penalties for illegal practice. There are ongoing		The new Nurses and Midwifery Act was passed in the National Assembly in January, 2010. Nurse and Midwifery Regulations were also passed in 2010.	The Act was revised to facilitate task shifting if/when a policy is endorsed.	

	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: MEWATA, MAT, TARENA, MOHSW, ALTS, APNM	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 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	Study	Initial			

	shifting policy exists - controversial issue meeting resistance in face of serious HW shortage; cadres performing non-designated tasks. Policy barriers to task shifting (eg. lay couselors can only counsel not test). Decisionmakers need more info. 2010 NIMR showed task shifing needs more exploration. Other stakeholders: AGOTA, CAs, PLHIV networks	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 evidence based advocacy required to promote policy development. Task Shifting Task Force established as first step towards policy development.	results of NIMR TS study presented to HRH TWG in November 2012. Final report expected first quarter 2013. Health Policy Initiative led by Futures Group released assessment report in Nov. 2012 on relevant policy, legal, and regulatory frameworks and whether they support or hinder the adoption of task shifting. TS Taskforce to follow up on			

			advocacy/policy development.			
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: Health Laboratory Practitioners Act 2007						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Ongoing	
Narrative	In force since 2008; Act provides for registration of health laboratory technologists, but lacks objective criteria for accreditation of training institutions of health laboratory practitioners at different levels. Challenges:	The Health Laborary Advisory Council met 1/12 and directed Registrar of the Council to seek partners to develop institutional training standards and review various aspects related to training. Stakeholders: Universities,	Regulations for ethics and professional conduct for health laboratory practitioners were completed in 2010. Preliminary draft of policy document developed to guide drafting of regulations (or guidelines) for training institutions	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 still need to develop appropriate training standards	

	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)	colleges, and independent investors who are interested in establishing laboratories in TZ	responsible for training laboratory practitioners (status: looking for partners for funding)			
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	Completed	Ongoing			
Narrative	Act came into force in 4/97. Plan for implmentation 2006-2011 developed.	Private Health Laboratories Board met twice in 2010 and agreed to proceed	Evaluation of the 2006 - 2011 implementation plan completed in 2012. The Board			

	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 standards/ services)	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, overlapping roles and responsibilities outlined in different acts/regulations	to meet to discuss the report. National Health Laboratory Standard Supplies list development in progress. Looking for funds to harmonize PHL regulation's Act and 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 revision to accommodate emerging needs resulting from HIV epidemic (eg HCT, PMTCTand ART).	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 revision yet). Stakeholders: Assoc. of Private Health Facilities in TZ; TZ Medical Assoc.	Seeking funding for consultations leading to Cabinet Paper in order to amend the Act. There will a board meeting in March 2013 to further discuss this			

	3) Prescribed fines for violation are too low and ineffective as deterrents.	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: 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, MARPs issues remain sensitive and controversial; there is limited information about the population size, locations,	TACAIDS, MoHSW/NACP & DCC regularly call key MARP stakeholders to meetings. Studies commissioned to increase knowledge	Stakeholders: TACAIDS, MoHSW/NACP, DCC, NIH, PEPFAR partners, University of San Fransisco; local research institutions	AIDS Prevention & Control Act endorsed 2008 Endorsement pending for several policy documents / guidelines that include adressing	FSW study in Dar concluded 2011, dissemonation done 2012 Round 2 MARPs surveillance in Zanzibar concluded 2012, awaiting	

	and access to services; high HIV rates; and S&D. Stakeholders: TACAIDS, MoHSW/NACP, DCC, local & international academia, with the assistance of development partners/ PEPFAR, UN, CSOs, CAs. Challenges: 1) Place the issue of MARPs on the agenda; 2) ensure that their needs are met for prevention and care services; 3) legal reform	about MARPs and inform services; inclusion in recent draft guidelines. 2011 HIV and AIDS policy identifies omission of MARPs in programming as human rights issue. Challenges: 1) Continued controversy over MARP issue; 2) criminalization, 3) lack of protection for MARPs	and universities (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 Existing Drug Act and Drug Policy are under review (DCC) National AIDS Policy 2001 is under review and NMSF III (2013-18) is under developmen	needs of MARPs for prevention and treatment services Challenges: including S&D; inadequate training of providers; HRH shortage - lack of adoption of task shifting strategy to expand services; weak health system, procurement.	dissemination in 2013 Studies of SW, PWUD and MSM in Tabora, Iringa, Shinyanga, Mbeya, Mara, Dar, Mwanza and Arusha in planning phase Drugs mapping study for mainland Tanzania is in planning phase Ongoing constitutional review process is an opportunity to integrate human rights issues relevant to MARPs	

			t			
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
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	Completed	Ongoing	Ongoing	
Narrative	Child rights scattered in several 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	Policy and law exist, but 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	Drafting of regulations began in 2010 under leadership of MCDGC in collaboration with MOHSW with TA from UNICEF -involvement of CSOs working on children's rights. Together for Girls funding in 2013 to facilitate completion and disseminati	Endorsement of regulations by Cabinet pending presentation by MOHSW. Challenges: Competing demands with other policies in the pipeline.	Law is being implemented despite lack of regulations. Once regulations completed, TFG/PEPFAR will support dissemination and training at national and local levels Implementation plan: Activities implemented by MCDGC, MOHSW, PMORALG,	

	and MOHSW both have mandates re: children's issues - competing demands and priorities	well prioritized and coordinated.	on of regulations, including at LGA level (with PMO-RALG) Challenges: Protracted process to develop regulations with several stakeholders		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: Orphans and Other Vulnerable Children						
Policy: National Costed Plan of Action for Most Vulnerable Children (NCPA11) 2013-2017 (MOHSW)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Ongoing	Ongoing	Completed	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	The MVC NCPA11 was launched on 1st February 2013	Working underway to consolidate the GOT and other DP commitment	

	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)		s to support the NCPA11 implementation as well as reinforcing the multi sectorial coordination of implementation.	

	implementation					
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: National Guidelines for Quality Improvement of Care, Support and Protection of MVC - 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 at the	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 providers;	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 mandates	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, community	AFRICARE and other stakeholders rolled out guidelines and assessed impact at the point of service delivery. The assessment resulted in modification and changes of the child status index tools to the household status index. Findings

	community level for providing protection and services for MVC	UNICEF, USAID, FHI, and CAs (eg. AFRICARE)	among ministries responsible for children required extensive consultation, which slowed the process		support, and local government funding; 3) lack of knowledge among providers about guidelines (now in need of updating); 4) low priority. Strong advocacy required	informed the MVC NCPA II and household centered interventions strategies for the MVC care and support.
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	Completed	Completed	Completed	Completed	Ongoing	
Narrative	Zanzibar was using the Mainland 2008 ART Treatment Guideline, that was outdated.	MOH established and led several thematic TWG that collaborated closely with ZAC,	MOH led process of adapting the Mainland 2012 National Guidelines for	Guidelines for the Management of HIV and AIDS was endorsed by the Zanzibar	Printing of the first Edition of the Guidelines for the Management of HIV and AIDS	

	MOH decided to adapt the newly developed comprehensive guidelines (from TZ mainland) after it was finalized. Updating needed to 1) Increase access to ARV; including Key Populations for Treatment as Prevention efforts 2) Comply w/ 2009 WHO guidelines; 3) Ensure ART integration with other services (PMTCT, RCH, TB/HIV);	WHO, development partners 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). 3) Inclusion of Key Population and Hepatitis B co-infection interverntions	Management of HIV and AIDS in 2012 with different TWG and organized workshops for larger groups of key stakeholders (different thematic areas) for review and feedback.	MOH in 2012	and its implementation is awaiting completion of the Monitoring and Evaluation tools	

	4) Include Positive Health, Dignity and Prevention strategy					
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	2012	2012	Ongoing	
Narrative	Issue: Service maintenance, Scale-up, and Quality:- Low access and coverage of Paediatric TB/HIV services in Tanzania. -Recognized TB/HIV updates include scale up of 3Is from the initial pilot	1) Tanzania was using the 2011 National HIV/AIDS management guidelines which was outdated (not in line with 2011 WHO guidelines).	National HIV/AIDS Management guidelines (including peds TBHIV guideline and training package) completed and disseminated in April 2012. 2) USG is supported development of national pediatric TB	The MoHSW issued a circular on adoption of comprehensive WHO treatment guidelines where TB/HIV coinfected patients are eligible for ART.	Partner meetings to reinforce inititiation of ART to all coinfected patients 2) NACP reingagement with NTLP and collaborating in the leadership role. 3) More sites for scale up of IPT in Tanzania	Development planning phase for an impact evaluation on provision of ART to co-infecetd patients. In addition, teams will conduct a programmatic analysis of IPT implementation at the initial sites

	sites Recognized low numbers of coinfected patients on ART		Guideline. The document has been finalized • USG continues to support ongoing phased implementation of IPT beyond demonstration sites.		already identified. 4) Roll out of pediatric TB/HIV trainings and on site supervision	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Guidelines for Management of HIV and AIDS (2011) MOHSW/NACP; Ch 8: ARV/adults and adolescents; Ch 9: ARV infants and children						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed	Completed	Completed	Completed	Ongoing	
Narrative	Review of 2009 guidelines initiated by MOHSW due to need to: 1. Increase access to ARV and	MOHSW established and led several thematic TWG that collaborated closely with TACAIDS,	MOHSW led process starting late 2009 with different TWG and organized workshops for larger groups of	Endorsed by the MOHSW in 2011; Printing of the fourth Edition of the National Guidelines for the	MOHSW has agreed to fully implement the 2012 Tanzania guidelines Guidelines for the Manageme	

	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).	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).	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	Management of HIV and AIDS done in 2012; Dissemination done	nt of HIV and AIDS i.e. adopting initiation of ART for all patients with CD4 <350cells/mm3, all patients with stage 3 and 4, all pregnant women, all children <5years and all TB/HIV co-infected patients. Ongoing efforts are geared towards simplifying treatement regimens i.e. Tenofovir based regimens. Negotiations are ongoing with the MOHSW	
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	2013	
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	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;	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	Guideline already endorsed by NACP, distributed and in use following WHO option A.	The MOHSW/NACP /RCH are in the process to adopt PMTCT option B+ which has already been endorsed by the MOHSW principle secretary. Subcommittees of steering committee are planning revisions in policy, guidelines, M&E, training and	

	for HIV positive pregnant women (70%) and for infants (76%) (below MNSF target of > 96% by 2012)	4) low ART compliance; early infant diagnosis; 5) weak linkage to related services; 6) HRH (numbers and skills)	to FP, STI and CTC services; 4) planning of local councils for PMTCT at facility and community levels		logistics. Implementation will start officially in July 2013.	
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	24,416,165	0
HKID	30,316,673	0
HVTB	9,192,238	0
PDCS	3,527,640	0
Total Technical Area Planned Funding:	**67,452,716**	**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	7,794,401	0
HVSI	8,546,575	0
OHSS	23,710,835	0
Total Technical Area Planned Funding:	**40,051,811**	**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	12,090,285	0
Total Technical Area Planned Funding:	**12,090,285**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	22,152,312	0
HMBL	5,138,211	0
HMIN	1,058,047	0
HVAB	2,071,261	0
HVCT	16,358,932	0
HVOP	19,019,409	0
IDUP	2,510,811	0
MTCT	43,317,060	0
Total Technical Area Planned Funding:	**111,626,043**	**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	15,226,915	0
HTXS	90,777,103	0
PDTX	10,752,811	0
Total Technical Area Planned Funding:	**116,756,829**	**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

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent 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 with known HIV status (includes women who were tested for HIV and received their results)	1,482,989	
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	55 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	63,582	
	Number of HIV-	116,160	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	19,075	
	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)	44,507	
	Single-dose nevirapine (with or without tail)	0	
	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)	0	
	Sum of regimen type disaggregates	63,582	
	Sum of New and	0	

	Current disaggregates		
P4.1.D	P4.1.D Number of injecting drug users (IDUs) on opioid substitution therapy	n/a	Redacted
	Number of injecting drug users (IDUs) on opioid substitution therapy	1,150	
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	309,000	Redacted
	By Age: <1	10,000	
	By Age: 1-9	0	
	By Age: 10-14	71,400	
	By Age: 15-19	84,749	
	By Age: 20-24	83,543	
	By Age: 25-49	59,308	
	By Age: 50+	0	
	Sum of age disaggregates	309,000	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection	2,050	Redacted

	through occupational and/or non-occupational exposure to HIV.		
	By Exposure Type: Occupational	450	
	By Exposure Type: Other non-occupational	600	
	By Exposure Type: Rape/sexual assault victims	1,000	
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	269,200	
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	n/a	Redacted

	minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	896,690	
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	225,470	

	and/or meet the minimum standards required		
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	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	120,700	
	By MARP Type: CSW	38,500	
	By MARP Type: IDU	4,000	
	By MARP Type: MSM	8,050	
	Other Vulnerable Populations	70,150	
	Sum of MARP types	120,700	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	5,982,442	Redacted
	By Age/Sex: <15 Male	157,427	

	By Age/Sex: 15+ Male	1,892,731	
	By Age/Sex: <15 Female	192,086	
	By Age/Sex: 15+ Female	3,740,198	
	By Sex: Female	3,932,284	
	By Sex: Male	2,050,158	
	By Age: <15	349,513	
	By Age: 15+	5,632,929	
	By Test Result: Negative		
	By Test Result: Positive		
	Sum of age/sex disaggregates	5,982,442	
	Sum of sex disaggregates	5,982,442	
	Sum of age disaggregates	5,982,442	
	Sum of test result disaggregates		
P12.5.D	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	260,860	Redacted
	By age: 0-4	115	
	By age: 5-9	3,561	
	By age: 10-14	21,014	

	By age: 15-17	28,050	
	By age: 18-24	52,127	
	By age: 25+	155,993	
	By geography: Districts*	260,860	
	By sex: Female	136,220	
	By sex: Male	124,640	
P12.6.D	Number of GBV-related service-encounters	26,625	Redacted
	By age: 0-4	292	
	By age: 5-9	1,998	
	By age: 10-14	6,455	
	By age: 15-17	10,250	
	By age: 18-24	5,540	
	By age: 25+	2,090	
	By sex: Female	22,930	
	By sex: Male	3,695	
	By type of service: GBV screening	9,080	
	By type of service: Post GBV-care	15,590	
P12.7.D	P12.7.D Percentage of health facilities with Gender-Based Violence and Coercion (GBV) services available (GBV pilot indicator)	37 %	Redacted
	Number of health facilities reporting that they offer (1) GBV screening and/or (2) assessment and	358	

	provision or referral to the relevant service components for the management of GBV-related health needs		
	Total number of health facilities in the region or country being measured.	976	
	By type of facility: clinical	197	
	By type of facility: community	161	
	By type of service: GBV screening	177	
	By type of service: Post GBV-care	181	
C1.1.D	Number of adults and children provided with a minimum of one care service	1,104,776	Redacted
	By Age/Sex: <18 Male	183,631	
	By Age/Sex: 18+ Male	250,144	
	By Age/Sex: <18 Female	210,832	
	By Age/Sex: 18+ Female	460,169	
	By Sex: Female	671,001	
	By Sex: Male	433,775	
	By Age: <18	394,463	
	By Age: 18+	710,313	
	Sum of age/sex disaggregates	1,104,776	

	Sum of sex disaggregates	1,104,776	
	Sum of age disaggregates	1,104,776	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	693,023	Redacted
	By Age/Sex: <15 Male	21,316	
	By Age/Sex: 15+ Male	207,385	
	By Age/Sex: <15 Female	43,276	
	By Age/Sex: 15+ Female	421,046	
	By Sex: Female	464,322	
	By Sex: Male	228,701	
	By Age: <15	64,592	
	By Age: 15+	628,431	
	Sum of age/sex disaggregates	693,023	
	Sum of sex disaggregates	693,023	
	Sum of age disaggregates	693,023	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	76 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	524,826	

	Number of HIV-positive individuals receiving a minimum of one clinical service	693,023	
C2.3.D	C2.3.D Proportion 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.	16,981	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.	0	
	By Age: <18	10,077	
	By Age: 18+	6,904	
	Sum by age disaggregates	16,981	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	95 %	Redacted
	Number of HIV-positive patients	659,534	

	who were screened for TB in HIV care or treatment setting		
	Number of HIV-positive individuals receiving a minimum of one clinical service	693,023	
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	27,987	
	Number of HIV-positive individuals receiving a minimum of one clinical service	693,023	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	25 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	29,346	
	Number of HIV-	116,160	

	positive pregnant women identified in the reporting period (include known HIV-positive at entry)		
	By timing and type of test: virological testing in the first 2 months	20,542	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	8,804	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	234,034	Redacted
	By Age: <18	152,426	
	By Age: 18+	81,608	
	By: Pregnant Women or Lactating Women	402	
	Sum of age disaggregates	234,034	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	143,231	Redacted
	By Age: <1	3,877	
	By Age/Sex: <15 Male	3,968	
	By Age/Sex: 15+ Male	43,298	
	By Age/Sex: <15 Female	8,052	

	By Age/Sex: 15+ Female	87,913	
	By: Pregnant Women	34,222	
	Sum of age/sex disaggregates	143,231	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	452,968	Redacted
	By Age: <1	5,194	
	By Age/Sex: <15 Male	12,419	
	By Age/Sex: 15+ Male	137,059	
	By Age/Sex: <15 Female	25,217	
	By Age/Sex: 15+ Female	278,273	
	Sum of age/sex disaggregates	452,968	
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	76 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	83,307	
	Total number of adults and children who initiated ART in	109,532	

	the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.		
	By Age: <15	6,634	
	By Age: 15+	76,673	
	Sum of age disaggregates	83,307	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	818	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	22	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	3,204	Redacted
	By Cadre: Doctors	203	
	By Cadre: Midwives	0	
	By Cadre: Nurses	1,183	
H2.2.D	Number of community health and para-social workers who successfully	7,059	Redacted

	completed a pre-service training program		
H2.3.D	The number of health care workers who successfully completed an in-service training program	57,071	Redacted
	By Type of Training: Male Circumcision	184	
	By Type of Training: Pediatric Treatment	1,289	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7232	Management Sciences for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,050,000
7234	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	40,856,000
7235	ICF Macro	Private Contractor	U.S. Agency for International Development	GHP-State	375,000
7241	PharmAccess	NGO	U.S. Department of Defense	GHP-State	3,074,149
7242	Central Contraceptive Procurement	Private Contractor	U.S. Agency for International Development	GHP-State	1,000,000
7629	AME-TAN Construction	Private Contractor	U.S. Agency for International Development	GHP-State	400,000
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	450,000
9595	National Institute for Medical	University	U.S. Department of Health and	GHP-State	910,000

	Research		Human Services/Centers for Disease Control and Prevention		
9614	American International Health Alliance Twinning Center	NGO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	2,225,000
9616	IntraHealth International, Inc	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	4,400,000
9627	World Health Organization	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,000
9630	Ifakara Health Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	450,000
9631	University of Dar es Salaam, University	University	U.S. Department of Health and Human	GHP-State	203,000

	Computing Center		Services/Centers for Disease Control and Prevention		
9634	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	280,000
9639	Bugando Medical Centre	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,942,820
9641	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
9642	American Society of Clinical Pathology	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	450,000
9643	Clinical and Laboratory Standards Institute	NGO	U.S. Department of Health and Human Services/Centers	GHP-State	332,684

			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	500,000
9665	Pathfinder International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	4,618,716
9678	Development Alternatives, Inc	NGO	U.S. Agency for International Development	GHP-State	1,400,000
9681	National Tuberculosis and Leprosy Control Program	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,125,000
9685	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-State	1,170,000
10044	Muhimbili University College of Health Sciences	University	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	0

			Control and Prevention		
10088	Drug Control Commission	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	250,000
10092	Tanzania Youth Alliance	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	915,000
10809	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,000
10811	Francois Xavier Bagnoud Center	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,081,500
10970	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	0
12193	Africare	NGO	U.S. Department of Health and Human	GHP-State	2,758,609

			Services/Centers for Disease Control and Prevention		
12196	United Nations Children's Fund	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,000,000
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	100,000
12203	National Alliance of State and Territorial AIDS Directors	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
12204	CDC Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,365,000
12208	Regents of the University of Minnesota	University	U.S. Department of Health and Human Services/Centers	GHP-State	100,000

			for Disease Control and Prevention		
12217	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	1,251,395
12227	Population Services International	NGO	U.S. Agency for International Development	GHP-State	2,300,000
12234	Tanzania Commission for AIDS	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
12238	Tanzania Interfaith Partnerships	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,035,000
12245	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	873,709
12246	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State, GAP	17,168,402

			Prevention		
12247	Harvard University School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,165,804
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 Prevention	GHP-State	940,000
12728	Research Triangle International	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	790,000
12738	FHI 360	NGO	U.S. Agency for International Development	GHP-State	3,550,000
12757	Research Triangle International	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	270,000
12810	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	6,490,000
12818	Catholic Relief	FBO	U.S. Department	GHP-State	12,710,637

	Services		of Health and Human Services/Centers for Disease Control and Prevention		
12823	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	12,726,499
12827	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHP-State	6,787,320
12829	JHPIEGO	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	700,000
12861	Africare	NGO	U.S. Agency for International Development	GHP-State	3,450,000
12906	Christian Social Services Commission	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	5,914,654
12907	Regional Procurement	Other USG Agency	U.S. Department of State/Bureau of	GHP-State	1,217,500

	Support Office/Frankfurt		African Affairs		
12926	Population Services International	NGO	U.S. Agency for International Development	GHP-State	2,900,000
13013	American Association of Blood Banks	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
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	3,400,000
13301	World Education	NGO	U.S. Agency for International Development	GHP-State	3,020,000
13351	Northrup Grumman	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	400,000
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	2,747,000

13359	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	5,687,474
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	739,000
13554	Foundation for Innovative New Diagnostics	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	850,000
13555	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	900,000
13662	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	200,000
13774	International Youth Foundation	NGO	U.S. Agency for International Development	GHP-State	1,000,000
14536	Ariel Glaser	NGO	U.S. Department	GHP-State	4,021,233

	Pediatric AIDS Healthcare Initiative		of Health and Human Services/Centers for Disease Control and Prevention		
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
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	250,000
14544	Tanzania Red Cross Society	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,250,000
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	250,000
14551	Kagera RHMT	NGO	U.S. Department of Health and Human Services/Centers	GHP-State	168,308

			for Disease Control and Prevention		
14552	Mtwara RHMT	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,001
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	1
14556	Tanzania Youth Alliance	NGO	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	300,000

			Control and Prevention		
14559	Management development for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	250,000
14560	African Society for Laboratory Medicine	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
14570	Management development for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	14,605,916
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	3,969,999
14653	African Medical and Research Foundation, Tanzania	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	300,000

			Prevention		
14680	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHP-State	9,669,893
14685	FHI 360	NGO	U.S. Agency for International Development	GHP-State	650,000
14689	Pastoral Activities & Services for People with AIDS	FBO	U.S. Agency for International Development	GHP-State	3,595,709
14690	Selian Lutheran Hospital, Tanzania	FBO	U.S. Agency for International Development	GHP-State	1,979,908
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
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
15063	Chamber of Minerals & Energy	Parastatal	U.S. Agency for International Development	GHP-State	0
16397	Deloitte Consulting Limited	Private Contractor	U.S. Agency for International Development	GHP-State	21,801,837
16497	ICF Macro	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0

16569	TBD	TBD	Redacted	Redacted	Redacted
16763	Henry Jackson Foundation	Private Contractor	U.S. Department of Defense	GHP-State	19,657,101
16781	TBD	TBD	Redacted	Redacted	Redacted
16782	TBD	TBD	Redacted	Redacted	Redacted
16784	TBD	TBD	Redacted	Redacted	Redacted
16786	TBD	TBD	Redacted	Redacted	Redacted
16787	TBD	TBD	Redacted	Redacted	Redacted
16788	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHP-State	602,472
16790	TBD	TBD	Redacted	Redacted	Redacted
16791	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	1,110,000
16792	TBD	TBD	Redacted	Redacted	Redacted
16820	Engender Health	Private Contractor	U.S. Agency for International Development	GHP-State	1,500,000
16872	Management development for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
16874	Tanzania Health Promotion Support (THPS)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,970,443
16876	TBD	TBD	Redacted	Redacted	Redacted

16877	Christian Council of Tanzania	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	250,000
16878	African Medical and Research Foundation, Tanzania	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	400,000
16884	Drug Control Commission	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	250,000
16885	Muhimbili University College of Health Sciences	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,300,000
16886	World Health Organization	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,000
16887	Ministry of Health	Host Country	U.S. Department	GHP-State	450,000

	and Social Welfare, Tanzania	Government Agency	of Health and Human Services/Centers for Disease Control and Prevention		
16891	TBD	TBD	Redacted	Redacted	Redacted
16892	TBD	TBD	Redacted	Redacted	Redacted
16899	TBD	TBD	Redacted	Redacted	Redacted
17082	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	2,876,514
17102	TBD	TBD	Redacted	Redacted	Redacted
17103	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,050,000	
Funding Source	**Funding Amount**
GHP-State	1,050,000

Sub Partner Name(s)

Not Applicable		

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	994,349
Motor Vehicles: Leased	9,354

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
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	900,000	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	50,000	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. 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 40,856,000	
Funding Source	**Funding Amount**
GHP-State	40,856,000

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	11,000,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
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
Care	HBHC	4,962,500	0

Narrative:

Comprehensive palliative care is essential to the health and well being of PLWAs. Volunteers are organized in Tanzania to provide home-based palliative care to people who are infected with HIV/AIDS or other critical chronic diseases. The home-based care kit provided to these volunteers is a backpack outfitted with medication for basic

pain and symptom management; bandages and other wound dressing; gloves; condoms; and materials for integrated counseling and testing (where appropriate), hygiene, malaria prevention, promotion of good nutritional practices, integrated prevention messaging, family planning, and other child survival interventions. The supplies not only facilitate
care but also endow the volunteer with credibility and a sense that they can provide concrete support as well as psycho-social assistance. Plus Up funding in the amount of $400,000 is requested for the purchase of these kits. The proposed funding would support the purchase of approximately 2,600 kits. Restocking would be provided through local GoT facilities as part of the overall service.
In addition, an additional $250,000 is requested for the purchase of nutritional support for people living with HIV/AIDS (PLWHA) who are receiving palliative care services through Home-based Care. HIV/AIDS and malnutrition are both highly prevalent in Tanzania, and their effects are integrated and exacerbated by one another. The current WHO recommendations for the nutrient requirements for PLWHA call for increases for energy over the intake levels recommended for healthy non-HIV infected individuals. The proposed intervention will support those who are HIV-infected with confirmed severe malnutrition. It is estimated that 15 - 20% of the adult population on ART will have severe malnutrition.
The requested funding will allow the piloting of the intervention. This pilot will be linked to the funding requested for nutritional support for orphans and vulnerable children. Broader implemention of the nutritional support for severely malnourished HIV-positive individuals will be planned with FY2008 funding.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	600,000	0

Narrative:

Funding for HVTB will go toward comodity support as well as integration of the TB supply chain which currently operates as its own stand alone system. SCMS will combine the latter into the intgrated logistics system for essential medicines. This will allow better and more efficient service to individual service delivery points, while creating a more substainable system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	707,316	0

Narrative:

This activity links to activities HLAB MOHSW 7758, 7779 NIMR, CDCBase 7834, CLSI 7696, APHL7682, AIHA7676, ASCP 7681, AMREF 7672, RPSO 7792, BMC 7685, ZACP 8224, DoD 7746; Track 1 ART CU7697/7698, EGPAF 7705/7706, HARVARD7719/7722, AIDSRelief 7692/7694, DoD7747, Blood Safety; CT NACP 7776, TB/HIV 7781, PMI, FHI 7712; SI NACP 7773, MOHSW 7761

With the FY 2007 funding USG/HHS/CDC will place $ 200,000.00 for negotiation of reagent procurement for the National Quality Assurance and Training Center (NQA&TC) currently under renovation and expected to be completed by December 2007. Through this mechanism various laboratory supplies and reagents and kits for HIV rapid testing and ELISA kits, PCR, CD4 count, Chemistry, Hematology Hepatitis, syphilis and Opportunistic infections tests kits will be procured.

When completed, equipped, and staffed, the laboratory will support MOHSW to introduce, develop and implement HIV/AIDS laboratory quality systems in Tanzania. Also the laboratory would conduct quality assessment of HIV/AIDS testing at Zonal, Regional and district laboratories, develop HIV laboratory training materials, train trainers in HIV/AIDS related testing and testing specific quality assurance, support and conduct HIV surveillance for prevalence, drug resistance threshold and Incidence testing, establish a central area for receiving and delivering distance-based training, and provide technical assistance for external quality assessment (proficiency testing) programs.

The reagents and laboratory supplies purchased will be used for these activities by the National Quality assurance and Training Center.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,363,934	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	6,685,000	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	HVCT	1,240,625	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
Prevention	MTCT	843,750	0

Narrative:
Additional $558,318 to support additional commodities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	15,000,000	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	9,452,875	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.

Implementing Mechanism Details

Mechanism ID: 7235	Mechanism Name: 2011-2012 THMIS, SPA, 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: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 375,000	
Funding Source	**Funding Amount**
GHP-State	375,000

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.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7235		
Mechanism Name:	2011-2012 THMIS, SPA, DHS		
Prime Partner Name:	ICF Macro		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	375,000	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: 7241	**Mechanism Name: PAI-DOD**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: PharmAccess	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,074,149	
Funding Source	**Funding Amount**
GHP-State	3,074,149

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)

Food and Nutrition: Commodities	100,000
Gender: GBV	200,000
Human Resources for Health	500,000
Motor Vehicles: Purchased	70,000
Renovation	400,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	280,000	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	190,000	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	54,000	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	280,000	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	80,000	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.

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	700,000	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	200,000	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	400,017	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	524,132	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	216,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

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.)

Key Issues

(No data provided.)

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	1,000,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	400,000

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	400,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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

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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 450,000	
Funding Source	**Funding Amount**
GHP-State	450,000

Sub Partner Name(s)

Pangaea Global AIDS Foundation		

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	100,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
End-of-Program Evaluation
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	100,000	0
Narrative:			
Continuing mechanism			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	100,000	0
Narrative:			
Continuing mechanism			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	150,000	0
Narrative:			
Continuing mechanism			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	100,000	0
Narrative:			
Continuing mechanism			

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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 910,000	
Funding Source	**Funding Amount**
GHP-State	910,000

Sub Partner Name(s)

Not Applicable		

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	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9595**
Mechanism Name:	**NIMR**
Prime Partner Name:	**National Institute for Medical Research**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	250,000	0

Narrative:

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	210,000	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	200,000	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	250,000	0
Narrative:			
$300,000 in funds are being moved to the ESIS mechanism (CDC contract) to competitively select an implementing partner for the impact evaluation. TBD partner will be identified by August 2012			

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,225,000	
Funding Source	**Funding Amount**
GHP-State	2,225,000

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)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Gender: GBV	150,000
Human Resources for Health	1,000,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Child Survival Activities
Safe Motherhood
Family Planning

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	245,000	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	900,000	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	180,000	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	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	300,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,400,000	
Funding Source	**Funding Amount**
GHP-State	4,400,000

Sub Partner Name(s)

ARUSHA MUNICIPAL COUNCIL	GEITA DISTRICT COUNCIL	MERU DISTRICT 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: GBV	350,000
Human Resources for Health	250,000
Motor Vehicles: Purchased	177,400

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Family Planning

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	2,600,000	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	1,800,000	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: 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: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-State	200,000

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	77,750
Key Populations: MSM and TG	50,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
TB

Budget Code Information

Mechanism ID:	**9627**		
Mechanism Name:	**WHO**		
Prime Partner Name:	**World Health Organization**		
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 Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ifakara Health Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 450,000	
Funding Source	**Funding Amount**
GHP-State	450,000

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)

Motor Vehicles: Purchased	13,173

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	450,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 203,000	
Funding Source	**Funding Amount**

GHP-State	203,000

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)

Human Resources for Health	60,000

TBD Details

(No data provided.)

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	147,000	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	56,000	0

Narrative:

COP 2013 funds will be used to provide support for the continued roll out of the care and treatment electronic system (CTC2) to additional facilities, including strengthened linkage ofto the CTC2 database with the MOHSW DHIS vision to improve data flow from the facility level to district, regional and national levels. In addition to improving data flow, the activity will enhance overall reporting functionality, analysis of data and provision of feedback to health centres and partners based on aggregate data.

A multi-site care and treatment database or monitoring tool will improve clinical outcomes, as care providers will

be able to monitor patients across multiple sites and produce a more accurate list of those patients requiring more specific interventions to improve retention and adherence of patients initiated on ART. *The target beneficiaries for this project will be all care and treatment patients and health service providers and managers; patients will benefit from improved records and follow up while service providers will have improved capacity to access, analyze and use data in decision making.* *The activity will also provide supportive supervision and training on the use of CTC2 paper and electronic 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 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 280,000	
Funding Source	**Funding Amount**
GHP-State	280,000

Sub Partner Name(s)

(No data provided.)

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)

Human Resources for Health	20,000
Key Populations: FSW	50,000
Key Populations: MSM and TG	50,000

TBD Details

(No data provided.)

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	280,000	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.*

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,942,820	
Funding Source	**Funding Amount**
GHP-State	2,942,820

Sub Partner Name(s)

Not Applicable		

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	570,160

TBD Details

(No data provided.)

Key Issues

Child Survival Activities
Mobile Population
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
Care	HBHC	7,452	0

Narrative:

A high priority goal is to improve the quality of life for PLHIV by providing integrated and high quality HBC services through trained community volunteers, and forging linkages for relevant support services for PLHIV. ComprehensiveCcare and support programming for BMC and support programming will focus on early identification of HIV individuals and provision of a complete and high quality clinical care package that will include physical assessment, WHO staging, CD4 and other lab monitoring, nutritional assessment, counseling and support, detection and management of Opportunistic Infections, Cotrimoxazole prophylaxis, ART management, screening for cervical cancer, Positive Health Dignity and Prevention (PHDP), pain management and end of life care. The partner will also conduct supportive supervision and mentorship to ensure quality delivery of this package. The partner will improve the linkage system to successfully enroll a newly diagnosed individual into care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	20,062	0

Narrative:

Bugando Medical Centre (BMC) will strengthen TB screening and case detection by implementing Intensified Case Finding (ICF) at care and treatment clinics (CTC), among pregnant women, OVC, pediatrics, uniformed forces and in congregate settings. The partner will also support the identification of TB suspects, diagnostic evaluation of suspects and treatment of of TB/HIV co-infected patients. BMC will support the provision of Isoniazid Preventive Therapy (IPT) for individuals who screen negative for TB symptoms, as well as implement infection control measures to prevent TB transmission in both TB and CTC settings. PHDP will be integrated into TB clinical settings, and comprehensive HIV care and treatment services (including ART initiation) for TBHIV co-infected patients will be provided. Provision of HIV services in TB clinics will be scaled up through increasing the number

of TB clinics with "One Stop" TBHIV services and/or renovation of TB clinics to allow for the provision of comprehensive care and treatment services. Scale up of pediatric TB/HIV services will also be supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	5,570	0

Narrative:

PDCS funds will go toward scale up of Cotrimoxazole prophylaxis for HIV-exposed and infected children, and support nutrition assessment, nutritional counseling, and referrals for severely malnourished children. These funds will also support incentives to community support groups to improve retention through tracking of lost to follow up among children and families. BMC will collaborate with other HBC partners to maximize efficiency and ensure a continuum of care for families.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	3,439	0

Narrative:

This activity links to activities HLAB MOHSW 7758, 7779 NIMR, CDCBase 7834, CLSI 7696, APHL7682, AIHA7676, ASCP 7681, AMREF 7672, RPSO 7792, ZACP 8224, DoD 7746; Track 1 ART CU7697/7698, EGPAF 7705/7706, HARVARD7719/7722, AIDSRelief 7692/7694, DoD7747, Blood Safety; CT NACP 7776, TB/HIV 7781, PMI, SCMS 8233, FHI 7712; SI NACP 7773, MOHSW 7761.

The Ministry of health and social welfare (MOHSW) has decentralized HIV/AIDS laboratory infrastructure and capacity building to the zonal referral laboratories to expand HIV/AIDS lab capacity and to embrace the network model for a continuum of HIV/AIDS prevention care and treatment services. BMC is a referral and teaching hospital for the six neighboring regions of the lake zone with a catchment population of approximately 13 million. The lake regions are Mwanza, Kagera, Shinyanga, Kigoma, Mara and Tabora.
The Bugando Medical Center (BMC) zonal referral laboratory capacity is currently inadequate and an obstacle in achieving the emergency plans for care and treatment goals of the lake zone.

BMC is being funded for the first time in FY 2007 with special focus to the laboratory services at the center. BMC will apply the quality system approach to build its own capacity as a center of excellence and support a network of regional, district faith based and private laboratories supporting HIV/AIDS prevention, care and treatment in the lake zone. The BMC will train staff at the BMC lab to perform testing for HIV diagnosis, disease staging and treatment monitoring in order to optimize prevention, care and treatment services, train laboratory and non-laboratory staff from other facilities providing similar services and support and help monitor performance through supportive supervision.

BMC had started to implement activities to strengthen laboratory capacity in collaboration with various implementing partners including Columbia University , HHS/CDC Tanzania, National Institute for Medical Research (NIMR), African Medical and Research Foundation (AMREF), the Association of Public Health Laboratories (APHL) the Clinical and laboratory standards Institute (CLSI), the American society for clinical pathology (ASCP), GTZ, JICA, AXIOS, Clinton Foundation, Track 1 partners and other ART partners. The high volume chemistry, Hematology and CD4 equipment have been procured by HHS/CDC Tanzania with FY 2005 funding and installed. Training of laboratory technologist on HIV/AIDS standard of care tests, equipment maintenance and preventive maintenance for users, rapid HIV test training to laboratorians and non lab staff from other intervention areas like PMTCT, Counseling and testing (CT), TB/HIV and introduction to Quality system approach in the laboratory services were implemented in FY 2006

With FY 2007 funding BMC laboratory will, in collaboration with partners implement quality system in the BMC laboratory and establish a network from which all laboratories levels will be supported. The Quality system implementation will follow active gap analysis strategy and focus on areas of specimen management, Quality assurance,

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	1,370,000	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	329,180	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	285,979	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 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	898,210	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	PDTX	22,928	0

Narrative:

PDTX funds will enhance the identification of HIV-exposed children through scaling up EID services and PITC in OPD settings, immunization clinics, TB/HIV clinics, OVC services and family testing at CTCs. Support will also include pre-ART review of all children in care to determine eligibility for the new 2012 NACP guidelines and treatment of all HIV-infected children under 24 months. These funds will also be used to improve monitoring response and adherence to treatment. These objectives will be achieved through training, on-site mentorship, advocacy, community mobilization, and implementing pediatrics specific quality improvement initiatives.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

Not Applicable		

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	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	500,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 450,000	
Funding Source	**Funding Amount**
GHP-State	450,000

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	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	HLAB	450,000	0

Systems			

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 332,684	
Funding Source	**Funding Amount**
GHP-State	332,684

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)

Human Resources for Health	100,000

TBD Details

(No data provided.)

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	332,684	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

Not Applicable		

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	500,000

TBD Details

(No data provided.)

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	500,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,618,716	
Funding Source	**Funding Amount**
GHP-State	4,618,716

Sub Partner Name(s)

D-Tree International	HAI DISTRICT COUNCIL	Ilala Municipal Council
Kahama District Council	Kinondoni Municipal Council	MERU DISTRICT COUNCIL
MOSHI MUNICIPAL COUNCIL	Shinyanga District Council	Tanga City Council
Tanzania Red Cross Society		

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	164,700
Education	325,000
Food and Nutrition: Policy, Tools, and Service Delivery	82,350
Gender: GBV	53,129
Human Resources for Health	450,000
Key Populations: FSW	4,500
Key Populations: MSM and TG	9,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increasing women's access to income and productive resources

Increasing women's legal rights and protection

Safe Motherhood

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	2,233,486	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	1,735,230	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	400,000	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	250,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,400,000	
Funding Source	**Funding Amount**
GHP-State	1,400,000

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	1,400,000

TBD Details

(No data provided.)

Key Issues

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	400,000	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.

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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 2,125,000	
Funding Source	**Funding Amount**
GHP-State	2,125,000

Sub Partner Name(s)

Bukombe	Chunya District council	Handeni District council
Igunga District Council	Ileje District council	Iramba District Council
Iringa District Council	Iringa Municipal Centre	Kahama District Council
Kilolo District council	Kilombero District Council	Kilosa District Council
KILWA DISTRICT COUNCIL	Kyela District Council	Lindi District council
Lindi Municipal Council	LIWALE DISTRICT COUNCIL	Ludewa District Council
Makete District council	Manyoni District Council	Masasi District Council
Maswa District Council	Mbeya City Council	Mbinga District council
Mbozi District Council	MEATU DISTRICT COUNCIL	Morogoro District Council
Mufindi District Council	Mvomero District Council	NACHINGWEA DISTRICT COUNCIL
Namtumbo District council	Nanyumbu District council	Newala District Council
NJOMBE DISTRICT COUNCIL	Nzega District Council	RUANGWA DISTRICT COUNCIL
Rungwe District Council	Shinyanga District Council	SHINYANGA MUNICIPAL COUNCIL
SIKONGE DISTRICT COUNCIL	Singida District Council	Singida Municipal Council
Songea District council	Songea Municipal Council	TABORA MUNICIPAL COUNCIL
Tanga City Council	Tunduru District council	Ulanga District 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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	600,000

TBD Details

(No data provided.)

Key Issues

Child Survival Activities
TB

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	2,125,000	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: Contract
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,170,000	
Funding Source	**Funding Amount**
GHP-State	1,170,000

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.)

Key Issues

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	1,170,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Not Applicable		

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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

End-of-Program Evaluation

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	0	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	0	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.

In COP 2012, 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	0	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. *In COP 2012 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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

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)

Human Resources for Health	150,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

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	250,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 915,000	
Funding Source	**Funding Amount**
GHP-State	915,000

Sub Partner Name(s)

Not Applicable		

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)

Gender: GBV	100,000
Human Resources for Health	50,000
Key Populations: FSW	50,000
Key Populations: MSM and TG	50,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Mobile Population
End-of-Program Evaluation
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	95,000	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	HVCT	200,000	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	620,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-State	200,000

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	120,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	200,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,081,500	
Funding Source	**Funding Amount**
GHP-State	1,081,500

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	76,540

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Safe Motherhood

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	1,081,500	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
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.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,758,609	
Funding Source	**Funding Amount**
GHP-State	2,758,609

Sub Partner Name(s)

(No data provided.)

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	189,949
Food and Nutrition: Policy, Tools, and Service Delivery	253,424
Gender: GBV	100,000
Human Resources for Health	253,424

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12193		
Mechanism Name:	Africare		
Prime Partner Name:	Africare		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	2,350,000	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	408,609	0

Narrative:

Africare will use 2013 COP funding to support the community component of PMTCT in Kagera, Mara and Manyara regions to increase PMTCT uptake and retention. Improved access to facility care and treatment services will be accomplished through scaling up and linking community maternal, newborn and child health services.

Africare will use HBC volunteers to support education on and access to HIV testing and counseling and integrated FP for pregnant women, syphilis and TB screening of women through community PHDP and PMTCT, and EID and treatment of HIV infected children.
Africare will train and use HBC volunteers to support community PHDP education; increase linkages and access to HIV testing and counseling, and integrated FP for pregnant women; promote syphilis and TB screening of women accessing PMTCT; and support EID and treatment of HIV infected children.

Africare will support initiatives to increase the number of male partners who attend RCH facilities during prenatal care, using this also as an entry point to link male partners to couples testing and counseling and to voluntary medical male circumcision services.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

Sub Partner Name(s)

Mothers 2 Mothers		

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)

Gender: GBV	100,000
Human Resources for Health	210,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	1,000,000	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: 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: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

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)

Human Resources for Health	47,450

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	100,000	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: 12203	**Mechanism Name: Prevention Scenario Model**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Alliance of State and Territorial AIDS Directors	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

a

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12203**		
Mechanism Name:	**Prevention Scenario Model**		
Prime Partner Name:	**National Alliance of State and Territorial AIDS Directors**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	100,000	0

Narrative:
Continuing mechanism

Implementing Mechanism Details

Mechanism ID: 12204	Mechanism Name: P4H
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,365,000	
Funding Source	**Funding Amount**
GHP-State	1,365,000

Sub Partner Name(s)

Deloitte Consulting Tanzania Limited	PharmAccess International	Text To Change
University of Dar es Salaam/Computer Sciences Department		

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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12204**		
Mechanism Name:	**P4H**		
Prime Partner Name:	**CDC Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	100,000	0
Narrative:			

PharmAccess will work in collaboration with the MOHSW on the stepwise certification to accreditation program. The program will enhance facility-based care by ensuring that facilities maintain a basic set of care standards while utilizing quality improvement methodology to achieve higher standards.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	490,000	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	75,000	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	300,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

Not Applicable		

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	30,000

TBD Details

(No data provided.)

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,251,395	
Funding Source	**Funding Amount**
GHP-State	1,251,395

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)

Gender: GBV	500,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

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	HKID	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 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	951,395	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.*

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,300,000	
Funding Source	**Funding Amount**
GHP-State	2,300,000

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.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	1,000,000
Education	1,000,000
Human Resources for Health	200,000
Key Populations: FSW	50,000
Water	200,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**12227**
Mechanism Name:	**Tanzania Social Marketing Program**
Prime Partner Name:	**Population Services International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	200,000	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	2,100,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 100,000	
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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	30,000

TBD Details

(No data provided.)

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,035,000	
Funding Source	**Funding Amount**
GHP-State	2,035,000

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.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	400,000
Food and Nutrition: Policy, Tools, and Service Delivery	70,000
Gender: Gender Equality	30,000
Motor Vehicles: Purchased	25,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	290,000	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	1,045,000	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	100,000	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	400,000	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	200,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 873,709	
Funding Source	**Funding Amount**
GHP-State	873,709

Sub Partner Name(s)

(No data provided.)

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)

Human Resources for Health	400,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	373,709	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	400,000	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	100,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 17,168,402	
Funding Source	**Funding Amount**
GAP	5,009,899
GHP-State	12,158,503

Sub Partner Name(s)

Bagamoyo District Council	Biharamulo DDH	Biharamulo District Council
Bugando Medical Centre	Bukoba District Council	Bukoba Municipal Council
Chato District Council	Heri Mission Hospital	Isingiro District Health Services
Kabanga Mission Hospital	Kagera Regional Hospital	Kagera RHMT
Kagera Sugar Hospital	Kagondo Hospital	Karagwe District Council
Kasulu District Council	Kibaha District Council	Kibaha Municipal

Kibondo District Council	Kigoma District Council	KIGOMA MUNICIPAL COUNCIL
Kisarawe District Council	Mafia District Council	Matyazo Health centre
Maweni regional Hosp	Mchukwi Mission Hospital	Misenye District Council
Mkuranga District Council	MKUTA	Mtwara DC
Mugana DDH	Muleba District Council	Murgwaza DDH
Ndolage Mission Hospital	Ngara District Council	Nyakahanga DDH
Nyakaiga Hospital	Ocean Road Cancer Institute	Pwani RHMT
Rubya DDH	Rufiji District Council	Rulenge Hospital
Service, Health, Development and Education for People with HIV/AIDS	TADEPA	Women Development Association
ZAIADA	Zanzibar AIDS Control Program	Zanzibar Association of People Living with AIDS
Zanzibar NGO Cluster	Zanzibar Youth Forum	ZAYEDESA

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)

Human Resources for Health	1,200,000
Motor Vehicles: Purchased	355,000
Renovation	800,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	170,000	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	200,000	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	190,500	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 Systems	HLAB	300,000	0

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	930,000	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	350,000	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	100,000	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	700,000	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	3,634,652	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	9,775,000	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	818,250	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,165,804	
Funding Source	**Funding Amount**
GHP-State	1,165,804

Sub Partner Name(s)

(No data provided.)

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)

Human Resources for Health	250,000

TBD Details

(No data provided.)

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**
Prevention	MTCT	200,000	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 ClASS 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	965,804	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 ClASS 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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 940,000	
Funding Source	**Funding Amount**
GHP-State	940,000

Sub Partner Name(s)

Not Applicable		

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)

Human Resources for Health	500,000

TBD Details

(No data provided.)

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	940,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 790,000	
Funding Source	**Funding Amount**
GHP-State	790,000

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

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	HVSI	590,000	0

Systems			

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.

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	100,000	0

Narrative:
RTI will continue working closely with the MOHSW on broad health information system planning, enterprise architecture and ICT infrastructure planning. OHSS funds will be invested in numerous information systems that would benefit from enhanced MOHSW capacity to coordinate and plan information systems. RTI is currently supporting the design of a master facility list and will be helping MOHSW define standards and data exchange mechanisms.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	100,000	0

Narrative:
RTI is tasked with providing technical assistance to the MOHSW, NACP and other stakeholders on the conceptualization, requirements definition and high level design of a HIV/AIDS care and treatment database system.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,550,000	
Funding Source	**Funding Amount**
GHP-State	3,550,000

Sub Partner Name(s)

Deloitte Consulting Limited	Faraja Trust	Pastoral Activities & Services for

		People with AIDS
Roman Catholic Diocese of Mahenge	Tanzania Women Lawyers Association (TAWLA)	Wanawake na Maendeleo (WAMA) Foundation

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	200,018
Food and Nutrition: Policy, Tools, and Service Delivery	57,908
Gender: GBV	100,706
Gender: Gender Equality	75,242
Human Resources for Health	303,321

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Increasing women's access to income and productive resources

Increasing women's legal rights and protection

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	3,550,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 270,000	
Funding Source	**Funding Amount**
GHP-State	270,000

Sub Partner Name(s)

Not Applicable		

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.)

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	90,000	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	180,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,490,000	
Funding Source	**Funding Amount**
GHP-State	6,490,000

Sub Partner Name(s)

Christian Council of Tanzania (CCT)	Human development Trust (HDT)	Saidia Wazee Karagwe (SAWAKA)
Tabora Development Foundation Trust (TDFT)	Tanzania Development and AIDS Prevention (TADEPA)	Tanzania Red Cross Society

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	100,000
Gender: GBV	350,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 12,710,637	
Funding Source	**Funding Amount**
GHP-State	12,710,637

Sub Partner Name(s)

Christian Social Services Commission	Kibara Hospital	Lushoto District Hospital
Mbulu District Hospital	Mennonite Mara	

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)

Food and Nutrition: Policy, Tools, and Service Delivery	12,838
Human Resources for Health	436,603
Motor Vehicles: Purchased	45,000
Renovation	137,536

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	130,000	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	200,000	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	362,509	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	140,000	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	2,674,069	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	8,164,956	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	1,039,103	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 12,726,499	

Funding Source	Funding Amount
GHP-State	12,726,499

Sub Partner Name(s)

AICC	ARUSHA MUNICIPAL COUNCIL	Gonja Lutheran Hospital
Hai District Hospital	Igunga District Council	ISTHNA ASHERI HOSPITAL
KIBONG'OTO TB HOSPITAL	KIBOSHO MISSION HOSPITAL	Kilema Hospital
Kilimanjaro Christian Medical Centre	KILWA DISTRICT COUNCIL	KIPATIMU MISION HOSPITAL
KITETE REGIONAL HOSPITAL	Lindi District council	LIWALE DISTRICT COUNCIL
LONGIDO DISTRICT COUNCIL	Machame Hospital	Marangu Hospital
MAWENZI REGIONAL HOSPITAL	MERU DISTRICT COUNCIL	MNERO MISSION HOSPITAL
MONDULI DISTRICT COUNCIL	MOSHI MUNICIPAL COUNCIL	MOSHI RURAL DISTRICT COUNCIL
MT. MERU REGIONAL HOSPITAL	MWANGA DISTRICT COUNCIL	NACHINGWEA DISTRICT COUNCIL
NDALA MISSION HOSPITAL	NGORONGORO DISTRICT COUNCIL	Ngoyoni Hospital
Nkinga Mission Hospital	NKOARANGA LUTHERAN HOSPITAL	Nzega District Council
ROMBO DISTRICT COUNCIL	RUANGWA DISTRICT COUNCIL	SAME DISTRICT COUNCIL
SIKONGE DESIGNATED DISTRICT HOSPITAL	SIKONGE DISTRICT COUNCIL	SOKOINE REGIONAL HOSPITAL
ST ELIZABETH HOSPITAL	St Walburg Hospital	TABORA MUNICIPAL COUNCIL
TPC HOSPITAL	Urambo District Council	Uyui District 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)

Human Resources for Health	1,831,004
Motor Vehicles: Purchased	210,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	130,000	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	250,000	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	345,845	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	200,000	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	10,900,157	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	900,497	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,787,320	
Funding Source	**Funding Amount**
GHP-State	6,787,320

Sub Partner Name(s)

Care International		

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.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
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	690,000	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	710,000	0

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	397,320	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	2,690,000	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	1,100,000	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	1,000,000	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	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHP-State	700,000

Sub Partner Name(s)

Not Applicable		

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)

Human Resources for Health	287,000
Renovation	50,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	700,000	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	Procurement Type: Cooperative Agreement

Development	
Prime Partner Name: Africare	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,450,000	
Funding Source	**Funding Amount**
GHP-State	3,450,000

Sub Partner Name(s)

Allamano Centre	Chama cha Uzazi na Malezi Bora Tanzania (UMATI)	Christian Council of Tanzania (CCT)
Futures Group	Iambi Hospital VCT Centre	Tanzania Home Economics Association (TAHEA)

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	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	30,000
Gender: GBV	350,000
Motor Vehicles: Purchased	168,889

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources

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	3,450,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,914,654	
Funding Source	**Funding Amount**
GHP-State	5,914,654

Sub Partner Name(s)

Mkula Hospital	Mwananchi Hospital	RAO Hospital

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	388,133
Motor Vehicles: Purchased	170,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	122,548	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	329,938	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	91,610	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
Governance and Systems	HLAB	56,561	0

Narrative:

CSSC will continue to focus mainly on strengthening HIV/AIDS related laboratory services in the supported districts, to improve the quality of clinical assessments and monitoring of enrolled clients.
To achieve this, CSSC will continue to support facilities with laboratory equipment, reagents and supplies to fill the gap during national stock-outs, and procure 15 Hemoglobin analyzers to support facilities identified by a high volume of enrolled clients and inadequate laboratory equipment.
CSSC will also continue to print and distribute job aids, guidelines, SOPs, reporting tools and other reference materials to guide and standardize laboratory services in the supported facilities. In addition, CSSC will strengthen the transportation of DBS samples and results to and from the Bugando PCR laboratory, shortening turnaround time of DBS results by entering into contractual agreement with relevant stakeholders.
For sustainability, CSSC will strengthen the Regional and District Health systems in overseeing laboratory services, including troubleshooting equipment problems, conducting joint supportive supervision on quarterly basis in each of the supported District, and providing technical assistance in creation of a line item for lab equipment maintenance in the Comprehensive Council Health budget. CSSC has budgeted for Planned Preventive Maintenance of selected laboratory equipment, especially CD4 count machines, during the transition of financial responsibility.
CSSC will mentor and coach district laboratories on quality improvement through the Strengthening of Laboratory

Management Towards Accreditation (SLMTA) process, with a target of at least one laboratory (Nansio District Hospital Laboratory) achieving one STAR WHO stepwise accreditation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,414,021	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	3,522,904	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.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	377,072	0

Narrative:

According to the transition plan agreed by CSSC, all 46 health facilities in Mwanza providing comprehensive care and treatment services will be transitoning from the LEAD project to CSSC.

Implementing Mechanism Details

Mechanism ID: 12907	**Mechanism Name: RPSO**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Contract
Prime Partner Name: Regional Procurement Support Office/Frankfurt	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,217,500	
Funding Source	**Funding Amount**
GHP-State	1,217,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Not Provided

Cross-Cutting Budget Attribution(s)

Construction	1,217,500
Human Resources for Health	767,500

TBD Details

(No data provided.)

Key Issues

Safe Motherhood

Family Planning

Budget Code Information

Mechanism ID:	12907		
Mechanism Name:	RPSO		
Prime Partner Name:	Regional Procurement Support Office/Frankfurt		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	767,500	0

Narrative:

The human resources for health (HRH) situation is a major challenge for the health sector in general, and for the HIV and AIDS response in particular. According to the Government of Tanzania's HRH Strategic Plan, Tanzania's public sector health facilities have a total of 29,063 out of a required 82,277 health professionals, meaning that only 38% of the required positions are filled. The National HIV/AIDS Care and Treatment Plan estimated that an additional 9,299 skilled medical personnel will be needed for HIV and AIDS care and treatment. The shortfall in available health workers threatens to become significantly larger in light of the MOHSW's launch of a 10-year primary health service development program to nearly double the number of primary health facilities.

The Ministry of Health and Social Welfare (MOHSW) is currently working with its partners including USG to support scale up of new health care worker (HCW) production. One of the major challenges to this initiative is the availability of classrooms and dormitories to accommodate the increased number of students. Therefore, in order to achieve this strategic objective, there is a need to invest in infrastructure development in these health institutes to expand enrollment capacity.

In addition to improving infrastructure in health institutes, the Tanzania MoHSW recognizes distance learning (DL) as a cost-effective method to address human resource challenges. In 1998, the MOHSW established the national Centre for Distance Education (CDE) which serves to develop, coordinate and implement DL programmes for HCWs. The USG, in collaboration with the MOHSW, assessed current DL programmes for HCWs in Tanzania to determine the feasibility of DL to meet the need of an increased and more skilled health workforce. The assessment found that if this centre was strengthened through developing the required infrastructure, it would be well positioned to support training of about 2800 HCWs.

The CDE in Morogoro currently has no physical infrastructure to accommodate the national and coordination functions of the centre. Therefore, with this funding, USG intends to enhance the Administrative Block with a meeting/conference room with a capacity for 30-50 people, as well as seven spacious offices to accommodate tutors and other administrators who support the program. The funds will also support construction of two classrooms/seminar rooms which can be partitioned to create four ordinary classrooms of 30 people each. The classrooms will used for face to face tutorials and student assessment for DE students, as well as for continuous training of tutors from the eight zones who provide support to students doing DE within their zones. Additionally, the funds will go toward construction of one computer laboratory with the capacity to accommodate 25 computers, a library room with a 30-person sitting capacity, and a cafeteria with a 30-person sitting capacity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	50,000	0

Narrative:

PEPFAR supports the implementation of PMTCT, integrated into improved Maternal, Neonatal and Child Health services. One of the challenges facing PEPFAR-supported facilities is low facility delivery, based on the DHS 2O10 which indicates that 50% of pregnant women deliver at home. Poor infrastructure is a significant factor, especially in the rural areas. COP 2012 funds will support the strategic expansion of PMTCT service delivery by conducting major renovation to and construction of maternal and child health clinics as well as maternity wards. This is expected to have positive effects on the increasing the following:

- number of pregnant women attending four ANC visits
- number of facility deliveries

- number of all women of reproductive age receiving family planning services
- number of all women of reproductive age receiving counseling and testing
- number of HIV positive women receiving ARV prophylaxis /treatment
- number of infants brought for testing and treatment

This activity plans to target three to seven RCH clinics and labor ward sites. A previous needs assessment executed in FY 2011 produced a long list of sites requiring renovation; the rural areas of Kigoma and Kagera will be priorities. The interagency USG team will make additional assessments and/or data calls to identify the types of facility needed (health center, dispensary, hospital). In turn, this will determine the total number of facilities, based on cost at that time, and degree of repair required. The USG team will identify speicifc sites in collaboration with the Council Health Management Team and implementing partners. After completion of the task, the sites will be maintained by the LGA and incorporated into the CCHP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	400,000	0

Narrative:

A previous needs assessment produced a list of sites requiring construction of new Care and Treatment Centers; the rural areas of Kagera will be priorities. The interagency USG team will make additional assessments and/or data calls to identify the size of facility needed (4-Room, 5-Room or 7-Room). In turn, this will determine the total number of facilities, based on cost at that time. The USG team will identify specifc sites in collaboration with the Council Health Management Team and implementing partners. After completion of the task, the sites will be maintained by the LGA and incorporated into the CCHP.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,900,000	
Funding Source	**Funding Amount**

GHP-State	2,900,000

Sub Partner Name(s)

(No data provided.)

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.

Cross-Cutting Budget Attribution(s)

Gender: GBV	110,000
Gender: Gender Equality	43,339
Key Populations: FSW	2,450,000
Key Populations: MSM and TG	205,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
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	HVOP	2,900,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

Not Applicable		

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	217,878

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	500,000	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: No
Global Fund / Multilateral Engagement: No	

G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 3,400,000	
Funding Source	**Funding Amount**
GHP-State	3,400,000

Sub Partner Name(s)

(No data provided.)

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	1,468,558
Motor Vehicles: Purchased	180,000

TBD Details

(No data provided.)

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	3,400,000	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 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,020,000	

Funding Source	Funding Amount
GHP-State	3,020,000

Sub Partner Name(s)

Maarifa Ni Ufunguo		

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.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	179,724
Education	551,570
Food and Nutrition: Policy, Tools, and Service Delivery	158,820
Gender: GBV	14,371
Gender: Gender Equality	59,301

Human Resources for Health	119,605
Motor Vehicles: Purchased	53,000

TBD Details

(No data provided.)

Key Issues

Increasing women's access to income and productive resources

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	3,020,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	

Funding Source	Funding Amount
GHP-State	400,000

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.)

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	400,000	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	Procurement Type: Cooperative Agreement

Prevention	
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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 2,747,000	
Funding Source	**Funding Amount**
GHP-State	2,747,000

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.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	45,660
Food and Nutrition: Policy, Tools, and Service Delivery	35,000
Key Populations: FSW	56,649

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13355**
Mechanism Name:	**ZACP**
Prime Partner Name:	**Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	97,000	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	50,000	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	390,000	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	325,000	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	HVCT	340,000	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	100,000	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	250,000	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	700,000	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	495,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,687,474	
Funding Source	**Funding Amount**
GHP-State	5,687,474

Sub Partner Name(s)

Not Applicable		

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)

Human Resources for Health	1,300,000
Motor Vehicles: Purchased	75,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	250,000	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	150,000	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	3,585,000	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	691,444	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	840,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 739,000	
Funding Source	**Funding Amount**
GHP-State	739,000

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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	HKID	239,000	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	HVCT	500,000	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.*

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 850,000	
Funding Source	**Funding Amount**
GHP-State	850,000

Sub Partner Name(s)

Not Applicable		

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	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	700,000	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	150,000	0

Narrative:

The goal of this project is to build capacity for diagnostic testing of tuberculosis (TB) through laboratory strengthening and integration of services. Together with several partners, FIND will implement a set of activities that strengthen the quality of laboratory services, introduce new and more rapid diagnostic tools, increase human resource capacity, and support the integration of laboratory services for diagnostic testing of TB, malaria and HIV. Building on previous achievements, FIND will support implementation of the Gene Xpert MTB/RIF system at the district level for rapid diagnosis of TB and/or MDR-TB through the following activities:

- Assist MOHSW to develop a procurement and distribution plan for Gene Xpert cartridges

- Procure Gene Xpert cartridges and supplies to support all machines in country (28) and facilitate annual calibration of all of them

- Train laboratory staff (40) on the operation and maintenance of Gene Xpert MTB/RIF machines.

- Establish an EQA scheme for Gene Xpert MTB/RIF for all 28 testing sites with the National Health Laboratory Quality Assurance Centre as the center for coordination and excellence

- Implement the electronic TB smear microscopy rechecking system.

- Support TB biosafety through lab infrastructure improvement and staff training

- Support the government of Tanzania to maintain Gene Xpert machines in the country

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 900,000	

Funding Source	Funding Amount
GHP-State	900,000

Sub Partner Name(s)

Ministry of Health and Social Welfare, Tanzania	Muhimbili University of Health and Allied Sciences	Not Applicable

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	900,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	900,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

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)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	200,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

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	500,000
Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Gender: Gender Equality	250,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	1,000,000	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,021,233	
Funding Source	**Funding Amount**
GHP-State	4,021,233

Sub Partner Name(s)

BUKOMBE DISTRICT COUNCIL	Kahama District Council	Maswa District Council
MEATU DISTRICT COUNCIL	MWADUI HOSPITAL	Shinyanga District Council
SHINYANGA MUNICIPAL COUNCIL	Shinyanga Regional Hospital	

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)

Human Resources for Health	254,014
Motor Vehicles: Purchased	197,480
Renovation	200,000

TBD Details

(No data provided.)

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	130,000	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	150,000	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	297,150	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
Governance and Systems	HLAB	30,000	0

Narrative:

HLAB funds will support a series of mentorship and capacity building activities towards laboratory accreditation of district labs and municipal laboratories in Shinyanga. These activities will focus on accurate forecasting, planning, and budgeting for laboratory program activitiescommodities and reagents; 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	3,074,083	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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	340,000	0

Narrative:

These funds are proposed for implementation of integrated pediatric HIV care and treatment services the following activities, for implementation in the Shinyanga region: enhanced early identification and diagnosis of HIV exposed for infants and children through scaling up of EID services, PITC in-patient and out-patient settings, such as immunization, OVC, and TB/HIV clinics; family testing at CTC; increased ART treatment enrollment of all HIV infected children <24 months to identify HIV infected children through implementation of updated WHO

treatment guidelines, including treatment of all HIV infected children <24 months; and pre ART review of all children in care to determine eligibility for the new 2012 NACP guideline. These funds will also be used to improve monitoring response and adherence to treatment.; linkages to testing and counseling and other relevant services for relatives and household members of clients. These activities will be achieved through training, on-site mentorship, advocacy, community mobilization, and implementing pediatrics specific quality improvement initiatives. The target is to reach 1,135 new pediatric patients and 1,796 current pediatric patients on treatment.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

MKUTA		

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)

Human Resources for Health	70,000
Motor Vehicles: Purchased	8,000
Renovation	30,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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**
Care	PDCS	500,000	0
Narrative:			

This funding will focus on building the capacity of health workers to provide comprehensive pediatric TB/HIV prevention services, providing care and treatment services through training, and conducting clinical mentorship and attachment. The project will ensure TB and HIV screening to all children attending the Dar es Salaam facility, while referring chidlren identified with TB disease for TB treatment. Children identified with TB disease will be initiated treatment, with the project ensuring that TB treatment is completed for these children.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

Not Applicable		

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	250,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	250,000	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: 14544	**Mechanism Name: TRCS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tanzania Red Cross Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,250,000	
Funding Source	**Funding Amount**

GHP-State	1,250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Tanzania Blood safety program is responsible for safety and adequacy of blood transfusion needs which is at least 10 units of blood for 1000 people a year (WHO recommendation). The current collection of 3.4 units per 1000 people a year is far from meeting the needs. There is need to improve current advocacy, recruitment and retention of eligible blood donors. So, in FY2011 a reputable local Technical Assistant (TA) provider in advocacy, mobilization and Information Education and Communication will be selected through competitive FOA, to provide TA to NBTS to increase safety and supply to acceptable levels in the next 5 years. Grantee for this FOA is expected to start work in October FY12.

The FOA winner will support equitable distribution of safe blood to transfusion services, prevention of transmission of HIV and other transfusion transmissible infections [TTIs]), TA provision in advocacy, mobilization of low risk voluntary repeat non-remunerated blood donors, build mobilization capacity, develop strong partnerships with educational institutions and ministries. Also develop strategies for engaging adult donors, leveraging public-private partnerships with workplace institutions, non-government organizations, and private enterprises to offset declines in donor during school holidays. Assist NBTS develop and distribute compelling IEC materials, hire/purchase vehicles and equipment for operations for own staff or NBTS. Broker public-private partnerships to support NBTS activities. Collaborate with NBTS and partners to organize blood drives, promote linkages to USG HIV programs, ensures proper documentation. Identify income-generating activities, train/mentor staff on best practices in transfusion services and efficent monitor and evaluate progress.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	451,966
Motor Vehicles: Purchased	237,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14544		
Mechanism Name:	TRCS		
Prime Partner Name:	Tanzania Red Cross Society		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	700,000	0

Narrative:

The objective of this intervention is to improve the quality of life for PLHIV by providing integrated and high quality HBC services through trained community volunteers, and forging linkages for relevant support services for PLHIV. TRCS funds will be allocated for activities and initiatives that utilize continuous quality improvement methods to demonstrate a measurable improvement in the community/home based care package and in the systems of linkages and retention.

The partner will conduct joint supportive supervision and mentorship to ensure delivery of a high quality and comprehensive home based care package that will reach targeted vulnerable households including HIV-exposed children and HIV-positive adolescents; increase engagement/participation of highly vulnerable populations through community platforms ; form support groups targeting children of infected parents; support joint efforts to improve retention of patient in enrolled in facility care (CTC, PMTCT and TB/HIV clinics); and support adherence.
The package of HBC services includes but is not limited to: TB assessment; NACS; provision of PHDP package; initiation of PLHIV support groups; and facilitation and support of economic strengthening activities that will increase involvement of PLHIV in project implementation; linkages to testing and counseling and other relevant services for partners, relatives and household members of clients; adherence support for clients on ARVs; and provision of water treatment to PLHIV households. The following are key activities that will be carried out using these funds:
- Training of 128 HBC providers in the care and management of PLHIV, using the national guidelines and curricula, and PEPFAR technical recommendations
- Coordinating logistics for providing working tools centrally supplied by other USG partners (eg, water treatment, ITNs) and job aids for providers. HBC providers will be offered with standard working tools as per national guidelines and SOPs.
- Linkages with clinical services and facilitation of referrals systems between HBC services and District Health

services through the Home based care unit. TRCS will work with CHMTs to identify CTCs to establish bi-directional referral systems and facilitate a linkage system which ensures that a newly diagnosed individual is enrolled into care and treatment. The partner will coordinate with care and treatment, HTC, TB, PMTCT and OVC partners in each of their districts to harmonize and improve the tracking system of patients enrolled in care. The partner will maximize efficiencies to ensure continuum of care.

- Continuous project monitor and supportive supervision of programmatic activities and financial expenditure to ensure effective use of resources. TRCS will record and report on project activities in a timely manner to the CHMT and to CDC as required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	550,000	0

Narrative:

The funding is to provide Techinical Assistance (TA) to the National Blood Transfusion Services (NBTS) for Zanzibar and the mainland, including other blood safety partners implementing blood services. The implementing partner will provide more robust advocacy of eligible safe donors from both first time and repeat donors. They will build the mobilization capacity of NBTS and partners for sustainability. Help NBTS to develop strong lasting relationships with educational institutions, non-governmental institutions and organizations, faith-based organizations to assist with blood donations. The implementing partner will assist NBTS to develop and produce IEC materials for different media that are compelling and appealing for repeat donation, and develop PPP strategies for income genarating plans and activities to suppliment USG and GOT funds. The IP will help to mentor programs for different blood safety cadres so as to develop excellence in relevant fields, and they will procure equipment and vehicles for staff of NBTS in order to assist with monitoring and evaluation of progess. They will support salaries and human resource development.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

Not Applicable		

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	250,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14545
Mechanism Name:	Dartmouth Fogarty AITRP
Prime Partner Name:	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	250,000	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 168,308	
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.)

Key Issues

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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 100,001	
Funding Source	**Funding Amount**
GHP-State	100,001

Sub Partner Name(s)

Not Applicable		

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	18,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
End-of-Program Evaluation
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	100,001	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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 168,310	
Funding Source	**Funding Amount**
GHP-State	168,310

Sub Partner Name(s)

Not Applicable		

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	40,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 168,310	
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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	31,654

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
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: No

Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1	
Funding Source	**Funding Amount**
GHP-State	1

Sub Partner Name(s)

None		

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.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

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	1	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	**Mechanism Name: Diffusion of Effective Behavioral Interventions**
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHP-State	300,000

Sub Partner Name(s)

N/A		

Overview Narrative

This new mechanism is designed for one to two indigenous Tanzanian partner agencies to become involved in the

roll-out of effective behavioral interventions in Tanzania. The goal will be to increase involvement of a local partner(s) in science-based, community, group, and individual-level HIV prevention interventions. In line with the Government of Tanzania and USG Partnership Framework Implementation Plan (PFIP), applications selected will contribute to increased access to prioritized and evidence-based HIV prevention interventions. Selection criteria will include increasing knowledge of HIV status among people living with HIV and their partners; reducing risk of HIV transmission from PLHIV; and reducing HIV acquisition among persons at risk for infection, as stipulated in the recently released new PEPFAR Prevention Guidance.

Priority will be given to interventions or programs that have already been tested and adapted for implementation in Tanzania and/or in the East Africa region. Special attention will be paid to the gender focus promoted under the Global Health Initiative strategy. Examples of interventions include programs targeting and serving HIV-infected women; interventions aimed at increased couples communication, disclosure, and support for discordant couples; and conditional cash transfer targeting girls and young women. Review criteria for applications will also include effectiveness in increasing referrals to biomedical interventions and linkages into care and treatment for proposed interventions targeting PLHIV. A competitive funding opportunity announcement for local indigenous organizations is currently being drafted. An outcome evaluation will be built into this mechanism.

Cross-Cutting Budget Attribution(s)

Gender: GBV	30,000
Gender: Gender Equality	15,000
Human Resources for Health	10,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Mobile Population
TB

Family Planning

Budget Code Information

Mechanism ID:	14556		
Mechanism Name:	Diffusion of Effective Behavioral Interventions		
Prime Partner Name:	Tanzania Youth Alliance		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	300,000	0

Narrative:

This new mechanism is designed for one to two indigenous Tanzanian partner agencies to become involved in the roll-out of effective behavioral interventions in Tanzania. The goal will be to increase involvement of a local partner(s) in science-based, community, group, and individual-level HIV prevention interventions. In line with the Government of Tanzania and USG Partnership Framework Implementation Plan (PFIP), applications selected will contribute to increased access to prioritized and evidence-based HIV prevention interventions. Selection criteria will include increasing knowledge of HIV status among people living with HIV and their partners; promotion of effective preventive services and products such as condoms and VMMC, and risk reduction conselling to PLHIV

Priority will be given to interventions or programs that have already been tested and adapted for implementation in Tanzania and/or in the East Africa region. The main focus of HVOP activities will be towards working with PLHIV and their partners. Examples of interventions include programs targeting and serving HIV-infected women such as WILLOW; interventions aimed at increased couples communication such as EBAN and disclosure; and support for discordant couples; . Review criteria for applications will also include effectiveness in increasing referrals to biomedical interventions and linkages into care and treatment for proposed interventions targeting PLHIV. A competitive funding opportunity announcement for local indigenous organizations is currently being drafted. The selection process is expected to be completed by August 2012. To assess the effectiveness of the selected intervention(s), outcome evaluations will be built into this mechanism.

$150,000 of the HVOP intervention budget will be used on outreach activities relying on peer educators to reach 5,000 people in higher risk groups with condom promotion messages.

Implementing Mechanism Details

Mechanism ID: 14559	**Mechanism Name: NHLQATC - EQA Support**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Management development for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

None		

Overview Narrative

The goal is to provide an efficient, timely and sustainable External Quality Assessment (EQA) for all HIV standard of care tests.

The main purpose is to support the National Health Laboratory Quality Assurance and Training Center (NHLQATC) to distribute, analyze and provide feedback of EQA materials to all health laboratories involved in HIV, TB, malaria and Opportunistic Infections (OIs) testing nationwide in order to assure the quality of testing services. This support will ensure that NHLQATC focuses on overall coordination, production of EQA materials and supportive supervision to participating facilities.

The grantee will also pilot the establishment of an efficient sample referral system utilizing the established EQA system in selected regions.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)

TB

Budget Code Information

Mechanism ID:	14559		
Mechanism Name:	NHLQATC - EQA Support		
Prime Partner Name:	Management development for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	250,000	0

Narrative:

Establish efficient External Quality Assessment (EQA) materials, analysis and feedback reports:

The grantee will provide technical, logistical and administrative support to the National Health Laboratory Quality Assurance and Training Center (NHLQATC). They will collect EQA panels from NHLQATC and distribute it to all participating laboratories. They will analyze the facility results and provide performance reports to NHLQATC for approval before mailing them back to participating facilities. They will also provide user training on all EQA tools, maintain an updated list of all participating facilities, and submit quarterly, semi-annual and annual reports to NHLQATC and CDC.

Establish and pilot sample referral and results feedback system:

From the experience gained in distribution of EQA materials, the grantee will develop and implement an efficient sample referral and results feedback system within the national laboratory network. Samples from the lower levels in the network that need referrals will be shipped to the reference laboratory in appropriate conditions and in a safe and timely manner (within the national turn-around-times (TATs)). Sample results from reference laboratory

will be transported back to the original facilities in a timely manner (within the nationally set TATs). Evaluation reports on the impact of the system on patient management will be conducted and reports will be submitted to the Ministry of Health and Social Welfare (MOHSW) and CDC.

Implementing Mechanism Details

Mechanism ID: 14560	**Mechanism Name: ASLM**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Society for Laboratory Medicine	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

High quality laboratory services is an essential component of a functioning healthcare system and a foundation for comprehensive HIV and AIDS interventions.

In 2010, the Tanzania Ministry of Health and Social Welfare developed the HIV/AIDS Research and Evaluation Agenda, which provides the research and evaluation priorities for 2010-2015. The Agenda identifies the current HIV and AIDS knowledge gaps and replaces the HIV/AIDS/STIs Research Priorities of the Health Sector HIV Strategic Plan I 2004-2008.

The goal of this mechanism is to guide the adoption of evidence-based best practices, provide practical policy recommendations and answer key operational questions about laboratory service delivery in Tanzania. It aims to evaluate identified information gaps within the laboratory system and share the findings with relevant authorities

for evidence-based decision making.

To be cost effective, most of the activities will be implemented alongside the program implementation and progressively build indigenously through training and mentorship.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14560**		
Mechanism Name:	**ASLM**		
Prime Partner Name:	**African Society for Laboratory Medicine**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	100,000	0
Narrative:			
The following four information gaps have been identified: *1) What is the validity of point-of-care CD4 testing in clinical setting?* *2) How reliable are the laboratory consumption data?* *3) How effective is centralized laboratory in-service training on staff performance at point of care?* *4) What is the quality of HIV rapid testing by non-laboratory healthcare workers in Tanzania.*			

Evaluation of information gap 1 and 2 is ongoing utilizing FY11 funds. *For information gaps 3 and 4, protocols are currently under development and it is expected that the clearance process will be completed by June 2012. The implementing mechanism will be identified in July 2012 and evaluation initiated in October 2012.*

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: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 14,605,916	
Funding Source	**Funding Amount**
GHP-State	14,605,916

Sub Partner Name(s)

Harvard University School of Public Health	Ilala Municipal Council	Kinondoni Municipal Council
Muhimbili University for Health and Allied Sciences		

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)

Food and Nutrition: Commodities	280,000
Food and Nutrition: Policy, Tools, and Service Delivery	20,000
Gender: GBV	250,000
Human Resources for Health	2,050,000
Key Populations: FSW	100,000
Key Populations: MSM and TG	100,000
Motor Vehicles: Purchased	120,000
Renovation	630,000
Water	50,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
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	130,000	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	280,000	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	275,721	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	90,000	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	1,482,770	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	11,294,539	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	1,052,886	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: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 3,969,999	
Funding Source	**Funding Amount**
GHP-State	3,969,999

Sub Partner Name(s)

Not Applicable		

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.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	449,629
Motor Vehicles: Purchased	75,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Workplace Programs
End-of-Program Evaluation
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	350,000	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	350,000	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	470,000	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	100,000	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	HVCT	400,000	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	200,000	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	1,500,000	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	299,999	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	300,000	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	**Mechanism Name: AMREF 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: African Medical and Research Foundation, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHP-State	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this funding is to progressively build an indigenous, sustainable response to the national HIV epidemic in Tanzania through training medical personnel to provide quality HIV/AIDS laboratory services. The focus group will include local laboratory specialists, scientists, technologists and technicians who perform essential HIV-screening and confirmatory tests, CD4 tests for disease staging, and basic chemistry and hematology tests to monitor therapy. It will also include non-laboratory staff involved in confidential HIV Counseling and Testing (HCT), the prevention of mother-to-child HIV transmission (PMTCT), the treatment of Tuberculosis and HIV (TB/HIV) co-infection and rapid HIV testing and screening for blood safety programs.

The aim is to reach everyone doing HIV rapid test (HRT) of which non laboratory healthcare workers are estimated

to be over 17,980 and distributed to about 5,600 testing sites; all laboratorians involved in HRT and standard of care tests in 23 regional and 130 district laboratories. In order to ensure quality of results, in addition to trainings, competency assessment will be done on all non Health Care Workers (HCWs). The training of laboratorians will compliment an accreditation process in earmarked laboratories and training participants will be drawn from both Tanzania mainland and Zanzibar testing facilities.

To ensure sustainability, the grantee will build the capacity of the Council Health Management Teams (CHMTs), Regional Health Management Teams (RHMTs), and local implementing partners on program supervision through joint supportive supervision visits and trainings. The program will be monitored through written quarterly, semi-annual and annual reports.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14653**
Mechanism Name:	**AMREF Follow On**
Prime Partner Name:	**African Medical and Research Foundation, Tanzania**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	300,000	0
Narrative:			

The goal is to strengthen the laboratory capacity in HIV identification and provision of HIV standard of care tests. It has three objectives: 1) to train laboratorian and non-laboratorian healthcare workers on HIV rapid testing (HRT) and standard of care tests to ensure that they perform the tests accurately; 2) provide competency assessment to non laboratorian healthcare workers performing HIV rapid testing to assure the quality of testing; and 3) to support supervision of testing facilities to ensure that knowledge gained during training is being put into practice correctly.

Although to date about 17,980 healthcare staff have been trained on HRT, the evaluation of the HIV testing algorithm planned for FY11 and the fact that WHO is no longer advocating for use of a tie-breaker in the algorithm may result in changing the current testing algorithm which uses a tie-breaker. This mechanism will support training of 10,000 laboratorian and non-laboratorian healthcare workers on the new algorithm.

Lack of a reliable CD4 point-of-care tests and an inefficient sample referral system, especially in remote areas, are among the challenges facing the expansion of HIV/AIDS prevention, care and treatment services in Tanzania. Currently, a point of care device for CD4 testing is being evaluated and if the results are favorable the device will be registered for use in the country. These funds will support training of additional laboratorian and non laboratorian healthcare workers on the use of the new device during rollout nationwide.

In Partnership Framework Goal 1, both the United States and the United Republic of Tanzania governments advocate for quality lab services, which is a major component in ensuring that quality care and treatment is provided to all Tanzanians accessing services in both public and private health facilities. Since non-laboratorian healthcare workers are doing laboratory work, which is not their primary task, this fund will support competency assessment of non-laboratorian testers and pass the database to the Health Laboratory Practitioner Council (HLPC) for licensing according to law (HLPC Act 2007).

The grantee will work closely with the Council Health Management Teams (CHMTs), Regional Health Management Teams (RHMTs), and local implementing partners in monitoring and evaluating the quality of laboratory services in the districts, regions, and at the national-level. The funds will support joint supportive supervision visits and training of CHMTs and RHMTs on management skills.

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 9,669,893	
Funding Source	**Funding Amount**
GHP-State	9,669,893

Sub Partner Name(s)

Bagamoyo District Council	BUKOMBE DISTRICT COUNCIL	GEITA DISTRICT COUNCIL
HAI DISTRICT COUNCIL	Igunga District Council	Kahama District Council
Kibaha District Council	Kilimanjaro Christian Medical Centre	KILWA DISTRICT COUNCIL
Kisarawe District Council	Lindi District council	Lindi Municipal Council
LIWALE DISTRICT COUNCIL	LONGIDO DISTRICT COUNCIL	Mafia District Council
Masasi District Council	Maswa District Council	MEATU DISTRICT COUNCIL
MERU DISTRICT COUNCIL	Mkuranga District Council	MONDULI DISTRICT COUNCIL
MWANGA DISTRICT COUNCIL	NACHINGWEA DISTRICT COUNCIL	Nanyumbu District council
Newala District Council	NGORONGORO DISTRICT COUNCIL	Nyamagana District Council
Nzega District Council	ROMBO DISTRICT COUNCIL	RUANGWA DISTRICT COUNCIL
Rufiji District Council	SAME DISTRICT COUNCIL	Shinyanga District Council
SIHA DISTRICT COUNCIL	SIKONGE DISTRICT COUNCIL	TABORA MUNICIPAL COUNCIL
Tandahimba District Council	Urambo District Council	Uyui District Council

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)

Economic Strengthening	65,725
Food and Nutrition: Policy, Tools, and Service Delivery	65,725
Gender: GBV	32,862
Human Resources for Health	1,394,625
Motor Vehicles: Purchased	228,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Safe Motherhood
Family Planning

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	2,100,000	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	7,569,893	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: 14685	**Mechanism Name: FANTA III**
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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 650,000	
Funding Source	**Funding Amount**
GHP-State	650,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The TBD will work through district councils and community structures to promote nutrition to address the needs of PLHIV, prioritizing HIV positive women and children. Objectives of the TBD will be to integrate nutrition assessment, counseling and support (NACS) with the PMTCT acceleration; strengthen be-way referrals and linkages between facility and community programs; strengthen the M&E component for nutrition assessment; and document the activity costs and achievements of the program.

The activity will contribute to the first goal of the PF which relates to service maintenance and scale-up. In addition, the TBD also addresses the GHI strategy objective of increasing access to quality comprehensive services for women and children.

Priority interventions include building the capacity of selected district councils to provide essential nutrition services; bringing NACS tools into application to standardize nutrition information provided to mothers; intensifying community case finding and management, referrals, and linkages; and improving household resilience through strategic wraparound activities with economic strengthening and food security initiatives.

This activity will also demonstrate the importance of positive deviant heart approach on behavioral changes, where vulnerable households learn from other households that are doing well within similar contexts.

The TBD prime partner will be a local partner while an international TA partner will be the sub-partner providing TA on key USAID grants and management regulations. Outcome indicators will be tracked at the project level. The data will be consolidated to contribute towards national targets.

One vehicle will be purhased to suppport daily logistics for a TBD prime local partner.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	650,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID:	14685		
Mechanism Name:	FANTA III		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	0

Narrative:

The TBD funds will be used to engage a local TA mechanism for provision of the nutritional assessment counseling and services (NACS) in community settings. The TBD will work with HBC, OVC, and PMTCT implementing partners to develop messages and interventions addressing NACS, including linkages with the PMTCT/NACS integration plan.

Activities for the TBD will include:
(1) Providing TA to URT and selected district councils on NACS/PMTCT integration, including planning, supervision, monitoring, and evaluations;
(2) Supporting the review of NACS tools and guidelines, printings, and dissemination of materials;
(3) Facilitating national dialogues and consultations on nutrition and HIV/AIDS, including infant and young children feeding;
(4) Providing TA to USG/T implementing partners on nutrition and HIV/AIDS;
(5) Ensuring quality improvement and standards, including tracking and reporting of key nutritional indicators;
(6) Monitoring the availability of key nutrition supplies and providing advice to the respective institutions and bodies, such as to the medical store departments to reduce stock outs of essential nutrition commodities; and
(7) Promoting and leveraging agriculture investments for nutrition through coordinating and collaborating with other initiatives, such as Feed the Future initiative to benefit more PLHIV and OVCs with food security and income growth.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	450,000	0

Narrative:

$150,000 - The TBD will work at the national level to support the URT. These funds will be used to demonstrate and scale best practices in community nutrition that will benefit orphans and vulnerable children through community structures. This will include bringing the NACS tools into universal application at the community levels. Also, the best practices from within the region and surrounding areas could be replicated and evaluated to

meet the needs of MVCs. The funds will be used to implement innovative, cost-efficient approaches to screen and support referrals for sick and malnourished children. By developing peer-to-peer relationships using the positive deviant heart approach, knowledge and skills will be transferred to child-headed households and other vulnerable households.

Para-social workers will be trained as part of strengthening the social services system to recognize the signs of malnutrition, such as severe wasting, oedema, dehydration, and micronutrient deficiency. Coordination with community health workers will be key to providing basic health services at community levels, as well as making and managing referrals.

This activity will build on the wealth of potential indigenous knowledge, skills, and resources that communities utilize as a line of response to build resilience and reduce their vulnerability. This may include promoting foster parenting and mentoring for MVCs, community early childhood development and psychosocial stimulation, which could be fostered through integrating the development of playgrounds with outreach growth monitoring.

$300,000 - Funds for this particular TBD will support the screening of OVCs as well as linking them to pediatric care from the community level to facilities. Implementation of community-level BCC on caring for HIV infected children will be a main activity, along with collaborating with PACT to pilot the GBV one-stop center.

These funds will be used to:

(1) Intensify undernourished case findings at the community level and improve linkages and referrals to the appropriate facilities and community programs;

(2) Promote positive behavioral changes through a positive deviant heart approach (facilitating households or group visits to learn best practices from each other);

(3) Implement community food-based approaches to rehabilitate moderate malnourished children by using local food resources and promoting food-based value chain interventions at the community level for stabilizing vulnerable household consumption;

(4) Procure anthropometric tools and equipment, such as MUAC tapes and print essential simplified NACS tools for usage by parasocial workers and other lay counselors and volunteers at the community level; and

(5) Map community initiatives that respond to the food and income needs of MVCs and older caregivers,

promoting BCC at the community level to care for vulnerable families (using a foster parenting approach).

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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,595,709	
Funding Source	**Funding Amount**
GHP-State	3,595,709

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)

Economic Strengthening	22,812
Education	142,190
Food and Nutrition: Commodities	39,461
Human Resources for Health	33,376
Motor Vehicles: Purchased	51,298

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
TB

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	400,000	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	648,209	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	100,000	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	340,000	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	1,762,500	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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,979,908	
Funding Source	**Funding Amount**
GHP-State	1,979,908

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)

Economic Strengthening	13,400
Food and Nutrition: Commodities	117,000
Gender: Gender Equality	8,500
Human Resources for Health	920,000
Renovation	24,200

TBD Details

(No data provided.)

Key Issues

(No data provided.)

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	400,000	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	247,245	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	HVTB	100,000	0

Narrative:

Selian's implementation of TB activities is consistent and fits into the country wide strategy for responding to TB. This includes the following activities supporting with COP 2013 funding:
- Strengthen TB screening and case detection by implementing Intensified Case Finding (ICF) at CTCs, among pregnant women, OVC, pediatrics, uniformed forces and in congregate settings.
- Identify TB suspects, including rapid action to conduct diagnostic evaluation of suspects and to treat the disease.
- Provide Isoniazid Preventive Therapy (IPT) for individuals who screen negative for TB symptoms.
- Implement infection control measures to prevent TB transmission in both TB and CTC settings.
- Integrate Positive Health, Dignity and Prevention (PHDP) into TB clinical settings.
- Provide HIV comprehensive care and treatment services (including ART initiation) for TB/HIV co-infected patients.
- Scale up provision of HIV services in TB clinics through increasing the number of TB clinics with one stop TBHIV services and/or renovation of TB clinics to allow provision of comprehensive care and treatment services. Support scale up of pediatric TBHIV services.

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	100,000	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	260,000	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 REIief 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	787,663	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: 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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
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.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	50,000
Food and Nutrition: Policy, Tools, and Service Delivery	150,000

TBD Details

(No data provided.)

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: 15063	**Mechanism Name: CME**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Chamber of Minerals & Energy	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Africare		

Overview Narrative

Not Provided

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	15063		
Mechanism Name:	CME		
Prime Partner Name:	Chamber of Minerals & Energy		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

The response to the HIV/AIDS epidemic originally was considered to be the primary responsibility of the Government of Tanzania (GOT), but eventually it was recognized by both the GOT and the business community that the private sector needed to dedicate more of its expertise and resources to complement the work of the public sector and other civil society organizations.

In this activity the Chamber of Minerals and Energy will reach out in COP 2010 to artisanal and small-scale mining (ASM) community, which is one of the most marginalized and isolated of MARP groups. An onsite clinic will be constructed or renovated and equipped by the CME with financial support from the mining company nearest to the ASM camp, and the district is to provide medical staff. Bridge2Aid (B2A), a charity providing dental care in Tanzania, has a mobile unit that it will loan to the project. The organization has granted permission to refit the unit as needed for the project at Chamber expense. Thus both facility-based and mobile clinic health care will be provided to ASM families. The mining company will make available its medical staff and facilities as needed and will partner with NGOs to help in conducting a comprehensive outreach program in prevention, testing/counseling, care/treatment and home-based care.

Implementing Mechanism Details

Mechanism ID: 16397	**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: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 21,801,837	
Funding Source	**Funding Amount**
GHP-State	21,801,837

Sub Partner Name(s)

AFNET	Afya Women Group	Allamano Centre
Berega Mission Hospital	Chamwino District Council	Christian Social Services Commission
Consolata Hospital Ikonda	Dodoma Municipal Council	Dodoma Regional Hospital
Faraja	Iambi Lutheran Hospital	Iramba District Council
Iringa District Council	IRINGA MUNICIPAL COUNCIL	Iringa Regional Hospital
Kilolo District council	Kilombero District Council	Kilosa District Council
Kondoa District Council	Kongwa District Council	Ludewa District Council
Lugala Lutheran Hospital	Lugoda Tea Estates Hospital	Makete District council
Makiungu Hospital	Manyoni District Council	Mirembe Referral Hospital
Morogoro District Council	Mpwapwa District Council	Mtibwa Sugar Estates Hospital
Mufindi District Council	Mvomero District Council	NJOMBE DISTRICT COUNCIL
Shalom Medical Centre	Singida District Council	Singida Municipal Council
Singida Regional Hospital	St. Carolus Hospital	St. Gemma Health Centre
St. Kizito Mikumi Hospital	Tanwat Hospital	Tosamaganga DDH
Turiani mission Hospital	Ulanga District Council	Usokami Health Centre
Village of Hope		

Overview Narrative

Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II

Cross-Cutting Budget Attribution(s)

Gender: GBV	36,161
Gender: Gender Equality	144,636
Human Resources for Health	1,874,723
Motor Vehicles: Purchased	212,500
Renovation	1,071,270

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16397**
Mechanism Name:	**Tunajali II**
Prime Partner Name:	**Deloitte Consulting Limited**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	2,250,000	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	450,000	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	228,000	0

Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	300,000	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	4,233,426	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	13,303,411	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	PDTX	1,037,000	0
Narrative:			
Moved from Deloitte Fac based and Community Services IMs to Deloitte's new mechanism Tunajali II			

Implementing Mechanism Details

Mechanism ID: 16497	**Mechanism Name: ESIS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: ICF Macro	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	

G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

N/A		

Overview Narrative

New ESIS TBD to be awarded Fall 2012 to conduct implementation science evaluations.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16497**		
Mechanism Name:	**ESIS**		
Prime Partner Name:	**ICF Macro**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	0	0

Narrative:
$220,000 - Funds to be used to strengthen the PMTCT costing element of the Costing Study task-order. $170,000 - These funds will be used to fund part of the PMTCT impact assessment which replaces the HOPE activity. The funds are being moved to the ESIS mechanism (CDC contract) to competitively select an implementing partner for the impact evaluation. TBD partner will be identified by Fall 2012

Implementing Mechanism Details

Mechanism ID: 16569	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16763	**Mechanism Name: HJFMRI**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Henry Jackson Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 19,657,101	
Funding Source	**Funding Amount**
GHP-State	19,657,101

Sub Partner Name(s)

HEALTH DEVELOPMENT FOUNDATION (HEDEFO)	RUVUMA ORPHANS ASSOCIATION (ROA)	Serve Tanzania (SETA)
THE LIFE HOOD CHILDREN AND DEVELOPMENT SOCIETY (LICHIDE)	USEVYA DEVELOPMENT SOCIETY (UDESO)	

Overview Narrative

HJF and its local body, HJFMRI, have worked in Tanzania and East Africa since 1998. It supports local

organizations with technical expertise in clinical, lab and M&E and has extensive experience in conducting scientifically rigorous studies to monitor and improve the quality and efficiency of services. In Tanzania, it supports the Mbeya Referral Hospital (MRH) and Regional Medical Offices (RMOs) in four regions to implement comprehensive HIV services: Mbeya, Ruvuma, Rukwa, and Katavi; with an HIV prevalence between 4.5-7.9% and a total population of 6 million. Advanced lab and clinical services are supported through MRH and facility-based services at regional hospitals and district CTCs through the RMOs. HJFMRI focuses on developing capacity of Regional Health (RHMT) and Council Health (CHMTs) management teams responsible for execution of HIV/AIDS M&E plans and to incorporate HIV interventions into their routine plans and budgets.

HJFMRI also supports local community organizations to improve technical competency of service delivery and administrative management. This ensures quality services for clients at all levels and points of care within the regions. To address the needs of key populations and PLHAs, scale-up of care/treatment services, and build capacity of indigenous organizations, fostering local ownership, HJFMRI will continue to support an integrated service platform tying in with the USG/T GHI Strategy.

Regions will be supported to improve quality and efficiency and decentralize services through supportive supervision, on-job mentorship, CQI, and strategic in-service trainings. Routine data collection and monitoring will be undertaken using standardized national tools.

Two vehicles will be purchase under COP 2013 - see vehicle justification narrative.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	202,547
Food and Nutrition: Commodities	303,703
Food and Nutrition: Policy, Tools, and Service Delivery	100,000
Gender: GBV	525,000
Gender: Gender Equality	175,000
Human Resources for Health	1,741,026
Motor Vehicles: Purchased	172,400
Renovation	867,089
Water	120,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
TB
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16763**
Mechanism Name:	**HJFMRI**
Prime Partner Name:	**Henry Jackson Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	2,000,000	0

Narrative:

HJFMRI will ensure a two-way continuum of care between the community and facility. Outreach partners will be responsible for the provision of HBC services, offering referrals to an appropriate facility for clinical services and ensuring that care services reach underserved communities. Static facilities will refer clients to community service providers for social and psychosocial support and basic follow up. HJFMRI, in collaboration with its medical and outreach implementing partners, will strengthen linkages and integration within and outside health facilities and the community. Emphasis will be put on client retention and tracing LTFU in order to increase the number of eligible clients in care and treatment services. The FY2013 COP 2013 targets reaching a total of 49,682 clients with adult care and support services.

HJFRMI will contribute to program sustainability by building capacity of partner institutions and health care providers, as well as promoting community involvement.

The FY2013 COP plans the following activities:

1. Provide integrated adult care clinical services (CTX, STI management, management of diarrhea and pain), linking these clients/services to other services such as FP, CCS, ANC, PNC, and TB/HIV.
2. Use Community Home Based Care (CHBC) providers to trace clients LTFU and link them back to CTC.
3. Strengthen nutritional assessment, counseling and support (NACS) at CTCs and HBC.
4. Ensure availability of care-related diagnostics, mediations, commodities and supplies, including insecticide-treated nets and safe water treatment materials.
5. Support economic strengthening activities to PLHIV through small scale IGAs and facilitate formation of income-generating projects.
6. Strengthen community mobilization activities through individual, small groups and community sensitization to improve local efforts that address GBV, stigma and discrimination and home-based VCT.
7. Strengthen adult care and support services through strategic in-service training, supportive supervision and on-the-job mentorship of CHBC providers in collaboration with local government officials such as District HBC Coordinators.
8. Provide psychological, spiritual support as well as bereavement services to PLHIV and their families, and link PLHIVs with available support mechanisms including PHDP services.
9. Provide prevention services such as partner/couple HTC, condom provision, risk reduction counseling and adherence counseling.
10. Strengthen the capacity of health workers to respond to GBV cases using the GBV and Violence Against Children (VAC) national guideline, trauma and psychosocial counseling, training on proper collection and management of specimens for forensic evidence including post rape care, and management of physical and psychological trauma/injuries.
11. Strengthen M&E systems at the national and district level to capture information on provision of GBV services, including PEP within health facilities.
12. Improve M&E framework by harmonizing data collection tools, data recording and reporting and facilitate the roll out of HBC recording and reporting system, PHDP and new HBC guideline
13. Facilitate HBC stakeholder meetings to discuss program data and share results, experiences/challenges for program improvement and promote ownership and sustainability of services in the four regions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	585,000	0

Narrative:

As of the FY 2012 APR, facilities in the regions of the Southern Highlands supported by HJFMRI screened 93,307 patients for TB, 94% of the target, of which 3,061 were started on TB treatment. In the FY2013 COP, HJFMRI will expand service delivery points and strengthen intensification of case finding, referrals and the practice of proper infection control. TB/HIV activities will be implemented in close collaboration with regional medical partners (Mbeya Referral Hospital (MRH) and Mbeya, Rukwa, Ruvuma and Katavi RMOs) and community groups. The improvement of TB diagnostics and services will continue to be executed with the NTLP, ensuring all activities are aligned with national priorities and policies. The involvement of PLHIV, TB patients and communities in planning and implementation will be critical to success. HJFMRI also continues to participate as a member of the PEPFAR/T treatment partners' group to share in lessons learned and address PEPFAR/T requirements for improving services in TB/HIV management and data quality.

A formal TB cohort review was conducted in 2013 at MRH, showing that introduction of the Gene Xpert MTB/RIF was associated with increased case detection of pulmonary TB, with a greater effect seen in HIV co-infected patients. It was also associated with a reduction in time to TB treatment of about two days. Analysis found that only about 35% of TB/HIV co-infected patients in the TB clinic were on ART. Implementation of a “One Stop Shop” for TB and ART services in Tanzania shows improvement in increasing the number of PLHIV receiving TB and ART treatment. The Songea Regional Hospital and a few sites in Tukuyu integrated ART into TB clinics recently. In the next year, all TB clinics at the MRH and the regional and district hospitals will be integrated with ART services using this model. Similar cohort reviews are planned for the regions to understand the impact of interventions.

Planned activities for the FY2013 COP include:

1. Scale-up TB/HIV Services at regional health facilities, improve screening, referral and integration of TB/HIV services into ART, HTC, PHDP and PMTCT and strengthen the linkages between RCH and CTC to improve pediatric uptake.
2. Expand quality TB/HIV services with TA to districts through in-service training, and on-the-job mentorship to HCWs on TB control practices and scale up of the three “I”s, identifying high prevalence/high volume sites in collaboration with RMOs and NTLP for strategic targeting of resources and increasing of trained and qualified staff.
3. Strengthen community-based referrals of TB suspects identified by HBC providers, incorporating TB identification as part of VCT and patient management through HBC.
4. Expand/improve TB lab diagnostics and QA, including fluorescent LED microscopy and placement of new Gene Xpert machines in strategic labs throughout the regions, with TA from the MRH advanced TB diagnostics lab.

5. Expand mobile TB diagnostic and treatment services to hard-to-reach and under-capacitated areas, extending the reach of the successful Mobile Diagnostic and Training Centre.
6. Improve the TB component of M&E system at 150 care and treatment health facilities by increasing the availability and use of national TB screening tools, and provide TA on the proper collection, management, analysis and use of data using these tools, as well as on the execution of routine data audits and chart reviews to improve overall data quality and patient managem

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	232,000	0

Narrative:

HJFMRI supports local referral to dispensary level health facilities in the implementation of clinical care services for HIV- infected children and their families in Mbeya, Ruvuma, Rukwa and Katavi. Pediatric HIV activities are implemented in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI) and will leverage MOHSW's basket funding and cost sharing mechanisms. HJFMRI will continue to support HCW participation in the Baylor pediatric HIV clinical attachment program, providing clinical mentoring and TA on the treatment of pediatric HIV/AIDS. FY2013 COP funding will expand the number of pediatric service delivery points from the current 149 facilities to provide care to 165,068 children.

HJFMRI has planned the following activities for the FY2013 COP:

1. Expand PCR testing for EID to all PMTCT sites and quick enrolment of HIV+ infants, focusing on instituting fast track protocols to work with families and caregivers. PMTCT, HCT and community groups will work collaboratively to improve access to testing for children at all points.
2. Expand pediatric services in PMTCT and adult programs. Sites will be modified to provide family friendly/centered services and improved referrals between programs.
3. Facilitate regular meetings between HCWs at PMTCT, pediatric and adult out-patient clinics. Specially trained staff in each clinic and in the community will facilitate referrals for children and caregivers, ensuring that community based services are received to improve follow up and management of women and children. Where possible, mother/child pairs will be escorted to health care facilities and/or community based services improving outreach to families and decreasing LTFU.
4. Strengthen and expand nutrition assessments and counseling, including additional training for caregivers in the principles of good nutrition, with an emphasis on better implementation of routine growth monitoring.
5. Develop counseling messages, capacity building and training to discourage high risk infant feeding practices (e.g. mixed feeding, unhygienic preparation/storage of food), directed at service providers, PMTCT programs, out-patient clinics, as well as PLHIV support groups and HBC networks.

6. Strengthen mechanisms for referral of GBV & Violence Against Children (VAC) survivors to respective services (e.g. community NGOs, legal, social welfare, police, safe homes, etc.) using the GBV & VAC national guideline.
7. Hold quarterly Zonal Pediatric meetings in collaboration with Baylor to exchange updates on clinical care issues, provide consultation on difficult cases, coordinate pediatric care activities in the zone, and identify and strengthen linkages.
8. Support trainings and distribution of job aids for nutritional support.
9. Improve the capacity of caregivers on pediatric treatment adherence and developmentally appropriate psychosocial support.
10. Establish a system of treatment supporters who will play a key role in linkages between different clinics and treatment services. and between facilities and communities.
11. Strengthen QA/CQI and mentoring, to ensure the HIV+ children are provided with basic health care and support (e.g. OI prophylaxis and treatment of OI's, screening for TB and related lab services, management of HIV complications and emotional support). All sites will receive regular onsite supportive supervision, QA, and TA visits from joint HJFMRI/Baylor teams, with an emphasis on CQI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	600,000	0

Narrative:

HJFMRI supports facility-level provision of accessible quality laboratory services required for HIV diagnosis, care and treatment, through a tiered structure with a bottom-to-top referral network. Through a comprehensive approach, the HJFMRI supports the expansion and improvement of laboratory capacity at Mbeya MRH, Regional Hospitals, CTCs, and the majority of PMTCT sites and TB clinics.

The FY 2013 COP activities include:

1) Availability of quality laboratory services required for scale-up of ART services: By September 2012, three supported regions reported a total of 140 facilities with lab capacity, 40 in Rukwa, 60 in Ruvuma and 40 in Mbeya. Due to interrupted national support services in this period, HJFMRI plans to fund processes allowing for equipment service and replacement and to strengthen procurement of reagents and supplies to ensure continuous service at sites. To guarantee quality, all lab personnel will be trained on QA processes that include supply planning, budgeting and forecasting, and GCLP. HJFMRI will also expand the reach of the successful Mobile Diagnostic and Training Centre (MDTC), which provides HIV and TB testing along with other OI diagnostics to more remote and under capacitated communities.

2) Access to EID: HJFMRI has been supporting the EID program in partnership with the URT-MOHSW and other partners. To improve access to this service to cover at least 80% of all PMTCT sites in the regions served, HJFMRI plans to install new instrumentation improving capacity and reducing test costs at the zonal EID lab. An improved electronic results feedback mechanism using SMS printers and courier delivery of hard copies is planned.
3) Diagnostic capacity for TB among PLHIV: To reduce mortality due to HIV-related TB, HJFMRI plans to continue support for improved diagnostic services. In the past year, integration of TB/HIV services has proven a successful strategy in effective delivery of services and utilization of resources. Plans to support the availability of LED smear microscopy and Gene Xpert MTB/RIF at high volume CTC sites, which will increase early case detection of TB and can reduce mortality in TB/HIV co-morbidity.

4) Quality Assurance and Accreditation: Provision of timely accurate and consistent laboratory services is a major priority for the HJFMRI Laboratory Program. It will support the implementation of laboratory Quality Management Systems (QMS). Under this effort, the MRH lab is enrolled in an international accreditation process under ISO 15189 while three regional labs and five district labs are enrolled in WHO/SLMTA accreditation process. HJFMRI will continue supporting QMS at these labs through training and mentorships.

5) Transition and Sustainability: the HJFMRI lab program will execute skills transition and promote sustainability through provision of technical and financial support to RMOs. HJFMRI regional lab managers will provide training mentorship and support to MOHSW facilities to increase and strengthen the capacity to deliver sustainable quality lab services for HIV/AIDS care and treatment. Through QMS and particularly SLMTA, HJFMRI will use these processes to set goals which empower facilities as they work toward accreditation. HJFMRI will continue to train/mentor staff and collaborate with partners for transition of skills to the facilities, ensuring quality lab results and improvement of clinical health services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	115,000	0

Narrative:

Data quality and data use continue to be challenges, and are often results of poor data management systems. Quality data are essential to adequately measure client/patient-level outcomes and improve the quality of services provided. In addition, the analysis and use of routinely collected information to inform service improvement are not established processes among many of the indigenous organizations supported. HJFMRI will work with local community and facility based partners though similar though distinct approaches to improve data quality, management systems and data utilization.

Activities planned for the FY2013 COP include:

1. Provide TA to 150 care and treatment health facilities and 665 PMTCT health facilities on the collection, management, analysis and use of clinical and programmatic data in the areas of PMTCT, TB, HIV care and treatment, pharmacy, and laboratory services.
2. Strengthen utilization at existing facilities of the CTC2 electronic medical record established by the MOHSW, and install the CTC2 database at 90 new health centers.
3. Improve clinical staff capacity on CTC2 reporting, including paper-based and electronic-based systems, and use of pharmacy modules to improve service delivery through accurate forecasts of pharmacy and laboratory supplies.
4. Provide TA on conducting routine data audits and chart reviews to improve overall data quality and patient management. CHMTs and RHMTs will be trained to analyze CTC2 reports that will improve the basic quality of care and patient retention.
5. Establish patient cohorts at facilities to train staff on monitoring and measuring mortality, mean and median CD4 counts, missed appointments, and identify contributors to LTFU and site-specific challenges to improve the quality of care provided to patients.
6. Perform biannual assessments of data quality and health management systems at the facility level, through a facility data quality and systems tool available at district and regional hospitals, and develop action plans to address gaps in data management systems and service delivery and assess resources utilization.
7. Conduct joint quarterly supportive supervision in collaboration with local government authorities and/or umbrella organizations to outreach partners, focusing on data quality and review of proper use of national data tools and reporting systems. Provide on-the-job mentorship, strategic in-service training and data review/source verification.
8. Support community-based outreach partners in data analysis in relevant service delivery areas (e.g. HBC, VCT, behavioral prevention, GBV) both for improving services and for measuring the strength of established referral networks.
9. Strengthen the M&E system at the national and district level to capture information on provision of GBV services, including HIV PEP within health facilities, establishing a regular mechanism for data sharing and assessing impact of programs on survivors and taking into account program results and impact at the community level.
10. Develop or adapt existing GBV information management databases to enable storage, analysis and confidential sharing of GBV incident data and established referral pathways.
11. Conduct quarterly review meetings between facility and community partners on joint interventions (e.g. HCT, GBV, ART adherence and LTFU tracing) to strengthen collaboration, ownership and sustainability of program implementation improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	2,350,000	0

Narrative:

Currently, HJFMRI supports VMMC activities in the two priority regions (Mbeya and Rukwa) via static, mobile/outreach and mass campaign approaches in collaboration with the MRH and Rukwa RMO. There are sixteen static sites providing routine MC services in both regions. A total of 72 clinicians have been trained in 24 teams. MRH provides TA to the four Southern Highland regions supported by PEPFAR/T, including training the teams of MC clinicians. More clinicians will be trained in the FY2013 COP , and mobile surgical units procured with FY2012 COP funds will facilitate outreach services to perform more procedures to reach the target of 50,000 clients.

The standard VMMC package consists of advocacy and stimulation of informed demand through mass media and targeted community outreach to include engagement of community leaders. Education on risks and benefits and safer sex practices are provided both through one–on–one counseling and group sessions. In addition to the MC procedure itself (provided under local anesthesia), clinical/VMMC teams receive training in waste management practices, wound care and safe healing, pre-op assessment and post–op counseling.

Activities planned for the FY2013 COP include:

1. Continue to scale up VMMC services as a comprehensive prevention package that includes counseling and testing, behavioral interventions to prevent new infections, and linkage to PHDP services.
2. Promote female partner participation in MC services to encourage a family-centered HIV prevention approach.
3. Provide quality HCT through individual, group and couples counseling and testing modalities.
4. Strengthen two-way referral and escorting system to ensure all clients tested positive are linked into care and treatment services.
5. Expand mobile services initiated to reach beyond the populations within easy reach of current static. Based on a successful model being implemented by the Makarere University Walter Reed Project in Uganda, fully stocked surgical vans operated by expertly trained providers will be able to reach isolated, rural communities, broadening the access of populations to this service.
6. Utilize outreach community-based partners and local dispensaries to engage communities as part of static services and/or prior to arrival of the mobile units, educating community members and creating demand as well as providing follow up care and reinforcing prevention messaging.
7. Continue participation in USG and nationally planned quality assurance reviews.
8. Assess VMMC services routinely to ensure availability of recommended MC equipment on-site through

regular support supervision and on-the-job mentorship.
9. Assess standard clinician performance, and recording and reporting of adverse event rates and compliance (both to treatment and preventive measures) through use of harmonized data collection and reporting tools.
10. Continue use of web-based MC reporting system utilized by other implementers in Tanzania for routine reporting and improvement of MC data quality.
11. Leverage national efforts to integrate of MC services into routine health care, especially supporting CHMTs in all districts to implement early infant MC as per national guidelines in collaboration with the MOHSW, WHO, and other PEPFAR partners and stakeholders in the zone.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	220,000	0

Narrative:

HJFMRI implements HVAB interventions mainly through four local CSOs that cover the four regions supported by DOD/WRAIR partners: SONGONET - HIV in Ruvuma; Resource Oriented Development Initiatives (RODI) in Rukwa; and Kikundi Huduma Majumbani (KIHUMBE) and Mbeya HIV Network Tanzania (MHNT) in Mbeya.

The target population will be men and women of reproductive ages (15- 49 years) and young boys and girls in and out of schools and training institutions. Interventions will address Multiple Concurrent Partnership, gender and GBV issues as well as inter-generational sex as factors that contribute to HIV infections. The program will also promote delay of sexual debut and address social and community norms to prevent HIV infections. Children and adults will be reached through the use of appropriate peer educators and home based care providers. A Community Resource Kit (CRK) tool will be used during small group discussions to facilitate and promote dialogues in order to eradicate sexual and cultural norms fueling the spread of HIV infections.

Activities planned for the FY2013 COP include:

1. Promote delay of sexual debut and secondary abstinence among youths through targeted messages to individuals, small groups and community members. Emphasis will be on providing individual and small group skills through peer education. Partners and regional governments will facilitate the commemorations of national and international events to increase targets and strengthen collaboration with respective government authorities.
2. Refine and distribute appropriate IEC materials and messages.
3. Promote Group education using the “Men As Partners” curriculum to create sustained behavior change

impacting their lives and that of their partners and families.
4. Improve relationships and reduce the potential for violence using “Couple Connect” to maintain healthy and respectful marriages/partnerships.
5. Form community youth clubs to promote adoption of safer sex behaviors and to impart risk reduction skills.
6. Conduct protection and education activities, and advocate for mainstreaming of Gender/GBV issues in school curriculum.
7. Integrate HVAB services with HTC, PMTCT, VMMC, GBV, condom promotion, STI management, ART, and care and support programs.
8. Train Peer educators to trace LTFU clients and link them back to respective CTCs.
9. Use the Tanzania Out Monitoring System for non-medical HIV and AIDS interventions which are forwarded to the Council HIV/AIDS Coordinators for compilation and channeling to Council AIDS Multi –Sectoral Committee and TACAIDS.
10. Conduct joint quarterly supportive supervision in collaboration with local government authorities and umbrella organizations to outreach partners. On-the-job mentorship, strategic in-service training, data review/source verification and TA will be provided to strengthen collaboration, ownership and sustainability of program implementation improvement.
11. Conduct quarterly meetings to coordinate HIV prevention programs with LGAs and other stakeholders to share progress and challenges and achieve program sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	801,431	0

Narrative:

In the F Y2012 APR, HJFMRI trained 150 HCWs in HTC and counseled and tested a total of 495,583 clients, including PMTCT, exceeding the target of 435,711 (113.74%) in all modes of HCT services. The Southern Highlands has a population of approximately 6,000,000, with HIV prevalence ranging between 4.9-7.9% in the individual regions and an estimated HIV+ population of 382,100. In the FY2013 COP, support will be provided to improve site-level forecasting and ordering to improve the availability of rapid test kits and other commodities in support of the national supply system. In recognition of the scale-up across all care, treatment and support programs , HTC services, in collaboration with both treatment and outreach partners, will reach 707,808 clients across all HCT modalities, approximately 42,000 new HIV+ clients.

HJFMRI will prioritize PITC and couples counseling modalities, among other HTC approaches. All clinical service delivery points will be engaged (i.e. at RCH/ANC, PMTCT, TB, STI clinics and inpatient/outpatient wards) and mobile TC services will strategically focus on high prevalence but low coverage areas,

specifically geared towards attracting men and at-risk population such as market sellers, trans-border traders, men's groups, fishing communities, and mining communities. Furthermore, collaboration with Baylor in pediatric PITC and the CSOs will ensure that both clinical and community programs are in alignment with targets. HTC services will also support partner and family members testing from index patients.

Those who receive HTC services will be recorded, reported and followed up using national tools, including referral forms for those found HIV positive. The program will also establish a system of referral coordinators at community and facility levels to coordinate and audit referrals between service delivery points. Also, the referral coordinators at the community level will ensure those that come from community TC services are well-supported to reach care and treatment or other health service delivery points. HTC clients will also be referred to other services including care and support services, PMTCT, TB/HIV, ART, FP and VMMC as needed. More emphasis will be made to ensure referral networks between community groups, social service providers and health care providers happen and are maintained.

Focused messages and demand creation activities will be done in identified locations to specifically expand HTC among. HTC awareness campaigns will employ peer-to-peer communication, with peer educators addressing issues of discordance and services addressing the youth and young couples.

HJFMRI will also support HCWs' trainings to improve capacity to execute the program interventions and build ownership. Based on the national training curriculum, refresher trainings to 200 HTC counselors/testers and supervisors will be conducted. HJFMRI will support expanding the pool of regional and district TOTs, and will participate in teams to ensure routine mentorship and support supervision. Lab mentors will be used to strengthen QA/QC practices to ensure that facilities send samples to referral hospitals for QA as per national guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,080,000	0

Narrative:

HJMRI will continue to work with local partners to implement community programs to increase the adoption of safe sex and reduce risky behaviors. Services are provided through health facilities and local community partners such as SONGONET - HIV in Ruvuma; Resource Oriented Development Initiatives (RODI) in Rukwa; and Kikundi Huduma Majumbani (KIHUMBE) and Mbeya HIV Network Tanzania (MHNT) in Mbeya. HJFMRI also supports the implementation of both facility-based and home/community–based activities for preventing and responding to GBV.

The primary target population of men and women of reproductive ages (15- 49 years) includes couples, at-risk populations such as fishing communities and small-scale miners, and communities along the Trans-African highways and in border towns with neighboring countries Zambia and Malawi. Other targeted groups will include workers in coffee plantations, truck drivers, food vendors, at-risk youth, alcohol users, mobile populations and people involved in transactional sex. Programs will aim to address related to sexuality, gender and cultural practices that fuel the spread of HIV among these groups.

Sub-partners will establish and adopt a combination prevention approach involving behavioral, structural and biomedical interventions. These activities will include provision of HIV and AIDS education and linkages to HTC, STI and PEP management, GBV service sites, and Family Planning services. HJMRI will reach its target groups through the use of peer education program. The Community Resource Kit (CRK) tool will be used during small group discussions to facilitate and promote community dialogues.

Activities in the FY2013 COP will include:

1. Procure, distribute and promote consistency and correct use of condoms in general population and in identified at-risk populations and high-risk areas;
2. Establish and strengthen existing condom outlets and ensure availability of both female and male condoms.
3. Link prevention activities to other service delivery platforms such as PHDP, HTC, care/support, ART, MC, STI and PEP management, PMTCT, family planning and GBV service delivery sites.
4. Promote Group education using the “Men As Partners” curriculum to create sustained behavior change, and reduce the potential for violence using “Couple Connect” to maintain healthy and respectful marriages/partnerships.
5. Promote changes in community norms, attitudes and behaviors through community mobilization, mass media campaigns and support to local leaders by engaging/building their capacity in raising awareness about violence in their community.
6. Strengthen the mechanisms for referral of GBV and Violence Against Children.
7. Support sexual behavioral change communication, including messaging on MCPs, transactional and intergenerational sexual practices, age at sexual debut and alcohol use.
8. Train peer educators to trace LTFU clients and link them back to respective care and treatment clinics
9. Promote coverage of HVOP services through individual, small groups and community sensitization messaging.
10. Support implementation of the Brief Motivational Intervention to address high-risk from alcohol use.
11. Conduct joint quarterly supportive supervision visits to support quality service provision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	3,174,112	0

Narrative:

HJFMRI supports the implementation of the global and national agenda on elimination of mother to child transmission of HIV (eMTCT) and reduction of maternal morbidity and mortality. In the Southern highlands zone, PMTCT services through the HJFMRI occur in 676 facilities through the Rukwa, Ruvuma, Katavi and Mbeya RMOs. The RMOs also support the implementation of facility-based adult care and treatment programs at the regional hospitals and all CTCs at district and other hospitals in their respective regions.

PMTCT services are highly required in these regions given the high ANC HIV prevalence rates of 12.6% in Mbeya, 7.2% in Rukwa and 8.2% in Ruvuma. In the FY2012 APR, HJFMRI reported 192,350 women who were counseled and tested for HIV and received results , and scaled up PMTCT services to 704 sites, surpassing the target of 648 sites. However, information on unit cost of infant-mother pair reached with PMTCT is not yet available.

Activities planned for the FY2013 COP include:

1. Scale up of PMTCT services to new sites in the four regions, including testing and counseling for all women attending ANC, L&D as well as improvement of adherence counseling to improve retention.
2. Complement emergency obstetric care (EmOC), FP and Focused Antenatal care packages through national TOT model by collaborating with district authority and health programs that support EmOC.
3. Integrate ART and TB/HIV services into PMTCT sites including supporting PMTCT sites to provide ART and more efficacious combination regimens. Training will continue for MCH health care providers in ART and pediatric HIV management, providing guidelines and job aids, and also CD4, biochemistry, hematology machine. HJFMRI ma participate in the roll out of Option B+ according to national planning and guidelines.
4. Procure ARV drugs, lab reagents, and essential supplies when not available through central procurement mechanisms.
5. Strengthen and support monitoring and evaluation and BPE, including PMTCT costing studies, to document gaps and support use of data to access site specific services and develop a plan of action to address challenges.
6. Promote infant feeding counseling options, linking mothers to safe water programs in their regions. For mothers choosing to breastfeed, the program will counsel them on breastfeeding and complement with either the mother or infant is on ARV prophylaxis. Evidence-based and -informed infant feeding and nutritional interventions during lactation will be promoted.
7. 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.

8. Build capacity of regional and district health teams to plan, execute and monitor PMTCT activities, and support DHMTs to include PMTCT activities in council health plans and budgets.
9. Support community partners to establish expert mothers groups and link HIV positive mothers and their families to HTC, ART, VMMC and other services such as community support groups. HIV infected-pregnant women will be linked to care and support services, including TB/HIV, FP and other prevention services including gender-based violence.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	6,971,558	0

Narrative:

As of the FY 2012 APR, HJFMRI reported 78,020 current on treatment in the Southern Highlands with an estimated HIV+ population of 382,100. ART coverage reached approximately 52% of those who are estimated to qualify for ART at more than 146 ART facilities and 676 PMTCT sites referring HIV+ mothers and exposed infants. Retention rate for the area is >75%. In the FY2013 COP, scale-up of enrollment will continue to reach 92,340 current on ART, approximately 60% of estimated treatment eligible, and a total of 156,326 with comprehensive care. By the end of FY14, HJFMRI will reach 106,660 with ART (70% of treatment eligible) and 182,610 with care.

HJFMRI will continue to build local skills for program sustainability and ownership. This includes training of RMO, RHMT, CHMT and facility-level staff in routine patient/facility data analysis for monitoring, QI and service planning, and TA in financial management, forecasting and budgeting. Service level TA will focus on improving the quality of ART clinic management, maintaining medical records, improving patient retention, strengthening community networks between facilities and NGOs, and increasing involvement of PLHIV to ensure local ownership of clients' well-being and needed services at all levels.
HJFRMI and partners will focus on key areas to increase enrollment and expansion of services through program efficiencies. This will include the activities below as well as reviews of current pre-ART adult and pediatric registries for patients who meet new ART eligibility criteria, scale-up of PITC and integrated PHPD services, and expansion of POC diagnostics at more remote sites.

Planned activities in the FY2013 COP include:

1. Implement a quality package of services and standard of care consistent with MOHSW's national guidelines ensuring integration of prevention into treatment.
2. Provide skill and competency based trainings and on-going clinical mentoring to physicians, nurses and pharmacist at all points of service.
3. Strengthen adherence and support services including individual and group counseling, patient

education, strengthening referral linkages, patient follow up, linkages to community based adherence support and defaulter tracing programs.
4. Collaborate with CSOs to establish networks of community volunteers, including PLHIV, to provide adherence counseling, treatment support and recover LTFU clients.
5. Distribute ART reference tools, including pocket guides, ART dosing cards, posters and detailed SOP.
6. Strengthen linkages between entry points, including PMTCT, ANC, TB, STI OPD and inpatient wards, HTC and palliative care services.
7. Execute pharmacy assessments and performance improvement plans. Capacity development will include all aspects of drug management, dispensing and storage, instruction in national treatment guidelines and SOP on security, quality control, storage and disposal.
8. Provide solar power to 40 rural health facilities and provide generators.
9. Prioritize linking patients to livelihood opportunities as well as HBC, support, community and social services and strengthen existing referral channels and support networks.
10. Monitor service with formal QI mechanisms, such as regular site visits by HJFMRI and RMO CQI staff on a quarterly basis or as needed. HJFMRI will convene and coordinate monthly zonal ART meeting with MRH and RMOs to discuss CQI findings and treatment rollout, identify areas of need, determine solutions and coordinate

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,528,000	0

Narrative:

As with pediatric HIV care, pediatric HIV ART services in the FY2013 COP will be implemented in collaboration with Baylor International Pediatric AIDS Initiative (BIPAI) as well as leverage MOHSW's basket funding and cost sharing mechanisms. HJFMRI will continue to support HCW participation in the Baylor pediatric HIV/AIDS clinical attachment program which provides clinical mentoring and TA on the treatment of pediatric HIV/AIDS.
The Southern Highlands program has a total catchment population of over 6 million people. The HIV prevalence ranges from 4.5% to 7.9%, with at least 23,500 children under 15 years of age in need of care and support services. Currently over 5,000 children receive treatment at over 149 facilities. The current pediatric enrollment rate is 8% but the aim is to achieve nearly15% based upon epidemiological estimates.

A primary objective of the program in addition to maximizing enrollment of HIV+ children is to mitigate barriers to prevention, care and treatment, and improve quality of services. Several of these steps are outlined in the PDCS section, with pediatric ART building upon those activities. FY2013 COP funding will be used to scale-up ART services including scaling up of PITC and linking to services such as palliative

care, psycho-social support and home-based care services. Particular emphasis will be placed on provision of the continuum of care services to improve pediatric enrolment, retention and adherence to ART. FY2013 COP targets 2,908 children to be newly initiated and 7,806 maintained on ART. Activities planned for the FY2013 COP include: 1. Integrate and strengthen linkages of pediatric care and treatment with other systems such as PMTCT, EID, maternal health, PITC, GBV, OVC, M&E and HBC to improve the continuity of care and quality of care and mitigate LTFU. 2. Expand adolescent-friendly and family-friendly services to more facilities to break down barriers to accessing pediatric treatment, including increased utilization of CHWs and nurses to ensure more access points for care and better continuity of care. 3. Ensure quality of care, central to the pediatric program, utilizing a system of mentorship, supervisory supervision, CQI and standardized evaluation tools to assess partners and facilities for lab, clinical, M&E and administrative services. 4. Strengthen adherence and support services including individual and group counseling, patient/care giver education, strengthening referral linkages, patient follow up, linkages to community-based adherence support and defaulter tracing programs. Collaborate with NGO partners to establish networks of community volunteers including PLHIVs to provide ongoing support to caregivers of pediatric patients to improve pediatric adherence to treatment and recover LTFU clients. 5. Implement updated pediatric-focused national care and treatment guidelines and WHO treatment guidelines, including treatment of all HIV-infected children <24 months. 6. Ensure utilization of specialized laboratory services such as viral load testing, PCR, and viral resistance testing capacity as required. 7. Strengthen overall monitoring and reporting of HIV-positive expectant women that receive treatment. An improved M&E system will reinforce the linkage between PMTCT and EID by tracking the cascade effect of women tested and counseled, women receiving treatment, infants born to HIV-positive women, infants tested and counseled, and infants receiving treat

Implementing Mechanism Details

Mechanism ID: 16781	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16782	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16784	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16786	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16787	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16788	**Mechanism Name: Health Research Challenge for Impact**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 602,472	
Funding Source	**Funding Amount**
GHP-State	602,472

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Tanzania Ministry of Health is scaling up a new Integrated Community-Facility Maternal Newborn and Child Health service package designed to ensure that HIV-positive pregnant women are linked to comprehensive MNCH services through an integrated approach implemented through community health workers (CHWs) and facility-based providers. Evidence-based approaches are needed to support the development and implementation of effective strategies for the roll-out and national scale-up of the approved package. Johns Hopkins University/HRCI will support implementation and evaluation research to identify policy and program strategies to maximize the program's effectiveness at improving continuity of care for HIV-positive and negative women. The objectives are:

1. To identify priority questions for effective scale up of the integrated package and design studies to answer those questions;

2. To provide technical assistance to partner organizations on the development of data collection instruments, protocols, and data analysis;

3. To disseminate project findings and promote the incorporation of recommendations into implementation strategies and policies.

In alignment with the Partnership Framework, this activity will enable the use of relevant and comprehensive evidence for planning and decision making. It is inherently designed to improve cost effectiveness of the Integrated Program over time by identifying strategies for enhancing program outcomes. Through key partner workshops, study findings will be translated into relevant program and policy guidelines transitioning the effort to local stakeholders, particularly the Ministry of Health. This effort will complement ongoing monitoring and evaluation activities within partner programs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	602,472

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**16788**
Mechanism Name:	**Health Research Challenge for Impact**
Prime Partner Name:	**Johns Hopkins University Bloomberg School of Public Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	202,472	0

Narrative:

The Ministry of Health and Social Welfare (MOHSW) of Tanzania has approved a national community health worker (CHW) program that will enable community-facility linkages and promote maternal and newborn health services for HIV-positive and HIV-negative women, including PMTCT, postnatal care, and postpartum family planning. The CHW package involves the recruitment and training of a new cadre of CHWs who will conduct home visits to pregnant and postpartum women, provide health education and promote facility-based services. In-service training will be provided to clinicians at health centers to improve integration of HIV and MNH services and improve the quality of postnatal care.
The JHU/HRCI will conduct implementation and evaluation research in support of the national scale up of Tanzania's Integrated Community-Facility Maternal Newborn and Child Health package (Integrated Package). Through stakeholder engagement and working with key partners in country, JHU-IIP will work with PEPFAR partners to actively translate the study results into recommendations for effective policy, planning and financial approaches that will support the ongoing development of appropriate strategies for the phased introduction and sustained national scale-up of the Integrated Package within the context of the existing health system. Additionally, research findings will also inform the multi-stakeholder National CHW task force discussions. The National CHW task force has been convened by the Department of Preventive Services within the MOHSW and has been charged to review and bring together lessons learned, as well as consolidate current status of implementation of community

health worker related activities and guidelines in country. Key implementation and scale-up challenges that may be addressed include:
1. The development of sustainable systems for CHWs, with a focus on supportive supervision and reasonable incentives.;
2. A need to formalize and standardize the CHW cadre, including recruitment criteria, training, and service packages;
3. Effective creation of sustained demand for services and referral by strengthening CHW program;
4. Definition of a cost and financing model for scale-up of the Integrated Program.
5. Weaknesses of existing platforms and the related impact on the coverage and quality that may be achieved through the Integrated Program.
6. Existing and projected program and financial constraints at the primary, periphery and tertiary level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	400,000	0

Narrative:

The Johns Hopkins Institute for International Programs (JHU-IIP) will support implementation and evaluation research on the national scale up of Tanzania's Integrated Community-Facility Maternal Newborn and Child Health package (Integrated Package). PMTCT and HIV/AIDS treatment services have been largely facility-based whereby PMTCT has been integrated with ANC and delivery services. The Ministry of Health and Social Welfare (MOHSW) of Tanzania has approved a community health worker (CHW) program that will enable community-facility linkages and promote maternal and newborn health services for HIV-positive and HIV-negative women, including PMTCT, postnatal care, and postpartum family planning. The CHW package will recruit and train a new cadre of CHWs who will conduct home visits to pregnant and postpartum women as well asprovide health education and promote facility-based services. In-service training will be provided to clinicians at health centers to improve integration of HIV and MNH services and improve the quality of postnatal care. Comprehensive evidence is needed to inform the roll out and support strategies for the national scale-up. By using evidence to evaluate and further develop its strategies, the Integrated Program will be better positioned to reduce loss to follow up from routine MNH services, and from PMTCT and long-term HIV treatment for HIV-positive women.

JHU-IIP will provide TA to implementing partners and the MOHSW to conduct implementation research and evaluation studies as the scale up goes forward. Specifically, JHU-IIP will work with PEPFAR-funded partners who are supporting the scale-up of the integrated program, including the CDC and EGPAF, the MOHSW and USAID, to identify priority operational research questions that will inform the strategies of the integrated program. JHU-IIP will collaborate with partners to design three to four

operational research studies that address priority questions, develop protocols and measurement instruments, and secure ethical approval. This approach will maximize efficient use of resources and uptake of research results by relying on partner infrastructure and management to conduct data collection. In some cases, more than one partner may contribute to the same study, by testing different implementation strategies and comparing outcomes. JHU-IIP will work with implementing partners to analyze data and disseminate results to stakeholders for incorporation into policy. Results from each study will be feed back into the program. Design and analysis workshops will be held annually in order to engage all stakeholders in the research and improve the policy uptake of results. Knowledge gaps and scale-up barriers that the proposed implementation research may address include: - In what way can health facilities communicate with CHWs to follow up with women who miss appointments? - What are the most effective approaches for training and supervising CHWs? What role can the dispensary play, and what other strategies can be employed? - What is the realistic scope of activities that CHWs can effectively complete? Can CHWs' scope be increased over time without a decrease in the quality/coverage? - Are there conditions under which CHWs i Tanzania can provide integrated community case management? By answering the above or other questions, this project will play an important role in the development of effective policies for a sustainable and successful CHW program in Tanz

Implementing Mechanism Details

Mechanism ID: 16790	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16791	**Mechanism Name: Strengthening Health Outcomes through the Private Sector (SHOPS)**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,110,000	
Funding Source	**Funding Amount**
GHP-State	1,110,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The SHOPS Project is a five-year cooperative agreement with a mandate to increase the role of the private sector in the sustainable provision and use of quality HIV/AIDS, family planning, and other health products and services. In Tanzania, SHOPS will support public and private sector organizations to initiate, implement, and scale up innovative, effective, and sustainable PPPs for health. These partnerships will leverage the private health sector to increase access to affordable treatment and prevention services that address the health goals outlined in both Tanzania' s Partnership Framework and GHI Strategy (e.g. preventing new HIV infections, improving HRH, scaling up delivery of quality health services to reduce morbidity and mortality from HIV/AIDS). Activities will address the capacity and willingness of stakeholders from the public and private sectors to identify and address opportunities to partner; the capacity of LGAs to contract the private for-profit health sector to deliver health services; and the ability of banks to develop innovative loan packages for medical education that will help address HRH shortages.

SHOPS will support local partners including but not limited to MOHSW, PPHFT, APHFTA, PRINMAT, and CSSC, to identify target populations for strategic interventions. By working through these local institutions, SHOPS will build local capacity to increase private sector participation in health. Key areas of focus will: 1) support evidenced-based advocacy and policy for health PPPs at the national level, 2) broker PPPs at the LGA level and 3) build capacity of private medical institutions to enhance human resources for health. A PMP will be developed in close collaboration with USAID, MOH and private sector partners.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16791		
Mechanism Name:	Strengthening Health Outcomes through the Private Sector (SHOPS)		
Prime Partner Name:	Abt Associates		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	700,000	0

Narrative:

This mechanism builds upon the 2012 private sector assessment conducted by SHOPS, which identified URT public private partnership capacity needs, particularly the PPP coordination units in the MOHSW, Tanzania Investment Center, and the Ministry of Finance and Economic Affairs. The project will demonstrate how these three units can work together to facilitate the development of PPPs in health. This will include establishing clear policies and procedures and establishing linkages with other departments within the MOHSW and building PPP unit capacity in feasibility analysis and due diligence approaches and costing of health services and other activities. With URT encouragement, a Public Private Health Forum in Tanzania (PPHFT) recently has been established and comprises representatives from private businesses, financial institutions, entrepreneurs, investors, philanthropists, foundations and other for- and not-for-profit non-governmental entities. This project will build the capacity of the PPHFT to engage in advocacy, policy analyses, and negotiations with the URT.

In addition to capacity building at national level, the project will build capacity at the local government level. For example, a barrier to increased private sector participation is government entering into service agreements with only faith-based facilities, thus excluding for-profit facilities. Given the MOHSW budgetary constraints, mobilizing private sector resource would be a significant contribution to improving health service delivery in the country. In addition, Comprehensive Council Health Plan guidance does not include tapping into private sector resources in the planning and budgeting processes of Local Government Authorities.

Another health systems barrier noted in the SHOPS assessment was the inability of medical students to

acquire student loans for medical studies. The project will explore ways in which the Higher Education Students' Loans Board (HESLB) can develop innovative loan packages for medical students. and ways in which commercial banks might be encouraged to enter the market. Furthermore, HESLB loans cannot be used for mid-level diploma or certificate programs, which is a significant limiting factor in building the base of the HRH system. Technical support for helping private banks to develop parent-student loans for students wishing to study medicine also will be pursued; this will increase financial access for pre-service training using domestic funding sources. In the FYCOP 2013, SHOPS will build the capacity of private medical institutions to raise revenue through consulting, research, alumni mobilization, and continuing education short-courses.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	410,000	0

Narrative:

The VMMC Program is currently operating in ten priority regions in the country. While the selection of regions for this award have yet to be determined, the partner will likely support activities in three to four regions. The awardee will work in approximately 90 health facilities and is expected to circumcise 10,000 men. In the spirit of a public private partnership, on-site support supervision will be provided by a Chief Mentor and Project Officer from the Association of Private Health Facilities in Tanzania, in collaboration with the District Health Management Team. The facilities will be selected from private self-financing, government and faith-based facilities in these regions.

The project will ensure that private facility providers are trained in the provision of provider-initiated HIV testing and counseling as well as VMMC services. The trainings will be provided by URT regional staff following national procedures and guidelines. The partner will also coordinate closely with other PEPFAR-supported VMMC partners in demand creation activities. To ensure adequate demand, this award will engage in limited community outreach activities in an effort to sensitize communities about the option of seeking VMMC services in non-traditional settings (read: private health facilities). The service will be provided free of charge to the client, at least in the first year of implementation.

Since private facilities attract individuals with some level of disposable income, the project should be able to identify men over the age of 20 at equal or greater success than the national VMMC program. While older men remain the top priority, VMMC services will be offered to any eligible male, including neonates once the program has been initiated.

The award plans to train 180 healthcare providers from the facilities on VMMC and PITC (if not already trained). Each healthcare provider trained will be provided with a training manual for reference during

their practice. Quality assurance standards would be adhered to as per the national program guidelines. All client data will be uploaded through the URT M&E VMMC database.

Implementing Mechanism Details

Mechanism ID: 16792	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16820	**Mechanism Name: RESPOND**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,500,000	
Funding Source	**Funding Amount**
GHP-State	1,500,000

Sub Partner Name(s)

Mothers 2 Mothers	The Centre for Counselling, Nutrition & Health Care, (COUNSENUTH)	

Overview Narrative

The Responding to the Needs for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) is a follow-on program to the ACQUIRE Tanzania Project that is coming to an end in March 2013. The program aims to implement PMTCT interventions in Manyara Region and advance the use of family planning (FP) and reproductive health (RH) services, with a focus on the informed and voluntary use of contraception throughout Tanzania. These interventions will contribute to Prong 1 of PMTCT interventions. The program

works with the Reproductive and Child Health Section of the Ministry of Health and Social Welfare (MOHSW) to support outreach and FP/HIV integration in PMTCT and care and treatment facilities, build the capacity of district leadership and management, work through public-private partnerships, and ramp up technological applications to increase access to and information about FP. EngenderHealth will apply its experience with engaging men as partners, strengthening couple communications, and scaling up "male-friendly" facilities as part of its gender approach, with the intention of reducing barriers to women's use of FP and other RH services and involving men in appropriate services addressing gender-based violence. RESPOND seeks to help Tanzanians achieve their desired family size and reduce maternal and infant mortality and HIV transmission. This will be achieved by the use a targeted, district-based sustainable approach to support capacity-building in the MOHSW and at the district level. The partner will also engage and support the URT to take ownership of and provide adequate coordination and resources for FP at the national, regional, and district levels.

Cross-Cutting Budget Attribution(s)

Gender: GBV	600,000
Motor Vehicles: Purchased	167,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16820**
Mechanism Name:	**RESPOND**
Prime Partner Name:	**Engender Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,500,000	0

Narrative:
The EngenderHealth RESPOND activities focus on integration of prevention of mother to child transmission (PMTCT) of HIV into Maternal, Neonatal and Child Health (MNCH), particularly family planning and reproductive health (FP/RH) services, by building the local capacity of health providers and improving the health care system. RESPOND will continue the work started under the ACQUIRE Tanzania Project to integrate FP/RH into the broader realm of health services included in PMTCT, and forge stronger partnerships, especially at the community, district, regional and national levels, to support the Global Health Initiative (GHI) in Tanzania. The program will work with a wide range of local partners, including nongovernmental organizations (NGOs), other health organizations, and other donor-funded projects working in the health arena in Tanzania. Specifically, RESPOND will - Work at the national level to promote policy on HIV integration with MNCH services, working with the national technical working group for integration of HIV into MNCH to develop and roll out national guidelines for integration of PMTCT into MNCH and FP/RH services; - Assist local partners to develop and implement action plans for providing integrated HIV and FP/RH services; - Promote early infant diagnosis and build the capacity of the districts to ensure that blood samples are efficiently taken to the processing centers and that results are made available on a timely basis; - Conduct training of service providers at PMTCT sites to assess, stage, initiate care for, and support HIV positive women and eligible infants with antiretroviral therapy; - Support districts to scale up integration of FP/RH into HIV care and treatment using national guidelines to make sure that family planning methods are provided in CTs); and - Ensure that referrals are offered for family planning methods that are not provided at the CTCs, especially long acting and permanent methods of contraception.

Implementing Mechanism Details

Mechanism ID: 16872	Mechanism Name: Operations Research - ART outcomes
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: Yes

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

These funds will be used to conduct basic HIV program evaluations of ART outcomes. Care and treatment outcomes for HIV patients receiving HIV/AIDS care and treatment services will be assessed. Demographic, clinical, and immunologic characteristics of the patients' population currently receiving ART will be described, and analyses of treatment outcomes over time on ART will be carried out. Findings from this study will provide policy-makers and implementing partners with information that will facilitate future ART program development. Quality provision of ART services is a priority of both PEPFAR and URT policies and guidelines. The findings of such evaluations have nation-wide relevance and are likely to impact on future cost-efficiencies and effective approaches to continue transitioning these services to local partners and government. These evaluations may also consider program integration, a key cornerstone of GHI policy.

The partner and sites to conduct these activities are still to be determined.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16872		
Mechanism Name:	Operations Research - ART outcomes		
Prime Partner Name:	Management development for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	50,000	0

Narrative:

PEPFAR/T care and treatment program, at the patient level, aims at driving viral loads to undetectable levels, increasing CD4+ T cell counts, reducing morbidity, and prolonging survival among clients receiving ARVs. By September 2012, a total of 364,000 patients were reported to be receiving ARVs across 976 PEPFAR supported facilities. Since the beginning of the program in 2004, Tanzania has been using former WHO recommendations in the management of HIV patients with CD4 <200 cells/mm3 and WHO clinical stage III and IV as criteria for treatment initiation. Early initiation of treatment, treatment simplification and adoption of the 2010 WHO treatment guidelines are some of the ongoing changes in the country. In order to understand the long-term and short-term treatment outcomes that are associated with these changes, PEPFAR/T will conduct an ART outcome study to understand the relationship between changes in treatment practices and patient outcomes across the selected PEPFAR-supported facilities throughout Tanzania.

Implementing Mechanism Details

Mechanism ID: 16874	**Mechanism Name: Local FOA 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: Tanzania Health Promotion Support (THPS)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,970,443	
Funding Source	**Funding Amount**
GHP-State	3,970,443

Sub Partner Name(s)

Not Applicable		

Overview Narrative

The goal of this program is to increase the number of local partners with the capacity to expand activities to maximize coverage through quality comprehensive HIV care and treatment services. The initial geographic focus regions are Pwani, Kigoma, Kagera, Zanzibar and Mtwara. Activities to be supported by one or more local indigenous partner in the FY2013 COP focus on six key objectives to accomplish; 1) Increase percentage of adults and children alive and on treatment at 12 months, from 67% to 85%; 2) Increase percentage of HIV positive pregnant mothers initiated on ART through PMTCT from 14% to 98% as a result of implementation of Option B+; 3) Increase percentage of TB/HIV co-infected individuals tested and treated with ARVs from 40% to 90% due to full adoption of WHO 2010 treatment guideline ; 4) Increase retention of HIV positive patients in care and treatment from 67% to 85% through improved adherence counseling and proper linkages, referrals and patient tracking; 5) Increase percentage of individuals confirmed with HIV positive test result from HTC sites and successfully linked to care and treatment services, from 60% to 80%, including testing services for male circumcision clients; and 6)Improve the ability of C/RHMTs to plan, implement, and manage an HIV program, as demonstrated by the ability to lead 100% of quarterly partner coordination meetings; and to increase their annual URT budgets to absorb 25% and PEPFAR supported-staff. The program supports Goals 1 (Services) and 5 (HRH) of the Partnership Framework. In order to establish local ownership and move towards sustainable programs, the partner will work closely with regional authorities and other local and international partners, and also support comprehensive care and treatment provision.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16874**
Mechanism Name:	**Local FOA Follow-on**
Prime Partner Name:	**Tanzania Health Promotion Support (THPS)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	380,000	0

Narrative:

Care and support programming will focus on two areas. The first priority area is early identification of HIV individuals, with a well-documented and closed loop linkage system and retention in care: the partner will also improve the linkage system to ensure that a newly diagnosed individual is enrolled into care and treatment, and be expected to demonstrate an improved adherence rate and a reduction in loss to follow up. The partner will coordinate with community, HTC, TB, and PMTCT partners in their region to harmonize and improve the tracking system of patients enrolled in care. The partner(s) will maximize efficiencies to ensure continuum of care. The second priority area is provision of a complete and high quality clinical care package, which includes: physical assessment, WHO staging, CD4 and other lab monitoring, nutritional assessment, counseling and support, detection and management of opportunistic infections, cotrimoxazole prophylaxis, ART management, screening for cervical cancer, Positive Health Dignity and Prevention (PHDP), pain management and end of life care.

The partner will provide supportive supervision and mentorship to ensure delivery of a high quality and complete clinical care package. Funds will be allocated for activities and initiatives that will utilize continuous quality improvement science and methods to demonstrate a measurable improvement in the complete clinical care package as well as systems of linkages and retention.

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

Narrative:

With these funds, the partner(s) will strengthen TB screening and case detection by implementing

Intensified Case Finding (ICF) at care and treatment clinics (CTC), among pregnant women, OVC, pediatrics, uniformed forces and in congregate settings. Identify TB suspects, act rapidly to conduct diagnostic evaluation of suspects and treat the disease. Provide Isoniazid Preventive Therapy (IPT) for individuals who screen negative for TB symptoms. Implement infection control measures to prevent TB transmission in both TB and CTC settings. Integrate Positive Health, Dignity and Prevention (PHDP) into TB clinical settings. Provide HIV comprehensive care and treatment services (including ART initiation) for TBHIV co-infected patients. Scale up provision of HIV services in TB clinics through increasing the number of TB clinics with one stop TBHIV services and/or renovation of TB clinics to allow provision of comprehensive care and treatment services. Support scale up of pediatric TBHIV services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	63,500	0

Narrative:

FY2013 COP funds for pediatric care will focus on scaling up cotrimoxazole (CTX) prophylaxis for HIV-exposed and infected children, and providing nutrition assessments, which include anthropometric measurements for growth monitoring, nutritional counseling, support and referral for severe malnourished children. Funds will also be used to provide incentives to community support groups to improve retention through tracking of loss to follow up in children and families. The facility care and treatment partner will collaborate with a HBC partner to maximize efficiency and ensure continuum of care for families. The program will target low coverage regions for ART for the partners to collaborate with Medical Professional bodies to cascade pediatric outreach services, training, mentorship, advocacy and community mobilization that will increase enrollment to treatment for children to reach WAD targets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,404,194	0

Narrative:

The proposed funds will support the rollout of Option B+ whereby all HIV positive pregnant women will be initiated on ART, regardless of CD4 count or WHO clinical stage. While preparing for B+, the PMTCT program will continue scaling up services to 100% of all facilities offering RCH services, providing prophylaxis/treatment to 95% of all HIV positive pregnant women identified. The partner will also increase coverage for EID sites to cover 80% of PMTCT sites with EID services, and scale up testing for HIV exposed infants to at least 60%.

Furthermore, additional efforts will be made to scale up community-based initiatives, including mother peer support groups, and follow-up of mother-infant pairs in the community to ensure timely delivery of DBS results to the mother and provide outreach services. Couples counseling will be advocated as well

as gender based violence andPHDP issues. Quality improvement will also focus on PMTCT and MCH services, and strengthen service integration and linkage of PMTCT and CTC services. The partner will also continue to support the national efforts to scale up BEmONC and FANC, and to initiate support for the roll out of post-natal care and the community health worker approach, which have just been approved by the MOHSW.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,699,999	0

Narrative:

FY2013 COP funds will focus on scaling up and maintaining ART services in the Kigoma, Kagera, Pwani, Zanzibar, and Mtwara regions. The partner will focus on intensive strategies and activities leading to increased identification of HIV positive people, timely ART initiation with maintenance of these patients on ART through quality clinical services, and retention of patients on care and treatment. The partner will ensure coordination and collaboration among the ART, HIV Testing and Counseling, and Home/Community Based Care partners to increase identification, strengthen linkages of identified HIV+ patients, refer them to care and treatment facilities, and retain them in care and treatment. In addition, to accommodate the full adoption of the new National ART guidelines, by which all patients with a CD4 count under 350 should be initiated on ART, the partner will promote increasing clinic days at facilities, conduct comprehensive reviews of pre-ART patient charts to determine eligibility, and enhance efforts to conduct outreach services. These initiatives will support the MOHSW and NACP to reach ambitious National ART targets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	272,750	0

Narrative:

The program will implement training, on-site mentorship, advocacy, community mobilization, and pediatric-specific quality improvement initiatives in Kigoma, Kagera, Pwani, Zanzibar, and Mtwara regions. Specific activities proposed include:

- Enhance the identification and diagnosis of HIV for infants and children through scaled up EID services, PITC in in-patient and out-patient settings, immunization, OVC services, and TB/HIV clinics;
- Encourage family testing at CTCs;
- Increase treatment enrollment to identify HIV infected children through implementation of updated WHO treatment guidelines, including treatment of all HIV infected children <24 months;
- Conduct pre ART review of all children in care to determine eligibility for the new 2012 NACP guideline.

FY2013 COP funds will also be used to improve monitoring response and adherence to treatment.

Implementing Mechanism Details

Mechanism ID: 16876	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16877	**Mechanism Name: DEBI-FBO**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Christian Council of Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

The Christian Council of Tanzania (CCT) is a local indigenous Faith Based Organization (FBO) and the lead affiliate of the Tanzania Interfaith Partnership (TIP). The goal of their overall program is to contribute to reducing HIV transmission by expanding the capacity of faith-based community organizations to devise and implement program strategies to prevent HIV/AIDS and to provide services to those with HIV/AIDS. This is accomplished by building the capacity of TIP's four FBO partners to deliver HIV prevention interventions, encourage counseling and testing for HIV, and provide care to the most vulnerable groups of people. This new mechanism aims at increasing FBO partner access to an evidence-based HIV prevention intervention, Women Involved in Life Learning from Other Women (WILLOW), that focus on behavioral and biomedical drivers of the epidemic and on underlying

structural factors that influence HIV transmission and vulnerability in Tanzania. WILLOW is a CDC curriculum-based intervention that aims at reducing HIV transmission and addressing sexual risk behaviors as well as increasing care and treatment service uptake among women living with HIV and AIDS. The WILLOW target group is HIV positive adult women in Shinyanga and Mara. Introduction of WILLOW will strengthening the role of FBO partners to ensure an effective and sustainable response to the epidemic. CCT will also work on training for data collection, management, analysis and utilization. This approach is aligned with PEPFAR priorities and the Tanzanian Government's Second Multi-Sectoral Strategic Framework on HIV/AIDS 2008-2012.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**16877**		
Mechanism Name:	**DEBI-FBO**		
Prime Partner Name:	**Christian Council of Tanzania**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	100,000	0
Narrative:			
This mechanism aims to reduce HIV transmission from people who are living with HIV and AIDS using an evidence-based program named Women Involved in Life Learning from Other Women (WILLOW). The WILLOW intervention contains an abstinence component. CCT plans to focus on addressing the needs			

of populations at higher risk of getting HIV infection using churches and mosques. The intervention will target HIV discordant couples with messages that encourage them to be faithful to one partner so as to reduce the spread of HIV. The trained faith leaders are expected to reach the groups of people living with HIV and AIDS in their villages through outreach services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	150,000	0

Narrative:

This mechanism aims to reduce HIV transmission from people who are living with HIV and AIDS using an evidence-based program named Women Involved in Life Learning from Other Women (WILLOW). The WILLOW intervention contains comprehensive HIV prevention package that addresses individual and structural barriers to HIV transmission prevention. CCT plans to focus on addressing the needs of populations at higher risk of getting HIV infection using churches and mosques. The intervention will target HIV discordant couples with messages that encourage them to be use HIV prevention products and adhrere to medication in order to reduce the spread of HIV. The trained faith leaders are expected to reach the groups of people living with HIV and AIDS in their villages through outreach services.

Implementing Mechanism Details

Mechanism ID: 16878	**Mechanism Name: DEBI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

The mechanism will use a combination of approaches to implement demand creation and linkages from (and to) couples HIV testing and counseling (CHTC) programs. Within these programs, AMREF will focus on communications and demand creation activities to enhance uptake of VMMC, PMTCT as well as care and treatment services. In collaboration with other partners, the partner will strengthen linkages and referrals to all of these services. The target population is male and females aged 24 to 49 years, who will be reached with messages and other interventions that aim at increasing the uptake of VMMC, PMTCT as well as care and treatment services.

AMREF will be implementing this program in Simiyu region. The region has HIV prevalence above the national average. One district will be selected for implementation during the first year of program roll-out. In addition, the partner will work with the MOHSW to play a coordinating role among all CHTC provider in order to maximize the national impact. In line with the Partnership Framework and FY2013 COP guidance, this mechanism aims at increasing the impact of CHTC programs at the individual, group and community level. This evidence-informed intervention includes process and outcome monitoring and evaluation plans to access the effectiveness of the intervention.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16878**

Mechanism Name:	DEBI		
Prime Partner Name:	African Medical and Research Foundation, Tanzania		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	200,000	0

Narrative:

In this new mechanism, AMREF will take a lead role in supporting the Ministry of Health and Social Welfare (MOHSW) in coordinating and expanding coverage of couples HIV testing and counseling (CHTC) services across all implementing partners, and will assist with the development of a communication strategy to increase service uptake. The partner will be the lead in supporting demand creation and promoting CHTC services nationally.
In addition to its role as national coordinator, AMREF, in collaboration with MOHSW, will implement CHTC services in Simiyu region where the HIV prevalence, at 7.4%, is higher than the national prevalence. Simiyu is a new region which is a product from the division of Shinyanga into three regions. Consequently, estimates are based on Shinyanga's prevalence. The proposed budget will also go toward creating demand in the region, and promoting and strengthening linkages and referrals to other prevention, care and treatment services, including VMMC and PMTCT.

The funding level takes into consideration the fact that the partner will be supporting other already existing PEPFAR efforts in HTC through PITC and VMMC. The budget is planned at a sufficient level to address the demand creation activities planned for Simiyu in the FY2013 COP. This partner is not funded through this mechanism to provide direct HTC services and thus no targets are reported.

Local media (FM radio) will be used for community mobilization and dissemination of information about HTC services (general and CHTC) as well as provision of information about post-test follow-up to ensure strong referral for VMMC, PMTCT and care and treatment services. The partner will use nationally developed promotional materials to reach a significant proportion of sexually active couples in both urban and rural settings. AMREF will strengthen outreach services to couples across the region. If necessary, adaptations to fit the regional or local context will be made. These might include the engagement of local authorities as well as community health workers. In line with PEPFAR II guidance on country ownership and transition of programs, AMREF will work in collaboration with other local indigenous organization to build the capacity for longer term sustainability of the program activities. All partners supporting HTC use National AIDS Control Program (NACP) M&E tools to report to national and local levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	200,000	0

Narrative:
The OP component of this mechanism will focus on demand creation for couples HIV testing and counselling program in Simiyu. In addition, AMREF will focus on communications and demand creation activities to enhance uptake of VMMC, PMTCT as well as care and treatment services among those seeking couples counseling and testing. In collaboration with other partners, the partner will strengthen linkages and referrals to all of these services. The target population is male and females aged 15 to 49 years who will be reached with messages and other preventive interventions that aim at increasing the uptake of VMMC, PMTCT as well as care and treatment services. AMREF will be implementing this program in Simiyu region where the HIV prevalence is above the national average. One district will be selected for implementation during the first year of program roll-out. In line with the Partnership Framework and FY2013 COP guidance, this mechanism aims at increasing the impact of couples testing and counseling programs at the individual, group and community level. Tools will be developed to assure strong linkage between couples counseling and testing programs and care and treatment, PMTCT and VMMC programs. This evidence-informed intervention has inherent process and outcome monitoring and evaluation plans to assess the effectiveness of the interventions in different settings.

Implementing Mechanism Details

Mechanism ID: 16884	Mechanism Name: DCC 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: Drug Control Commission	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

Pangaea Global AIDS Foundation		

Overview Narrative

The purpose of this program is to provide coordination, guidance, oversight and support for HIV testing, prevention, and care and treatment for people who use drugs (PWUD) and people who inject drugs (PWID) in Tanzania Mainland.

Objectives:

1. To advocate for and facilitate integration of evidence based strategies for HIV testing, prevention, and care and treatment for people who use drugs in relevant policies and guidelines and to coordinate technical assistance (TA) with national and international collaborators.

2. To provide and track resources and services for HIV testing, prevention and care for PWUD and PWID, in collaboration with Ministry of Health and other stakeholders through appropriate monitoring and evaluation systems to ensure sustained essential services in prioritized locations in the country.

3. To coordinate stakeholders through development and regular review of research plans, including PWUD and PWID surveillance, size estimations and special studies conducted in Tanzania to increase evidence and data available about drug use in the country and facilitate dissemination and utilization of aquired information to prevent duplication of efforts among stakeholders.

Through this program, Tanzanian government stakeholders receive technical support to establish an enabling environment for a public health approach to addressing substance abuse as a contributor to HIV in the country. Having overcome the heavier initial investments towards these interventions, the Tanzania government will be in a position to sustain the program using local resources.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	16884		
Mechanism Name:	DCC Follow-on		
Prime Partner Name:	Drug Control Commission		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	250,000	0

Narrative:

It is estimated that there are at least 25,000 persons who inject drugs (PWID) in mainland Tanzania and many more persons who use drugs (PWUD) through other routes. Available data from Dar es Salaam, the commercial capital, indicate HIV prevalence of 42% among PWID compared to 11% among the general population in the city. Risky injection practices have been documented among PWID, such as sharing needles, coupled with risky sexual practices. HIV prevalence has been consistently higher among female PWUD and PWID coupled with trading sex for money and drugs, high numbers of sexual partners, inconsistent condom use, intimate partner violence, rape and alcohol abuse. This program targets PWUD and PWID where there are concentrated populations in Dar es Salaam and other parts of mainland Tanzania with specific initatives to strategically reach those at highest risk, such as females and those without a social support network.

The program aims to support the recommended nine-component comprehensive package of services for HIV prevention and care among PWID and PWUD with a focus on facilitating access to medication-assisted treatment for opioid addiction and other harm reduction initiatives, and facilitating linkages to and retention in HIV care and treatment for those found to be HIV positive.

The Tanzania Drug Control Commission serves a national coordination and quality assurance role, in collaboration with the approrpiate technical sector, for the interventions in collaboration with health service providers, academia and law-making and enforcement bodies.

Implementing Mechanism Details

Mechanism ID: 16885	**Mechanism Name: MUHAS-TAPP**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1,300,000	
Funding Source	**Funding Amount**
GHP-State	1,300,000

Sub Partner Name(s)

Kimara Peer Educators and Health Promoters (KPE)	Youth Volunteers Against Risky Beahviours (YOVARIBE)	

Overview Narrative

The second phase of the Tanzanian AIDS Prevention Project (TAPP 2) aims strengthen existing program by developing an integrated user-friendly system of HIV prevention and treatment services for key populations (KPs) in Dar es Salaam (then Tanga and Arusha thereafter), including people who use drugs (PWUD) and men who have sex with men (MSM). The program will provide MSM and PWUD with easily accessible HIV prevention, HIV care and drug treatment services in a safe and friendly manner. This aligns with the second goal of the Partnership Framework, to prioritize accessible HIV prevention programming targeting drivers of the epidemic. MUHAS will continue to collaborate with local indigenous organizations for this activity.

The TAPP 2 consortium will expand HIV testing and counseling (HTC), prevention, care, and HIV and drug treatment services for KP throughout the three municipalities of Dar es Salaam. Violence and alcohol interventions will be integrated to existing programs and couples will be targeted for HTC and other interventions. Quality assurance (QA) measures will be applied to ensure the program functions according to clearly defined standards of excellence. The partner will also develop the leadership capabilities of the community-based organizations to maximize facilitation of KP outreach. Treatment navigators will be established to help MSM access HIV prevention, care and treatment. The PWUD HIV prevention outreach and methadone treatment activities will be strengthened by implementing women-centered strategies to link more female PWUD into services. The partner will provide technical expertise in supporting national initiatives to scaling up KP interventions. Quarterly reports in line with the MOHSW standard M & E documents will be provided.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Family Planning

Budget Code Information

Mechanism ID:	**16885**
Mechanism Name:	**MUHAS-TAPP**
Prime Partner Name:	**Muhimbili University College of Health Sciences**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	400,000	0

Narrative:

TAPP will continue to focus on supporting PITC services with the aim to increase identification of HIV infected patients in need of care and treatment. The program will also continue to support HTC services targeting the general population, couples, children, and key populations through mobile and static facility based services. PITC will be offered in health settings, including to those persons accessing medically assisted therapy (MAT) services, while client initiated services will be offered both at the static Muhimbili Health Information Centre and mobile caravans services.

20% of the clinic population come as couples for client-initiated testing both at facility and mobile services. Training and service provision targeting couples will continue to be offered at PITC services. Promotional activities around HTC for demand creation will be offered to the general population, key populations and couples.

The project will strengthen and integrate alcohol screening and brief motivational intervention in HTC services. TAPP will ensure that all of its staff and PITC trainees receive training and supportive supervision to address the issue of alcohol use among their clients.

Funds will be used to support and track referrals and linkages from HTC services to appropriate care and treatment support and strengthen the escorted referral system in the services offered to key populations to tracking of service outcome.

MUHAS will continue to support training for health care providers, to update them on new guidelines for HTC services, Standard Operating Procedures and QI for HTC. In collaboration with implementing partners in Dar Es Salaam , MUHAS will attend district/regional partnership meetings aimed at strengthening coordination, collaboration and sustainability and monitoring of the implementation of joint strategies to achieve World AIDS Day targets. MUHAS will continue to document the best practices in M&E and disseminate the reports locally and international. Funding will also be used to maintain the electronic data base for HTC clients.

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

Narrative:

This mechanism implements the Tanzanian AIDS Prevention Program (TAPP), with the aim of reducing HIV transmission and providing HIV care and treatment for key populations, especially people who inject drugs (PWID) and MSM, in Dar Es Salaam. Building upon experience gained in providing outreach services to persons who use drugs, TAPP works with non-governmental organizations and community-based peer support networks of men who have sex with men (MSM) to provide outreach services and comprehensive HIV prevention and care interventions to MSM in Dar es Salaam. TAPP works closely with these local NGOs to provide training and supportive supervision to ensure the quality of outreach services is maintained. Preliminary data estimates HIV prevalence among MSM in Dar es Salaam to be 30%, with evidence of very low access to HIV testing and counseling.

The project will target key populations and their sexual or injecting partners, through community outreach by facilitating access to HIV testing, care and treatment, substance abuse therapy, and STI and TB treatment. The program targets MSM in Dar es Salaam through direct service provision. Specific interventions include:
- community-based outreach to promote HIV testing and harm reduction, including distribution of condoms and water-based lubricant for HIV prevention and sexual risk reduction and bleach kits for injecting risk reduction;

- HIV testing and counseling; targeted prevention information, education and communication;
- screening and treatment for STIs;
- screening and treatment for TB;
- screening, prevention and management of viral hepatitis; and
- linkage to HIV care and antiretroviral treatment. The program will facilitate strengthening linkages to, and supporting retention in, HIV care and treatment.

The program also focuses on training of various cadres of health service providers and providing technical support to the scale-up of comprehensive services to MSM in other parts of the country. TAPP will continue to work in Dar es Salaam, with expectations of expanding interventions for key populations in Tanga and Arusha.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	800,000	0

Narrative:

It is estimated that there are at least 25,000 persons who inject drugs (PWID) in mainland Tanzania and many more persons who use drugs (PWUD) through other routes. Available data from Dar es Salaam, the commercial capital, indicate HIV prevalence of 42% among PWID compared to 11% among the general population in the city. Risky injection practices such as sharing needles have been documented among PWID, coupled with risky sexual practices. HIV prevalence has been consistently higher among female PWUD and PWID coupled with trading sex for money and drugs, high numbers of sexual partners, inconsistent condom use, intimate partner violence, rape and alcohol abuse. This program targets PWUD and PWID where there are concentrated populations, in Dar es Salaam and other parts of mainland Tanzania, with specific initiatives to strategically reach those at highest risk, such as female sex workers and those without a social support network.

TAPP contributes to the recommended comprehensive package of interventions for HIV prevention, care and treatment among PWUD, by providing direct services in Dar es Salaam. Specific interventions include
- community-based outreach;
- HIV testing and counseling;
- targeted prevention information, education and communication;
- condom promotion and distribution;
- screening and treatment for STIs;
- screening and treatment for TB;
- screening, prevention and management of viral hepatitis;

- medication-assisted treatment for opioid addiction;
- and antiretroviral treatment.

Other services such as alcohol screening and screening for other blood borne diseases such as HBV and HCV, will be provided to all methadone clients at the clinics. More emphasis will be placed on linkage to and supporting retention in HIV care and treatment services.

The program also focuses on training various cadres of health service providers and providing technical support to the scale-up of comprehensive services to PWUD throughout the country. Technical assistance to other medication-assisted treatment facilities will be provided. Other services such as psychosocial sessions with clients and family meetings will be emphasized to ensure reintegration of methadone clients into their family. During this year, MUHAS will be required to put special focus on strengthening linkages of people who use drugs to continuum of care and treatment services in their respective localities.

Being a parastatal academic institution, MUHAS is strategically placed to provide necessary technical input to Tanzanian government entities having the public health mandate over PWUD, such that policy and programs are technically sound and informed by scientific evidence. In close collaboration with the Ministry of Health and Social Welfare and the Drug Control Commission, TAPP is able to demonstrate effective use of a secure database for monitoring and tracking services to persons who use drugs. TAPP works closely with local non-governmental organizations, providing training and supportive supervision to ensure the quality of outreach services is maintained.

Implementing Mechanism Details

Mechanism ID: 16886	**Mechanism Name: WHO 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: World Health Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	

Funding Source	Funding Amount
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

WHO/Tanzania will receive PEPFAR/Tanzania support under the CDC-PEPFAR-Multi-Center Program called "Support Services for the HIV Pandemic." The main goal of the WHO/Tanzania component of this multi-country agreement is to collaborate with PEPFAR/T to support the URT in providing comprehensive HIV/AIDS care and treatment services to all patients eligible for treatment nationwide.

As the WHO provides more high level strategic technical assistance, the collaboration will include components such as strengthening advocacy to the Ministry of Health and Social Welfare (MOHSW), adapting key policies into national guidelines, and providing technical expertise to relevant stakeholders in Tanzania. Through this mechanism, WHO/Tanzania will provide technical assistance and expertise among various program areas to the MOHSW, all aiming to support the government of URT in reaching their national goals for putting 489,000 people on ART by June 2013. This support will also prove instrumental to PEPFAR/T's achievement of World AIDS Day targets for enrolling and maintaining 451,000 people on ART by the end of September 2013. The activities planned through this mechanism go toward advancing both Goal 1 (Services) and Goal 3 (Leadership) of the Partnership Framework.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	155,500
Key Populations: MSM and TG	100,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
TB

Budget Code Information

Mechanism ID:	**16886**
Mechanism Name:	**WHO Follow-on**
Prime Partner Name:	**World Health Organization**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	200,000	0

Narrative:

FY2013 COP funds will support the URT and PEPFAR/Tanzania in reaching as many HIV-positive people with ART services as possible throughout Tanzania. The programmatic activities will be implemented with the primary purpose of identifying and initiating people on ART. The WHO focus includes supporting the treatment guideline implementation, by ensuring that all patients eligible for ART are initiated and maintained on ART. The URT is currently rolling out the full adoption of the WHO guidelines released in 2010, recommending ART initiation for all patients with a CD4 count of less than 350. Additionally, the WHO will support implementation of PMTCT Option B+ by revising the national PMTCT guidelines and tools, in order to initiate all HIV-positive pregnant women on ART and link them to care and treatment clinics; and also support TB/HIV service integration by scaling up Isoniazid Preventive Therapy and ensuring that all TB/HIV co-infected patients are initiated on ART and link them to care and treatment clinics.

HIV testing and counseling is expected to increase throughout Tanzania with the planned revision process of the national HIV testing and counseling guidelines. This includes printing and dissemination of the new algorithms, including for PITC to healthcare providers, and training appropriate stakeholders on the new guidelines. This will directly impact PEPFAR/T and national numbers of people on ART, as more people are identified as HIV-positive and referred and linked to care and treatment clinics.

The WHO currently provides, and will continue to provide, technical expertise in the Treatment as Prevention (TasP) initiative in Zanzibar, which specifically focuses on increasing the numbers of key

populations on ART. The roll out of the TasP program will continue through FY 2013 and FY 2014, to ensure that all HIV positive patients, regardless of eligibility and social status, will be initiated and maintained on ART. In addition, the organization will focus efforts on advocating to the MOHSW to improve the quality of services for key populations and develop national guidelines specific to key population-based interventions. As part of the continuum of care among HIV positive patients on ART, PEPFAR/T is expanding PHDP interventions to ensure that those patients on ART maintain healthy living and adhere to care services and antiretroviral treatment. The WHO will support the implementation and expansion of PHDP interventions by revising the national guidelines to expand facility-based PHDP services, indirectly supporting the goal of maintaining patients on ART. The WHO will also support the strengthening of laboratory services through the national accreditation process, and improve the quality of M&E activities to accurately capture patients currently on ART at any given time. Finally, in order to ensure that all HIV-positive patients are able to be identified, enrolled, and maintained on ART through a qualified healthcare provider, the WHO will support the development of the Human Resource for Health Production Plan. This will increase the number of skilled staff to provide comprehensive ART services to all patients in care and treatment facilities nationwide.

Implementing Mechanism Details

Mechanism ID: 16887	**Mechanism Name: MOHSW - 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: Ministry of Health and Social Welfare, Tanzania	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 450,000	
Funding Source	**Funding Amount**
GHP-State	450,000

Sub Partner Name(s)

Not Applicable		

Overview Narrative

The purpose of this new mechanism is to support a local, sustainable, cost-efficient response to the HIV epidemic through ongoing strengthening of the capacity and systems of the Ministry of Health and Social Welfare (MOHSW), building upon previous CDC-MOHSW collaborations. This strengthened capacity lays the foundation upon which all other HIV and AIDS interventions are built. Integrating this strengthening within the public health system will ultimately ensure the achievement of GHI goals, especially to promote improved quality of integrated services. The MOHSW now requires targeted support in order to further strengthen their capacity. Key challenges facing the MoHSW include inadequate HRH in epidemiology and laboratory management; a lack of coordinated, timely and accurate monitoring and evaluation (M&E) systems; inadequate services for key populations (KP); and poor quality of infection prevention and control (IPC). This mechanism includes a focus on 1) enhanced field epidemiology and laboratory training of MOHSW staff and others; 2) enhanced evidence-based decision-making through the coordination of resources and the implementation of the M&E Strengthening Initiative Combined Plan; 3) active engagement in integration and regulation of services for HIV prevention, care and treatment for KP; and 4) support of the IPC program. Future strengthening of other partnerships are anticipated, including increased contributions from other funding sources, and greater government buy-in and support of transition plans consistent with the Partnership Framework, resulting in URT ownership of these programs. These programs have nationwide coverage and target HCWs, MOHSW staff, KPs and clinic providers and patients. All programs include process indicators for ongoing M&E.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Malaria (PMI)

Child Survival Activities
Safe Motherhood
TB
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16887**
Mechanism Name:	**MOHSW - Follow On**
Prime Partner Name:	**Ministry of Health and Social Welfare, Tanzania**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	100,000	0

Narrative:

With FY2013 COP funds, PEPFAR/T will continue to provide financial and technical support to the Ministry of Health and Social Welfare (MOHSW) to strengthen national M&E, HMIS and ICT systems, and enhance coordination of Strategic Information inputs across multiple donors and implementers. Through a co-operative agreement with the MOHSW, CDC will provide direct government-to-government funding to the central MOHSW M&E section, including Surveys and Surveillance and HMIS units and the Central MOHSW ICT section.

PEPFAR will build individual, institutional, and organizational capacity in country monitoring and reporting results, support health information systems, strengthen national systems, and conduct related analyses and data dissemination activities.
The MOHSW established the M&E Strengthening Initiative (MESI) to bring together the Global Fund, the Netherlands, PEPFAR and other partner resources, and to coordinate the efforts of multiple implementing partners into one coordinated strengthening initiative. The initiative uses a comprehensive approach to build capacity for evidence-based decision-making, which includes the roll out of new harmonized M&E tools, deployment of DHIS software for enhanced data management, strengthening of data analysis and dissemination capabilities, and longer term support for Strategic Information capacity through the development of In-service and Pre-Service M&E training programs.

The PEPFAR inputs to the MOHSW specifically support coordination of investments through the MESI

and help ensure that the MOHSW is able to provide leadership to all health programs to realize efficiencies and ensure national systems evolve to meet the HIV and other vertical program requirements. HIV/AIDS M&E will be integrated into central MOHSW systems and support analysis and dissemination of evidence to all stakeholders for evidence based decision making. The MOHSW is planning on completing a roll-out of updated and harmonized HMIS tools to all 160 districts by September 2014.
HVSI funding will also support the ICT section to strengthen its capacity to coordinate multiple system investments so that they are “architected” to enable data-sharing and integration across different business functions. The initiative is targeting 2014 for approved e-health infrastructure and enterprise architecture plans for the health sector.

The MOHSW direct cooperative agreement funding complements technical assistance from RTI and the m-health PPP. In addition, the NACP, UCC and the new FY2013 COP TBD, New HIS-UCC Follow On, are all strengthening HIV/AIDS-specific M&E systems, and the MESI will incorporate these into a broader national vision over time. NIMR is also supporting GIS and Master Facility List activities that are also included in the MESI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	100,000	0

Narrative:

In support of both PEPFAR/T and URT priorities that are aligned with the GHI strategy to improve the quantity and quality of the health workforce, the goal of this program is to assist the Ministry of Health and Social Welfare (MoHSW) to ensure that the country has a health workforce qualified to use data for decision-making. This includes the collection and analysis of surveillance data from clinical and laboratory sources. District health staff forms the front line health workforce. They experience the greatest turnover but also the greatest need to understand the collection and appropriate use of health data for decision making. The MOHSW will be supported to design and develop a formal certificate-based in-service training program intended to equip existing health workers with key competencies in epidemiology, surveillance, and lab management. This builds on previous short course training experiences and emphasizes field projects and formal recognition of this training by the MOHSW to ensure that participants utilize new knowledge and skills and are recognized for this capacity. In the FY2013 COP, 80 health personnel from district, regional, and national levels will receive training in these key competencies, and all of participants will be encouraged to conduct field-based projects relevant to key public health issue in their geographic area. Additionally, the program aims to work with the Ministry and its technical support partners to gradually transition full management and coordination of the FELTP

program to the URT, with development of a transition plan as a key outcome of this process.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	150,000	0

Narrative:

Infection Prevention and Control (IPC) is an integral component of quality health care service provision, but there are gaps in the national program, including inadequate health care worker capacity in IPC & quality improvement (QI); inadequate implementation/operationalization of existing post exposure prophylaxis (PEP) guidelines; lack of supportive supervision for IPC; and inadequate infrastructure for safe and appropriate management of medical waste in health facilities. As a result of FY2013 COP funding, the MoHSW will be expected to have systems and capacity in place to prevent transmission of infections through exposure to blood and other body fluids as well as other communicable infections in healthcare settings.

This program will also:
1) Strengthen the capacity of Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs) and Health Management Teams (HMTs) to implement policy guidelines and standards for IPC;
2) Build capacity of the health training institutions to incorporate IPC in their curriculum;
3) Promote universal precautions to reduce risk of medical transmission of HIV by supporting needlestick surveillance, advocating for PEP and hepatitis B vaccination for health care workers, and improving the safety of phlebotomy practices; and
4) Ensure safe and appropriate health care waste and sharps management in high output health care facilities.

PEPFAR/T plans to transition these programs by 2015, which will reinforce country ownership, strengthen the capacity of URT to manage IPC programs, and facilitate transition of project activities to local partners, ensuring the sustainability of IPC interventions without ongoing USG financial support. Finally, PEPFAR/T and the MOHSW will jointly develop a performance evaluation tool to enable national, district and health facility authorities to master IPC indicators.

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

Narrative:

Key populations (KP) are a driver of the HIV and AIDS epidemic, yet they are not receiving adequate preventive and care services due to stigma and lack of targeted interventions. Although health and

non-health personnel are delivering some services through outreach, there is a need for improved MoHSW coordination outside of formal facilities. Through this mechanism, the MoHSW will deliver comprehensive targeted HIV prevention, care, and treatment services to KP, including people who inject drugs, men who have sex with men, and sex workers. Goals include : 1) Ensure an adequate supply of medical commodities unique to KP (e.g. methadone) and those used at a higher rate when serving KP in facilities and programs that provide services to KP; 2) Institute quality assurance mechanisms in services for KP, including accreditation of training curricula and facilities, and supportive supervision of personnel; and 3) Recruit and train health care workers and deploy them to districts to provide specialized prevention and treatment services to KP targeted areas based on epidemiology, and track provision of prevention and treatment services to key populations through the HMIS. The MOHSW will integrate appropriate monitoring and evaluation to reflect KP accessing health services (ART, HTC, TB, among others) for appropriate tracking. This will support country ownership and efforts to achieve PEPFAR's goals.

Implementing Mechanism Details

Mechanism ID: 16891	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16892	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16899	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17082	**Mechanism Name: ASSIST**
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: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,876,514	
Funding Source	**Funding Amount**
GHP-State	2,876,514

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the Applying Science to Strengthen and Improve Systems (ASSIST) project in Tanzania is to support the Ministry of Health and Social Welfare (MOHSW) and Implementing Partners to achieve and sustain delivery of quality HIVAIDS care, through capacity building on applying and adapting modern quality improvement (QI) approaches to care delivery practices. In addition to scaling up QI to new regions, the technical scope of the interventions in the FY2013 COP will be enhanced to test applications of modern QI methods to new program areas, including pediatrics and PMTCT Option B+, to produce additional improvements. These will include testing the application of QI approaches to enhance provider performance in Mtwara, HBC SOPs in Tanga and Morogoro, feasibility of Patient Self Management in ART in Morogoro, and modalities of improving management capacities of CHMTs through application of QI techniques to strengthen district health management performances. Furthermore, ASSIST will assist the MOHSW to roll out, benchmark and improve the quality of OVC services, and assess the quality and impact of integrated PMTCT and RCH services. Throughout the plan period, ASSIST will mainstream gender into all its activities, and partner and leverage resources from other stakeholders to harmonize work and maximize outcomes. ASSIST will capacitate the MOHSW structures to ensure sustainability and strengthen the MOHSW knowledge management system, in order to monitor progress and results of the work plan.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	200,000
Gender: Gender Equality	100,000
Human Resources for Health	600,000
Motor Vehicles: Purchased	60,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Safe Motherhood
TB
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**17082**
Mechanism Name:	**ASSIST**
Prime Partner Name:	**University Research Corporation, LLC**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	100,000	0

Narrative:

"University Research Corporation, in collaboration with the MOHSW and HBC implementing partners (IP), has completed the process of developing Standard Operating Procedures (SOP) for HBC services. As part of SOP development, prototyping of the SOP in Morogoro and Tanga regions is ongoing, to demonstrate and model how its application improves practice and to document associated effectiveness using routine M&E tools. The completion of this endeavor will be followed by introduction and application of the SOP in routine service delivery.

In the FY2013 COP, ASSIST will continue to support the MOHSW and IPs to introduce SOP in service delivery and document resulting care outcomes. This support will provide a formal and standardized mechanism for linking existing non-HIV community-based programs such as family planning, community IMCI, immunization and nutrition. Furthermore, in strengthening the M&E system, ASSIST will continue to support the NACP, IPs and council staff on using the HBC/UWANYU database, as well as on linking routine M&E indicators with client-level program performance measures. The HBC SOP provides detailed descriptions of steps and procedures for providers in performing specific tasks including referrals management, adherence to treatment, and linkages for clients to PLHIV support groups, IGA, family planning and TB clinics to mention a few. It follows that appropriate use of SOP is expected to result in harmonized HBC practices across councils and IPs, improved coordination, and efficient program monitoring and evaluation as well as better health and social outcomes for PLHIV and their families.

In this endeavor ASSIST will collaborate with the NACP's M&E department, HBC IPs and the University of Dar Es Salaam computing centre to train all regional and district HBC coordinators on how to use the HBC/UWANYU database. A total of 155 staff will be trained on HBC/UWANYU database, across 25 regions and around 130 districts in Mainland Tanzania.

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, ASSIST will build the capacity of MOHSW, councils and IPs to be able to measure key HBC outcomes using routine M&E tools.

ASSIST will also support SOP training to national and regional HBC coordinators and trainers from the government and IPs from the remaining 13 regions, using a cascade model in which a national team will train regional teams which in turn 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	253,000	0

Narrative:

"The goal of this project is to strengthen the capacity of the MOHSW, Implementing Partners (IP) and local structures in providing quality care, support and protection of OVC in Tanzania.

ASSIST will continue to provide national level TA to support scaling up and utilizing QI job aides by local structures. Efforts will be directed to skills building for social welfare officers, parasocial workers and other key staff at LGA s, to facilitate effective implementation of national QI guidelines at the service delivery level and to improve data collection and use from MVC registers for planning and decision making.

Support to local multisectoral structures, e.g. MVCC, child protection teams, local CBOs, is key for sustainability, ensuring these structures are capable of mobilizing resources to provide direct social services, and identifying and addressing various issues related to child protection, including violence, abuse, exploitation and neglect; all of which underpin the growth and development of OVC. ASSIST will support teams to identify, plan and implement different changes in accordance to standards, and norms and structures which are to the best interest of OVC.

FY2013 COP funds will go toward enhancing the utilization of available resources for integrating and linking OVC services with other HIV programs such as PMTCT, care and treatment, and HBC, to improve retention but also explore opportunities in other sectors to strengthen the economic capacity of families in caring and supporting OVC and as well as meeting other household basic needs.

Lastly, ASSIST will support gathering evidence and documentation of QI processes on the impact and efficiency of QI models as well as on best practices through mentoring and coaching to local partners and LGA in leveraging resources to avoid duplication of efforts and scaling up in other areas applicable to the context. This will enable local structures to harmonize and utilize tools to document implementation of OVC standards at the 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	1,600,000	0

Narrative:

"In the FY2013 COP, ASSIST will support the MOHSW and IPs to sustainably scale up PMTCT quality improvement services, with a specific focus on Option B+. ASSIST will carry out the process in phases in conjunction with the planned rollout of Option B+ across the country. In the new regions, baseline assessment of the quality of HIV services will be determined to provide initial learning on quality gaps. This will be followed by identification of QI teams in each facility providing PMTCT/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.

ASSIST will train the teams on the use of QI techniques to test changes that provide optimal improvement of PMTCT services. The guiding principles are that good PMTCT services will ensure that all patients in need of ART receive services, that they are retained in services and that they experience good outcomes from the treatment. A modular course of three learning sessions alternating with coaching and mentoring sessions is planned for all teams. During the learning sessions, each facility will share observations of their QI efforts. RHMTs and CHMTs in each region will be trained as program mentors and coaches, and they will facilitate sessions and coaching visits in preparation for transition. It is envisaged that their involvement will increase QI program sustainability while also helping improvement in other programs under their jurisdiction.
"

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	800,000	0

Narrative:

"In the FY2011 COP, University Research Corporation supported the MOHSW to finalize the National QI Guidelines 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, covering so far 12 regions.

In the FY2013 COP, ASSIST will support the MOHSW and IPs to sustainably scale up QI of ART services to new regions. In 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.

ASSIST will train the teams on the use of QI techniques to test changes that provide optimal improvement of ART services. The guiding principles are that good ART services will ensure that all patients in need of ART receive services, that they are retained in services and that they experience good outcomes from the treatment. A modular course of three learning sessions alternating with coaching and mentoring sessions is planned for all teams. During the learning sessions, each facility will share observations of their QI efforts. RHMTs and CHMTs in each region will be trained as program mentors and coaches, and they will facilitate sessions and coaching visits in preparation for transition. It is envisaged that their involvement will increase QI program sustainability while also helping improvement in other programs under their jurisdiction."

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	123,514	0

Narrative:

"In the FY2013 COP, ASSIST will support the MOHSW and IPs to sustainably scale up pediatric quality improvement services. They will build on adult ART QI interventions, and baseline assessments of the quality of HIV services will be determined to provide initial learning on quality gaps in pediatric ART. This will be followed by identification of QI teams in each facility providing pediatric 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.

ASSIST will train the teams on the use of QI techniques to test changes that provide optimal improvement of PMTCT services. The guiding principles are that good pediatric ART services will ensure that all patients in need of ART receive services, that they are retained in services and that they experience good outcomes from the treatment. A modular course of three learning sessions alternating with coaching and mentoring sessions is planned for all teams. During the learning sessions, each facility will share observations of their QI efforts. RHMTs and CHMTs in each region will be trained as program mentors and coaches, and they will facilitate sessions and coaching visits in preparation for transition. It is envisaged that their involvement will increase QI program sustainability while also helping improvement in other programs under their jurisdiction."

Implementing Mechanism Details

Mechanism ID: 17102	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17103	**TBD: Yes**
REDACTED	

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		353,100		353,100
ICASS		780,000		780,000
Institutional Contractors		2,022,920		2,022,920
Management Meetings/Professional Developement		282,700		282,700
Non-ICASS Administrative Costs		575,300		575,300
Staff Program Travel		197,700		197,700
USG Staff Salaries and Benefits		3,012,308		3,012,308
Total	**0**	**7,224,028**	**0**	**7,224,028**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		353,100
ICASS		GHP-State		780,000
Management Meetings/Professional Developement		GHP-State		282,700

Non-ICASS Administrative Costs		GHP-State		575,300

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		43,000		43,000
ICASS		504,000		504,000
Management Meetings/Professional Developement		37,000		37,000
Staff Program Travel		202,000		202,000
USG Staff Salaries and Benefits		680,166		680,166
Total	**0**	**1,466,166**	**0**	**1,466,166**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		43,000
ICASS		GHP-State		504,000
Management Meetings/Professional Developement		GHP-State		37,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing		100,000		100,000

Computers/IT Services	150,000	495,000		645,000
ICASS	200,000	777,419		977,419
Institutional Contractors	1,912,979	891,388		2,804,367
Management Meetings/Professional Developement		5,000		5,000
Non-ICASS Administrative Costs		750,000		750,000
Staff Program Travel	35,000	548,301		583,301
USG Staff Salaries and Benefits	0	3,701,250		3,701,250
Total	**2,297,979**	**7,268,358**	**0**	**9,566,337**

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		GAP		150,000
Computers/IT Services		GHP-State		495,000
ICASS		GAP		200,000
ICASS		GHP-State		777,419
Management Meetings/Professional Developement		GHP-State		5,000
Non-ICASS Administrative Costs		GHP-State	CDC is requesting this amount to cover the following administrave costs - Shippment charges for new USDH and office supplies from	750,000

			the US $ 200K; Utility bills for water, electricity, telephone etc 130K; Printing $ 1,000; Contractual services $ 194,894; Office supplies & materials $ 193K; Furniture & equipment $ 80K.	

U.S. Department of Health and Human Services/Office of Global Health Affairs

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing		20,000		20,000
ICASS		46,000		46,000
Management Meetings/Professional Developement		15,000		15,000
Non-ICASS Administrative Costs		132,000		132,000
Staff Program Travel		60,000		60,000
USG Staff Salaries and Benefits		165,760		165,760
Total	**0**	**438,760**	**0**	**438,760**

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		46,000

Management Meetings/Professional Developement		GHP-State		15,000
Non-ICASS Administrative Costs		GHP-State		132,000

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		71,000		71,000
Total	**0**	**71,000**	**0**	**71,000**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		71,000

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		10,120		10,120
Management Meetings/Professional Developement		18,818		18,818
Non-ICASS Administrative Costs		7,400		7,400
Peace Corps Volunteer Costs		1,905,253		1,905,253
Staff Program Travel		10,000		10,000
USG Staff Salaries and Benefits		348,409		348,409
Total	**0**	**2,300,000**	**0**	**2,300,000**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services	1	GHP-State	IT Equipment & Supplies	10,120
Management Meetings/Professional Developement	3	GHP-State	Meetings & Staff Deevelopmet	18,818
Non-ICASS Administrative Costs	2	GHP-State	Admin & Support Costs	7,400