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2006

Tanzania

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Country Contacts

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Table 1: Country Program Strategic Overview

Will you be submitting changes to your country's 5-Year Strategy this year? If so, please briefly describe the changes you will be submitting.

☑ Yes ☐ No

Description:

While there have been no major alterations to the Five Year Strategy, 2005 has been a turning point for the USG team in Tanzania which warrants some description. The HIV/AIDS team has made great strides in implementing activities that support the Five Year Strategy. This includes significantly expanding access to and provision of ART, extending home-based care (HBC) services in and around clinical sites, increasing services for children made vulnerable by HIV and expanding access to HIV prevention information. All of these advances have been made in close partnership with the Government of Tanzania (GOT).

This considerable growth has been accompanied by several dramatic changes. The USG portfolio is now overseen by a new Ambassador and Deputy Chief of Mission, and the USG team has received new Directors at CDC, USAID, Peace Corps, and in the Office of the Defense Attaché. Leadership changes within the GOT are also anticipated over the next few months and the USG is poised to forge partnerships with these new counterparts. While a change in the GOT will provide new opportunities, it will take time for the cabinet to be formalized, which could present a challenge to moving forward swiftly. However, all of this signals a renaissance for the Emergency Plan and heralds a new era in the battle against HIV/AIDS in Tanzania.

The provision of ART has been slow in Tanzania with full first-line regimens not available nationally until January 2005. Despite this delay, the number of people receiving ART increased from 1,500 in October 2004 to over 14,000 in just ten months. Currently, identifying patients and training the large number of people that will be needed to administer these life-saving drugs remain serious limiting factors. Innovative strategies are being developed through intensive meetings between the GOT, USG and other stakeholders. These strategies must be employed successfully if the USG's goal of supporting 45,000 people on ART by the conclusion of FY06 is to be met. Reaching the GOT's ambitious goal of treating 100,000 patients with ARVs by the end of 2006 will clearly be even more difficult.

Two strategies that the GOT and USG will use to address the human capacity shortage, will be to strengthen the management of health facilities and deploy an emergency action plan for placing unemployed skilled workers, such as retirees, in critical shortage areas. The USG team will consolidate ART expansion to regionally focused areas. Using a "hub and spoke" formula, the USG will be able to reach down from regional hospitals into district and smaller facilities. In sites not supported by the Emergency Plan, the USG will deploy mentors to provide hands-on supportive supervision to health providers as they initiate treatment. The USG will also strengthen the link between HBC and ART programs to formalize the continuum of care, with a coordinated expansion of activities and the development of functional referral networks. This will help solidify a network that reaches beyond the urban centers to patients in their communities.

The USG is pursuing bold new ways of reaching Tanzanians with greater use of mobile VCT and pushing for new guidelines that allow provider initiated/opt out testing at facilities. Prevention programs will increase interventions with high-risk populations and target communities along the transport corridors. AB programs will be significantly expanded with the strengthening of youth focused programs and introduction of a "Zero Grazing" intervention targeting male social norms.

The USG will continue its strong support of the Global Fund and support the GOT in accessing these resources in a timely fashion, moving forward on procurements, ensuring correct quantification, and providing alternative options. Despite the challenges, the USG will build upon its successes and its good relationship with the GOT to forge ahead and meet its Emergency Plan goals.

Table 2: Prevention, Care, and Treatment Targets

2.1 Targets for Reporting Period Ending September 30, 2006

	National 2-7-10	USG Direct Target End FY2006	USG Indirect Target End FY2006	USG Total target End FY2006
Prevention				
	Target 2010: 490,417			
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		213,325	90,000	303,325
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		7,539	4,320	11,859
Care				
	Target 2008: 750,000	146,621	1,624,333	1,770,954
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting peri		31,850	570,150	602,000
Number of OVC served by an OVC program during the reporting period		104,670	1,054,183	1,158,853
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		571,200	100,000	671,200
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		10,101	0	10,101
Treatment				
	Target 2008: 150,000	25,000	20,000	45,000
Number of individuals receiving antiretroviral therapy at the end of the reporting period		25,000	20,000	45,000

2.2 Targets for Reporting Period Ending September 30, 2007

	National 2-7-10	USG Direct Target End FY2007	USG Indirect Target End FY2007	USG Total target End FY2007
Prevention				
	Target 2010: 490,417			
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		264,900	90,000	354,900
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		9,904	4,320	14,224
Care				
	Target 2008: 750,000	239,222	1,542,233	1,781,455
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting peri		54,850	547,150	602,000
Number of OVC served by an OVC program during the reporting period		163,770	995,083	1,158,853
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		772,113	100,000	872,113
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		20,602	0	20,602
Treatment				
	Target 2008: 150,000	50,000	40,000	90,000
Number of individuals receiving antiretroviral therapy at the end of the reporting period		50,000	40,000	90,000

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Targeted Evaluation

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3591
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: AIDS Business Coalition Tanzania

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3654
Planned Funding($): [redacted] B5
Agency: Department of State
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner:

Mechanism Name: ART MIS

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3655
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Counseling and Testing Pilot

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3739
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Male Zero Grazing RFA

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3519
Planned Funding($): [redacted] B
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Orphans Follow On

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3743
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

B5

Sub-Partner: Heifer International
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Sub-Partner: Health Scope
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:
Associated Program Areas: OVC

Sub-Partner: Muhimbili University College of Health Sciences
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:
Associated Program Areas: OVC

Sub-Partner: Faraja Orphans and Training Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Sub-Partner: Umoja wa Majeshi Kibaha, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:
Associated Program Areas: OVC

Sub-Partner: The Mosques Council of Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Sub-Partner: Uhakika Kituo cha Ushauri Nasaha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Sub-Partner: Jipeni Moyo Women and Community Organization
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Sub-Partner: Ikwiriri Mission Clinic and Dispensary
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Alpha Dancing Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Allamano Centre, Iringa
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Evangelical Lutheran Church in Tanzania - South Central Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Lugoda Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Afya Women's Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Patuu
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Diocese of Central Tanganyika
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Tanzania Red Cross Society
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Kikundi cha Wajane Kondoa
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Archdiocese of Mwanza
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Africa Inland Church Health Ministries
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Mwanza Outreach Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Evangelical Lutheran Church in Tanzania - East of Lake Victoria Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Adventists Community Health Outreach Project
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Selian Lutheran Hospital, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Archdiocese of Arusha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Evangelical Lutheran Church in Tanzania - Northern Diocese, Karatu Lutheran Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Mechanism Name: Palliative Care Follow on

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3740
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Police Prevention Program

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3592
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: TBD-FBO Initiative

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2885
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: No

Mechanism Name: USAID TBD (former BBC)

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 4023
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: No

Mechanism Name: Youth

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3492
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: Yes

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes

New Partner: Yes

Associated Program Areas: Other Prevention

Mechanism Name: Zanzibar MARPS

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3603
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: To Be Determined
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2849
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Academy for Educational Development
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3500
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Adventist Development and Relief Agency
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2863
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: African Medical and Research Foundation
New Partner: No

Mechanism Name: USAID

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2852
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: African Medical and Research Foundation
New Partner: No

B5

Sub-Partner: Evangelical Lutheran Church in Tanzania - Selian Lutheran Hospital Arusha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Kigoma Clinic VCT Centre
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Muhimbili Health Information Centre
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Seventh Day Adventist Makao Mapya VCT Site Arusha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Anglican Church of Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Chama cha Uzazi na Malezi Bora Tanzania, Iringa
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Counseling and Testing

Sub-Partner: Evangelical Lutheran Church in Tanzania - South Central Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Uhai Baptist Centre Mbeya
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Upendo Africa Inland Church of Tanzania VCT Site Mwanza
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Africa Inland Church of Tanzania Diocese of Shinyanga
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Moravian Church, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Anglican Church of Tanzania - Diocese of Tanga
Planned Funding:
Funding is TO BE DETERMINED: Yes

New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Peramiho Mission Hospital PMTCT Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT
Counseling and Testing

Sub-Partner: Africare
Planned Funding: $40,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Evangelical Lutheran Church in Tanzania - Southern Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Anglican Church of Tanzania - Diocese of Mara
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Evangelical Lutheran Church of Tanzania, Diocese of Konde
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Evangelical Lutheran Church of Tanzania - Diocese of Karagwe
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Iringa Municipal Centre
Planned Funding:

Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Machame Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Marangu Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Anglican Church of Tanzania - Diocese of Ngara
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Counseling and Testing

Sub-Partner: *Peramiho VCT Centre Songea*
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Singida Town Council
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Sumbawanga Town Council
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Aga Khan Foundation
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Counseling and Testing

Sub-Partner: Kilimanjaro Christian Medical Centre
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: Lindi Town Council
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined

Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Counseling and Testing

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3505
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Africare
New Partner: No

Sub-Partner: Emerging Markets
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Zanzibar NGO Cluster for HIV/AID Prevention
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: Catalyst Organization for Women Progress in Zanzibar
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: Track 1 OVC Additional Funding

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2847
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Africare
New Partner: No

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Sub-Partner: Wamata Pemba Branch
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC
Counseling and Testing

Sub-Partner: Zanzibar AIDS Association for Support of Orphans
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Zanzibar Association of People Living with AIDS
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: Zanzibar NGO Cluster for HIV/AID Prevention
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention
Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Other Prevention

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3555
Planned Funding($):
Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Prime Partner: American International Health Alliance
New Partner: Yes

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Sub-Partner: Muhimbili University College of Health Sciences
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other/policy analysis and system strengthening

Sub-Partner: University of Michigan
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other/policy analysis and system strengthening

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2874
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: American Red Cross
New Partner: No

Sub-Partner: Tanzanian Red Cross National Society
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3578
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: American Society of Clinical Pathology
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3572
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Association of Public Health Laboratories
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2882
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Bugando Medical Centre
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2850
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: CARE International
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount: [redacted]
Early Funding Request Narrative: OVC [redacted] B5

The Tumaini Alliance has been funded since 2004 to provide palliative care and orphan services. The existing agreement ends on March 31, 2006, and will need to be extended until September 30, 2006 to avoid gaps in essential services to over 25,000 orphans. The Mission requests early funding to extend this agreement until the activity can be re-competed in FY2006.

Palliative Care [redacted] B5

The Care/Tumaini Alliance has been supported since FY04. The early end of project date of March 31, 2006, threatens disruption of service to 23 existing sub-grantees and over 15,000 people living with HIV/AIDS (PLWHA) being served by the program. This early funding will extend the current end date until the end of September, 2006. This extension will allow adequate time to re-compete the activity and transfer recipients to the new program without threatening vital services to them.

An assessment was conducted with the assistance of OGAC staff based in South Africa to help inform the new activity. Using the results from the assessment, an updated program will be designed focusing on improving the quality of the interventions as well as defining a more comprehensive program. It is expected that, in addition to taking on new subgrantees, the new program will continue to support existing high performing partners.

Early Funding Associated Activities:

Program Area:OVC
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in palliative care (non-ART); palliative care TB/HIV; and,

Program Area:Palliative Care: Basic health care and support
Planned Funds: [redacted] B5
Activity Narrative: This activity relates to the Care/Tumaini OVC activity supported by the USG. Palliative home-based

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Healthscope Tanzania Ltd
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Heifer International
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Muhimbili University College of Health Sciences
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Faraja Orphans and Training Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Umoja wa Majeshi Kibaha, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: The Mosques Council of Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Uhakika Kituo cha Ushauri Nasaha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Jipeni Moyo Women and Community Organization
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Ikwiriri Mission Clinic and Dispensary
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Alpha Dancing Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Allamano Centre, Iringa
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Evangelical Lutheran Church in Tanzania - South Central Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Lugoda Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Afya Women's Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Pamoja Tujikinge na Ukimwi
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Diocese of Central Tanganyika
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Tanzania Red Cross Society
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Kikundi cha Wajane Kondoa
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Archdiocese of Mwanza
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Africa Inland Church Health Ministries :
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Mwanza Outreach Group
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Evangelical Lutheran Church in Tanzania - East of Lake Victoria Diocese
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Adventists Community Health Outreach Project
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Selian Lutheran Hospital, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Archdiocese of Arusha
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Evangelical Lutheran Church in Tanzania - Northern Diocese, Karatu Lutheran Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2878
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: Track 1 OVC Program

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2873
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Catholic Relief Services
New Partner: No

Sub-Partner: Pastoral Activities & Services for People with AIDS
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Mechanism Name: AIDSRelief Consortium

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2886
Planned Funding($): B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Catholic Relief Services
New Partner: No

Sub-Partner: Interchurch Medical Assistance
Planned Funding: B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: TB/HIV

Sub-Partner: The Futures Group International
Planned Funding: B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Strategic Information

Mechanism Name: AIDSRelief Consortium

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2888
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2898
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Central Contraceptive Procurement
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3582
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Clinical and Laboratory Standards Institute
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2876
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University
New Partner: No

Mechanism Name: UTAP

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2865
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Columbia University
New Partner: No

Sub-Partner: Muhimbili National Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes

New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Bugando Medical Centre
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Kagera Regional Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Sekou Toure Hospital, Mwanza
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Ministry of Health - Zanzibar, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Ocean Road Cancer Institute
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:

Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3547
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Crown Agents
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2857
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Deloitte Touche Tohmatsu
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Palliative Care: TB/HIV

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:

Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Iringa Regional Hospital, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Lugalo Military Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: Pastoral Activities & Services for People with AIDS
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined

Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2875
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Mechanism Name: Project HEART

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2887
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

B5

Sub-Partner: Baylor University, College of Medicine
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Drugs

Sub-Partner: University of California at San Francisco
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Drugs

Sub-Partner: John Snow, Inc.

Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Drugs

Mechanism Name: USAID

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2844
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Sub-Partner: EngenderHealth
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Axios Foundation
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: The Moravian Board of World Mission
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT

Sub-Partner: Newala District Hospital
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Nzega District Hospital
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Anglican Church of Tanzania
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: Kilimanjaro Christian Medical Centre
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner:

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: PMTCT

Mechanism Name: YouthNet

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2869
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Family Health International
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount: [redacted]
Early Funding Request Narrative: AB [redacted] B5

The global YouthNet Cooperative Agreement comes to an end in September '06. To ensure that funds are obligated to the agreement before it closes, early funding is requested so YouthNet can front load many AB activities and assure a timely roll-out and achievement of these activities. This expanded base of activities will also form the springboard for a new Youth RFA which will be competed (Please see the 'To Be Determined – Youth' activity description for details). Early funding will be critical, as it will create a smooth and efficient transition and help the USG team avoid programming gaps.

Other Prevention [redacted] B5
The global YouthNet Cooperative Agreement comes to an end in September 2006. As such, the program has front loaded many activity components in order to assure a timely roll-out and implementation. This activity will form the springboard for a new Youth RFA which will be competed in the coming year (Please see the OP/'To Be Determined – Youth' activity description for details). A smooth and efficient transition is needed to avoid programming gaps.

Early Funding Associated Activities:

Program Area:Other Prevention
Planned Funds: [redacted] B5
Activity Narrative: This activity is related to other activities in Other Prevention, and to activities in AB and OVC.

Program Area:Abstinence/Be Faithful
Planned Funds: [redacted] B5
Activity Narrative: To date, YouthNet/Tanzania (YN/T) has directly reached over 2.25 million young people and 750,000 co

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Sub-Partner: Chama cha Uzazi na Malezi Bora Youth Centre Site
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Sub-Partner: Africare

Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Abstinence/Be Faithful
Palliative Care: Basic health care and support

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2864
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Family Health International
New Partner: No

Sub-Partner: International Center for Research on Women
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Strategic Information

Sub-Partner: Muhimbili University College of Health Sciences
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Strategic Information

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Strategic Information

Mechanism Name: *REDSO Transport Corridor Initiative*

Mechanism Type: *Locally procured, country funded (Local)*
Mechanism ID: 3490
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Family Health International
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2877
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Harvard University School of Public Health
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3621
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Harvard University School of Public Health
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Treatment: ARV Services

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Treatment: ARV Services

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2841
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Henry M. Jackson Foundation Medical Research International, Inc.
New Partner: No

Sub-Partner: Anglican Diocese of the Southern Highlands
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Caritas International
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Iringa Residential and Training Foundation
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: OakTree Foundation
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Serve Tanzania (SETA)
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Service Health & Development for People Living with HIV/AIDS
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Mango Tree
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Evangelical Lutheran Church of Tanzania, Diocese of Konde
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Igogwe Roman Catholic Mission Hospital
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Palliative Care: Basic health care and support
OVC

Sub-Partner: Moravian Church Mission Hospital
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: OVC

Sub-Partner: To Be Determined
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner:

Associated Program Areas: OVC

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3532
Planned Funding($):
Agency: Department of State
Funding Source: GAC (GHAI account)
Prime Partner: International Rescue Committee
New Partner: Yes

B5

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3501
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: International Youth Foundation
New Partner: No

Sub-Partner: Tanzania Red Cross Society
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: CAPACITY

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2866
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2848
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: JHPIEGO
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2856
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: John Snow, Inc.
New Partner: No

Mechanism Name: Deliver

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2853
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: John Snow, Inc.
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2834
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Kikundi Huduma Majumbani
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2881
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Kilimanjaro Christian Medical Centre
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3548
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Kilombero Community Trust
New Partner: Yes

Sub-Partner: Service Health and Development for People Living Positively with
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Counseling and Testing

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Counseling and Testing

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2851
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Lake Tanganyika Catchment Reforestation and Education Project
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2861
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Macro International
New Partner: No

Sub-Partner: National AIDS Control Program Tanzania

Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Strategic Information

Sub-Partner: Ministry of Health, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Strategic Information

Sub-Partner: Tanzania Commission for AIDS
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Strategic Information

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Mechanism Name: M&L

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2862
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Management Sciences for Health
New Partner: No

Mechanism Name: RPM+

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2872
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Management Sciences for Health
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Drugs

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Treatment: ARV Drugs

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2833
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Mbeya Referral Hospital
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2837
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Mbeya Regional Medical Office
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2859
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Medical Stores Department
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3511
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Ministry of Education and Culture, Tanzania
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2893
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Ministry of Health - Zanzibar, Tanzania
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2892
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Ministry of Health, Tanzania
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2883
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Mnazi Mmoja Referral Hospital
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2843
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Muhimbili National Hospital
New Partner: No

Sub-Partner: Muhimbili Health Information Centre
Planned Funding: [redacted]
Funding is TO BE DETERMINED: No
New Partner: Yes

Mechanism Name: Rapid expansion of successful, innovative programs

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2889
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Muhimbili University College of Health Sciences
New Partner: No

Sub-Partner: University of Michigan School of Nursing
Planned Funding: [redacted]
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Other/policy analysis and system strengthening

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2835
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: *GAC (GHAI account)*
Prime Partner: National AIDS Control Program Tanzania
New Partner: No

Sub-Partner: Muhimbili Health Information Centre
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Sub-Partner: Tanzania Youth Aware Trust Fund (TAYOA)
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other Prevention

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2845
Planned Funding($): [redacted]
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: National Blood Transfusion Services, Tanzania
New Partner: No

Sub-Partner: Ministry of Health - Zanzibar, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: *Blood Safety*

Sub-Partner: Tanzania Red Cross Society
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Blood Safety

Sub-Partner: To Be Determined
Planned Funding: [redacted]
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Blood Safety

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2842
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: National Institute for Medical Research
New Partner: No

Sub-Partner: Muhimbili University College of Health Sciences
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: Yes

Sub-Partner: University of California at San Francisco
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Other/policy analysis and system strengthening

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2868
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: National Tuberculosis and Leprosy Control Program
New Partner: No

Mechanism Name: Pact Associate Award

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2836
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Pact, Inc.
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: OVC

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 3745
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Pastoral Activities & Services for People with AIDS
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2871
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Pathfinder International
New Partner: No

Sub-Partner: Interchurch Medical Assistance
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Sub-Partner: Tanzania Red Cross Society
Planned Funding: [redacted] B5
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Palliative Care: Basic health care and support

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2838
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: PharmAccess
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3623
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: Program for Appropriate Technology in Health
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2880
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Regional Procurement Support Office
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2839
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Rukwa Regional Medical Office
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2840
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: Ruvuma Regional Medical Office
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3502
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Salesian Mission
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3506
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: Salvation Army
New Partner: No

Sub-Partner: Pact, Inc.
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: OVC

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 2899
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Sanquin Consulting Services
New Partner: No

Mechanism Name: Policy Project

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3616
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: The Futures Group International
New Partner: No

B5

Sub-Partner: Christian Council of Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Other/policy analysis and system strengthening

Sub-Partner: National Muslim Council
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:
Associated Program Areas: Other/policy analysis and system strengthening

Sub-Partner: Ministry of Justice and Constitutional Affairs, Tanzania
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No
Associated Program Areas: Other/policy analysis and system strengthening

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: Other/policy analysis and system strengthening

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 3538
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: University of Medicine and Dentistry, New Jersey
New Partner: Yes

B5

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2901
Planned Funding($):
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: University of North Carolina Carolina Population Center
New Partner: No

B5

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Strategic Information

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Strategic Information

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Strategic Information

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: Strategic Information

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2900
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: University Research Corporation, LLC
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2903
Planned Funding($): [redacted] B5
Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: Base

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2907
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Base (GAP account)
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: Country staffing and TA

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2894
Planned Funding($): [redacted] B5
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2895
Planned Funding($): [redacted] B5
Agency: Department of Defense
Funding Source: GAC (GHAI account)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, country funded (HQ)
Mechanism ID: 2905
Planned Funding($): [redacted] B5
Agency: Department of State
Funding Source: GAC (GHAI account)
Prime Partner: US Department of State
New Partner: No

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2891
Planned Funding($): [redacted] B5
Agency: Peace Corps
Funding Source: GAC (GHAI account)
Prime Partner: US Peace Corps
New Partner: No

Mechanism Name: N/A

Mechanism Type: Headquarters procured, centrally funded (Central)
Mechanism ID: 3504
Planned Funding($): [redacted]
Agency: U.S. Agency for International Development
Funding Source: N/A
Prime Partner: World Vision International
New Partner: No

Sub-Partner: To Be Determined
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding: [redacted]
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Sub-Partner: To Be Determined
Planned Funding: [redacted]
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: Abstinence/Be Faithful

Mechanism Name: N/A

Mechanism Type: Locally procured, country funded (Local)
Mechanism ID: 2908
Planned Funding($):
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Prime Partner: Zanzibar AIDS Commission
New Partner: No

able 3.3.01: Program Planning Overview

Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01

Total Planned Funding for Program Area: [redacted]

B5

Program Area Context:

PMTCT services in Tanzania have seen a significant increase in both geographic coverage and institutional capacity over the past two years. Support from USG has aided the Government of Tanzania (GOT) in expanding PMTCT services to cover 75 districts within the 21 regions on the mainland and the five in Zanzibar. Currently the USG supports over 281 facilities, contributing to over 80% of FY05 expansion through direct support at points of service. As a result of this expansion, 42,000 women received PMTCT services and over 2,500 received a complete course of ARV prophylaxis.

With assistance from the USG, the MOH has developed National PMTCT guidelines, implemented a PMTCT monitoring system, and institutionalized a national PMTCT training curriculum. Similar support to the Zanzibar AIDS Control Program has led to the formation of a fully functioning national PMTCT coordinating unit. Though an aggressive expansion for PMTCT was planned, prior to 2005, PMTCT services were not linked to the national ART roll out. Recently, the PMTCT unit of the MOH has been moved under the National AIDS Control Programme in charge of ART implementation to facilitate this need for coordination and strengthen linkages between the two efforts.

Despite documented improvement of PMTCT services by individual sites, nationally service uptake is still slow. Data from the Tanzania Demographic Health Survey and Tanzania HIV/AIDS Indicator Survey 2003-2004 indicate that women attending ANC have an HIV prevalence of 9.6% and even though 94% of women attend an ANC at least once during their pregnancy, only 5% access PMTCT services. With an observed vertical transmission of nearly 40%, 72,000 HIV-infected infants are expected among approximately 143,000 births annually. Other confounding factors include low promotion of health facility deliveries (43%) and poor partner and community involvement. In addition, mother-infant pair follow-up post delivery and poor referral systems between ANC and HIV Care and Treatment Centers (CTC) still remains an issue.

To overcome these challenges and align with the USG Five Year Strategy, activities in FY06 include supporting the MOH geographic coverage strategy with an improved linkage to ART roll out both through national coordination and direct strengthening of points of service. The USG will provide direct technical support to the PMTCT national coordinating unit to strengthen national and zonal/regional technical committees and work with the MOH to optimize treatment regimens and update current guidelines. USG's GOT and NGO partners will work to sensitize communities to increase service uptake, promote partner counseling, and reduce stigma. In collaboration with the WHO, the USG is working with the MOH to develop training for traditional birth attendants, sensitizing them and communities as to the benefits of PMTCT and promoting facility based deliveries. Across the continuum of care the USG will continue to support the MOH in efforts to move towards an "opt out" approach in counseling and testing, increasing the number of women and their children who will benefit from PMTCT services. USG ART partners are also playing a role by formalizing linkages for patients identified through PMTCT services to CTC at their sites. This will ensure follow up of HIV+ women and their infants for ongoing monitoring and staging for treatment eligibility.

Though the USG is the major donor supporting PMTCT efforts, several other donors contribute to improvement of these services in Tanzania including the German Technical Cooperation and UNICEF. However, these organization's efforts are regionally focused with limited service provision. The USG will maintain a platform to enhance donor and partner collaboration and influence PMTCT policies and strategies at a national level. Activities in FY06 will contribute to the USG's continued support of the national goal of reaching 80% of HIV sero-positive pregnant mothers by 2008.

Program Area Target:

Number of service outlets providing the minimum package of PMTCT services according to national or international standards	426
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	9,904
Number of health workers trained in the provision of PMTCT services according to national or international standards	1,055
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	264,960

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: PharmAccess
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3393
Planned Funds: [redacted] B5
Activity Narrative: This activity relates to activities in treatment (PharmAccess).

The Tanzanian Peoples Defense Forces (TPDF) has a network of eight military hospitals through out the country, supporting a total of over 40,000 enlisted personnel and an estimated 60,000 dependents. The services at these hospitals are not limited to the military or their dependents with 80% of their patient load attributable to the civilian populations surrounding the facilities. Of these eight hospitals, seven offer district level services with the largest hospital, Lugalo, located in Dar es Salaam serving the role of a national referral center for military medical services. Strengthening of HIV/AIDS prevention and care and treatment programs with the TPDF and at military health facilities not only targets the high-risk, uniformed population but also their dependents and other civilians from the surrounding communities.

The TPDF and PharmAccess, a large not-for-profit organization based out of the Netherlands, have developed a strong working relationship over the past four years in the area of health service provision. PharmAccess is experienced in providing management services, products and technical assistance supporting HIV/AIDS care and treatment in resource poor settings in collaboration with governments, donor organizations, NGOs, and corporations through out Africa. In Tanzania, it has also been working directly with the MOH in implementing MTCT-plus programs in several referral hospitals and in May 2004, became the official implementing partner of the Tanzanian National AIDS Control Programme (NACP), overseeing site evaluation and readiness for national ART roll out.

In FY03 the TPDF started offering PMTCT at Lugalo Hospital, provided with technical support from Muhimbili National Hospital. With Emergency Plan FY05 funds, the TPDF is introducing these services in three additional regional military hospitals (Mbeya, Mwanza and Morogoro). These sites were chosen to assure that TPDF was contributing to national expansion, and prioritizing sites where ART would be initiated concomitantly. These activities are only now beginning due to the late arrival of funds.

Under this submission, PharmAccess will work with the TPDF to strengthen and expand PMTCT services at the military treatment facilities in Mbeya, Mwanza and Morogoro. In addition, PMTCT services will be initiated at the four remaining regional military hospitals in Arusha, Tabora, Ruvuma and Zanzibar. Services will include routine, opt-out pre-test counseling (group and individual) in both ANC and as an integral part of labor and delivery. Those testing negative will be given primary prevention counseling. HIV positive mothers will receive posttest "prevention for positives" counseling and information on care and treatment services. These women will be encouraged to bring in family members (especially partners) for counseling and testing (C&T) at either the ANC or the hospital's VCT center.

All eight TPDF regional hospitals will be included in FY06 plans for C&T, PMTCT, TB and ART services thereby ensuring a comprehensive approach to clinical HIV prevention, care and treatment. All HIV-infected women will be referred for further evaluation and qualification for TB treatment and ART within each facility. Those not qualifying for ART will be provided SD NVP for mother and infant and encouraged to return to the hospital for delivery. Mother and infant will then be referred for care, including pediatric follow up care with cotrimoxazole and serologic diagnosis. HIV positive mothers will be provided with infant feeding counseling options (AFASS) and for those choosing breastfeeding, counseled to exclusively breast feed with early weaning.

The introduction of opt-out C&T in January 2005 has proven very effective at Mwenge Maternal Child Health Centre, the ANC serving the Lugalo Hospital, This strategy has led to a very high (95%) uptake of PMTCT services at this site. Thus, this strategy will be introduced at all military sites providing HIV services. In FY06, it is anticipated that a total of 5,000 pregnant women will be counseled and tested at the eight sites combined, 300 (6%) of which are expected to test positive and receive full prenatal and delivery PMTCT services (including their children) over a twelve month period by September 2007. Of those identified positive, approximately 20 will contribute to the treatment numbers for the TPDF.

This funding will fully develop PMTCT services in the network of eight military hospitals, and will rely upon staff at the Mwenge MCH Center providing technical support to newer sites. Funding will support the introduction and improvement of PMTCT services which will include initial (or refresher) training of three health care workers per site,) construction or renovation of counseling and delivery rooms, procurement of test materials and protective safety gear, and community education efforts to increase access to services and partner testing. NVP will be procured through the Boehringer donation.

Expansion of PMTCT activities in FY06 will ensure a close linkage of military implementation to national strategies and programs supporting MOH goals of providing this service to 80% of the projected HIV positive mothers by 2008. Funding for the TPDF through PharmAccess will provide much needed technical support, management assistance and M&E for all TPDF activities in this COP. The military referral hospital in Dar es Salaam, Lugalo Hospital, will serve as the coordinating body for services and over see quality assurance following national standards. Additional support for military facilities in Mbeya and Ruvuma will be provided by the US Department of Defense field office overseeing civilian based activities in these regions.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	8	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	300	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	21	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	5,000	☐

Target Populations:

Infants

Military personnel (*Parent:* Most at risk populations)

Pregnant women

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Dar es Salaam

Mbeya

Morogoro

Mwanza

Arusha

Songea Urban

Tabora

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Rukwa Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3398
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in treatment (Rukwa).

Rukwa is one of four regions in the Southern Highlands which also includes Iringa, Mbeya and Ruvuma and is served by the Mbeya Referral Hospital for all its advanced care and supervisory needs. This referral hospital works in concert with but not over the regional medical offices. The Rukwa Regional Medical Office (Rukwa RMO) supports the implementation of prevention, care and treatment programs throughout its region, providing funding and supervision to the regional hospital and district level facilities. This includes supporting direct care services, providing quality counseling and testing (C&T) and PMTCT services, and strengthening referrals between facilities and services. As part of the network of care in the Southern Highlands, activities in this submission will build upon a comprehensive program throughout Mbeya, Ruvuma and Rukwa under the supervision and support of the Mbeya Referral Hospital and the US Department of Defense (DoD).

Over the past year, the MOH began expansion of PMTCT programs into the Rukwa Region. This region, in part due to its geographic isolation in the far southwest of the country, still has nascent PMTCT services as part of its public care provision. There is not ANC data on HIV prevalence among pregnant women in this region, so the national estimate of 9.6% will be used in determining approximate number of HIV+ women who will qualify and be served with full PMTCT services. In support of PMCTC expansion, FY06 funding will be provided to the Rukwa RMO for modifications to ANC infrastructure at the Nkasi District Hospital. This will include the support for the training of six counselors at the ANC at each facility and integration of PMTCT services as part of regular antenatal care. Similar infrastructure modifications and training as part of FY05 support are just been initiated at the regional hospital due to the late arrival of funds. Continued funding in FY06 EP directly to the Rukwa Regional Medical Office supporting point of service provision will complement both MOH and USG efforts at the national level.

Community education and mobilization initiated in FY05 will continue to be undertaken in FY06 as part of provision of this service in the region. Uptake targets include 3,000 pregnant women for counseling and testing with approximately 150 women participating in full PMTCT services from these three sites in a twelve month period by September 2007. Assessment for further expansion of this service in Rukwa will be conducted as part of comprehensive HIV clinical services roll out and in support of national PMTCT expansion plans.

Services will include pre and post test counseling. Those testing negative will be given education on protective measures and practices for avoiding infection. Mothers found to be HIV positive will be provided with post-test counseling, provided "prevention for positives" information and education on the benefits of NVP prophylaxis. These women will be encouraged to bring in family members for counseling and testing at either the ANC or the hospital's VCT center. HIV positive mothers will also be provided with infant feeding counseling options (AFASS) and for those choosing to breastfeed, counseled to exclusively breastfeed with early weaning.

As part of the continuum of care, HIV positive women identified at these centers will be referred for evaluation for full ART at the respective HIV Care and Treatment Centre (CTC) at the facility, with support for these services and strengthening of the referral system as part of the activities undertaken under treatment activities. Their infants will be followed for the first 18 months for monitoring, cotrimoxazole treatment and serologic diagnosis. Those not qualifying for ART will receive NVP

prophylaxis upon onset of labor and their infants PEP within 48 hours of delivery from the PMTCT centers. Direct technical assistance and oversight will be provided by the Mbeya Regional Medical Office and Mbeya Referral Hospital and through collaboration with the DoD. Both of these Mbeya facilities are very experienced and successful in implementing nationally sanctioned PMTCT programs. This program will be integrated into the national effort over the course of FY06.

Funds in this submission will support national MOH contributions to expanding PMTCT in this region for commodity procurement for services including reagents for confirmatory diagnostics and safety kits for delivery, technical assistance, referral mechanisms, community mobilization efforts, and contribute to national M&E. NVP will be provided through the MOH and Boehringer donation.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	3	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	150	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	8	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	3,000	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Rukwa

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ruvuma Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3402
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in treatment (Ruvuma).

Ruvuma is the second of the four regions in the Southern Highlands, which includes Iringa, Mbeya and Rukwa, to be included as a prime partner for PMTCT under the US Department of Defense. As with Rukwa, the Mbeya Referral Hospital supports Ruvuma for all its advanced care and supervisory needs, working in concert with but not over the regional medical office with the later supporting direct implementation of prevention, care and treatment programs throughout its region. Situations surrounding HIV services in Ruvuma are very similar to Rukwa and development of PMTCT services will mirror plans for Rukwa. Both are geographically isolated areas of the Southern Highlands and lacking support for basic, let alone more complex, services. Programs in all three regions (Mbeya, Rukwa and Ruvuma) supported through the US Department of Defense (DoD) are implemented in a coordinated and almost parallel fashion, directly supporting the MOH's desire for donor agencies to undertake a more regional focus in developing networks of care.

As with the Rukwa Region, the Ruvuma Region still has only nascent PMTCT services as part of its public care services. In support of national expansion desired by the MOH, direct Emergency Plan funding in FY06 to the Ruvuma Regional Medical Office will augment MOH support of PMTCT at the Ruvuma Regional Hospital in Songea and the Tunduru District Hospital. There is not ANC data on HIV prevalence among pregnant women in this region, so the national estimate of 9.6% will be used in determining approximate number of HIV+ women who will qualify and be served with full PMTCT services. This program will be integrated and reflect the current national program and not be a stand alone, isolated effort. This effort is to assist the capacity of the MOH to expand these services throughout new regions in FY06.

Funding in FY05 will support renovation of the ANC, training, community education/mobilization efforts and commodities procurement for the Regional Hospital. This implementation has just been initiated due to the late arrival in funds for FY05. In FY06 modifications to clinic infrastructure at Tunduru will be conducted to allow integration of this service into regular antenatal care. Three counselors per site, for a total of six, will be trained in basic PMTCT services following national guidelines. Community education and mobilization under FY05 funding will be supported into FY06 as part of necessary implementation of this service in the region to encourage uptake. With similar numbers accessing ANC services at the regional hospital and demand for PMTCT as high as in Rukwa, it is estimated that this program will also be able to target 3,000 pregnant women for counseling and testing with approximately 120 to 150 women participating in full PMTCT services from these three sites by September 2007.

Services will include pre and post-test counseling (group or individual). Those testing negative will be given education on protective measures and practices for avoiding infection. Mothers found to be HIV positive will be provided with post test counseling, provided "prevention for positives" information and education on the benefits of NVP prophylaxis. These women will be encouraged to bring in family members for counseling and testing at either the ANC or the hospital's VCT center. HIV positive mothers will be provided with infant feeding counseling options (AFASS) and for those choosing to breastfeed, counseled to exclusively breastfeed with early weaning.

Again, as with Rukwa, since these services will be introduced at the regional hospital, HIV positive women will be evaluated for full ART at the regional hospital with support for these services and strengthening of the referral system as part of

treatment activities. Those not qualifying for ART will receive NVP prophylaxis upon onset of labor and their infants PEP within 48 hours of delivery from the PMTCT centers. Infants will be referred for pediatric follow up care with cotrimoxazole and serologic diagnosis.

Introduction of PMTCT at a time that ART is introduced at the regional hospital is critical in ensuring a continuum of care and a means of identifying potential patients. As part of implementation of the network model, with higher level or better equipped facilities providing technical oversight, the Mbeya Regional Medical Office, Mbeya Referral Hospital and the US Department of Defense supported efforts in care and treatment in the Southern Highlands will provide direct assistance to Ruvuma in the implementation of this and other aspects of prevention, care and treatment as they are introduced and expanded in the region. This program will be integrated into the national effort over the course of FY06.

Funds in this submission will support national MOH contributions to expanding PMTCT in this region for commodity procurement for services including reagents for confirmatory diagnostics and safety kits for delivery, technical assistance, referral mechanisms, community mobilization efforts, and contribute to national M&E. NVP will be provided through the MOH and Boehringer donation.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	3	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	150	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	6	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	3,000	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Gender

Coverage Areas

Ruvuma

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Harvard University School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3414
Planned Funds: [redacted]
Activity Narrative: This activity relates to scaling-up of the MDH program including Muhimbili University College of Health Sciences (MUCHS), the Dar es Salaam City Council, and the Harvard School of Public Health (HSPH). As a result of PEPFAR-related activities, a strong collaboration currently exists between MUCHS, Dar es Salaam City Council and HSPH in the provision of PMTCT services. With FY06 funding, we will continue to expand on this collaboration through PMTCT activities at Antenatal clinics (ANCs) within the Dar es Salaam region.

B5

Clinic and labor ward staff at eight large antenatal clinics in the three municipalities of Dar es Salaam will receive training to ensure that all patients are offered testing for HIV and PMTCT services within the national guidelines. Activities proposed at these sites include strengthening counseling and testing (C&T) services in the clinics, provision of counseling on safe infant feeding practices for HIV positive women, enhancing referral systems to ensure care and treatment for pregnant HIV positive women, provision of regular training to clinic and labor ward staff to ensure that all women are offered testing for HIV and PMTCT services within the national guidelines, and post-partum HIV treatment at the MDH supported sites.

Additional activities include the provision of refresher training for physicians, nurses, and midwives. Throughout the year other identified staff will be provided training on various aspects of HIV care and treatment. This training program will emphasize provider initiated counseling and testing, as well as counseling on infant feeding and nutritional support. Furthermore, linkages and referral systems among various stakeholders particularly in the area of home based care will be improved. Lab related diagnostic services will be provided at district level sites, which have sufficient capacity to conduct these tests. HIV-positive pregnant women will be given first preference when they are referred to all MDH sites for care and treatment.

In order to reduce stigma and discrimination towards PLWHA, we will seek to increase the number of community care and support groups for PLWHA and use the existing system to actively mobilize the community to seek PMTCT services at all sites. Quality control systems will be put in place to ensure that patients receive high quality care at all times, as well as follow up.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	6	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	950	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	50	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	8,500	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Gender

Coverage Areas

Dar es Salaam

Morogoro

Table 3.3.01: Activities by Funding Mechanism

Mechanism: USAID
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3415
Planned Funds:
Activity Narrative: EGPAF is the major USG technical assistance provider and implementer of PMTCT/PMTCT+ and works within the MOH national program. In addition to expansion, efforts this year will focus on quality, linkages, M&E, and networks of higher and lower level facilities to serve larger populations. EGPAF works with multiple sub-partners, including FBO, NGO and MOH (district hospital) partners. The PMTCT program will be programmatically and geographically linked to care and treatment programs carried out either by EGPAF's HEART project or other care and treatment programs funded through the USG /MOH partners. The PMTCT program will also be linked to local community based OVC, Home based care and other HIV programs in the geographic locations in which they will work.

B5

Currently, EGPAF supports PMTCT services in 124 health facilities, located in 17 districts in 8 regions of the country. All these sites are implementing a PMTCT package of services. Multiple sites are clustered within four regions: Tabora; Arusha; Kilimanjaro and Morogoro. Building on the first two years of experience in the implementation of PMTCT and Care and Treatment in Tanzania, EGPAF will continue to coordinate and implement the PMTCT program to increase access and quality of PMTCT services dramatically, integrate services into routine Reproductive Child Health Services (RCHS) and provide care, support, and treatment for women, children and their families in selected current and in new project sites.

To expand access, EGPAF proposes expansion of support of PMTCT services to 6 additional districts. This expansion will be through providing additional sub grants to districts health authorities, FBOs and/or other NGOs to strengthen facility infrastructure for better quality PMTCT services. Strengthening activities will include: infrastructure improvement based on needs, renovations (counseling rooms, labs, delivery areas), and equipment (eg. laboratory, delivery sets and/or beds, furniture) and computers for better record keeping and communication.

In addition to expansion to new districts, EGPAF also plans to expand to strategically selected dispensaries and health centers in district where we are currently working, based on location and high patient load (# deliveries) to increase access at local level. Access to PMTCT will be augmented by ensuring that in project sites, all pregnant women attending ANC are offered opt-out C&T at ANC, in the labor ward and in the postnatal clinic. The EGPAF PMTCT program will continue to promote point-of-service rapid testing with same day results (Capillus, Determine). This will contribute to increasing the uptake of not only testing, but also ART prophylaxis for PMTCT.

Currently, the MOH advocates the use of single dose (SD) NVP. This approach is simple, has the least cost and is easier to implement. The EGPAF program will make sure it continues to access the AXIOS NVP donation program and will assure NVP availability at sites. EGPAF will continue to work with AXIOS in promoting the innovative approach and use traditional birth attendants (TBA) to reach out to HIV-positive women who deliver at home and who would like to access PMTCT services. The PMTCT program will continue to promote this approach, while working with MOH to consider more efficacious regimens (AZT + SD NVP; HAART for eligible women, in accordance with evolving international guidelines). Where there are ART sites, major emphasis will be placed on trying to implement CD4 screening for pregnant women and treatment of those eligible, and screening and referral for post delivery care of women not screened earlier.

EGPAF will continue to improve the quality of PMTCT services and will help develop a PMTCT quality assessment tool. EGPAF aims to have 90% of women agree to be counseled and tested and 80% of mothers and 75% infants get their NVP dose. To

facilitate this, the following components will be supported: community approaches such as the use of TBAs; promotion of male involvement; identification, follow up and care (including cotrimoxazole) of HIV-exposed infants; and follow-up of mothers).

It is expected that with current and new sites, a total of 296 sites in eight regions (including Tabora, Mtwara, Arusha, Kilimanjaro, Tanga, Dodoma, Singida, and Morogoro) will be supported in providing PMTCT services by the end of FY2007. Together they will counsel and test 115,000 pregnant women. At least 330 service providers will be newly trained in PMTCT service provision and an additional 270 health care providers will receive additional PMTCT related trainings. Health care providers trained will include doctors, nurses, midwives, and laboratory technicians. Training will cover both public and private health care workers.

In five of the current PMTCT supported sites, EGPAF proposes to support the care and treatment provided at the sites. A model on how PMTCT and Care and Treatment teams can work together has been developed and will be piloted, and shared with other USG partners. The exposed children with their HIV infected mothers will be followed up at the MCH clinic for normal under five (U5) child care, vaccinations and HIV care (for mother and if necessary for child) till they are tested at 15-18 months, unless either the mother or child is eligible for treatment. Polymerase Chain Reaction (PCR) for early HIV diagnosis will be utilized as soon as it is operational at Kilimanjaro Christian Medical Center (KCMC) to assist with HIV diagnosis in babies. A team consisting of MCH service providers and CTC service providers will be formed to work together to provide care and treatment and smooth referral between the service provision sections, and mechanism to track clients will be developed. The program expects to put 800 adults and 200 children on ART in the 5 sites within the next year, 90% of these coming directly from the PMTCT sites. Activities will be training of health care providers, supportive supervision, improvement of infrastructure and community mobilization. EGPAF will help implement the USG PMTCT-MS (monitoring system) which the MOH has adopted as national system. EGPAF will work closely with USG PMTCT and SI groups to support and evaluate this system in the field.

EGPAF will work with local partners to ensure community mobilization activities will be carried out in the new districts to sensitize and increase acceptance, demand and uptake of the services and to reduce stigma. Gender issues will be addressed as there will be a focus on involving men and providing support to young women

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	296	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	4,600	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	330	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	115,000	☐

Target Populations:

Community leaders
Faith-based organizations
Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
Traditional birth attendants (Parent: Public health care workers)
Infants
Non-governmental organizations/private voluntary organizations
Pregnant women
Program managers
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
Religious leaders
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Traditional birth attendants (Parent: Private health care workers)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Arusha

Dodoma

Kilimanjaro

Morogoro

Mtwara

Singida

Tabora

Tanga

Table 3.3.01: Activities by Funding Mechanism

Mechanism: USAID
Prime Partner: African Medical and Research Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3432
Planned Funds:
Activity Narrative: This activity links to activities in counseling and testing (AMREF) and treatment.

B5

African Medical Research Foundation (AMREF) is an independent non for profit NGO that aims to improve the health of disadvantaged people in Africa and support Reproductive Health programs in Tanzania. AMREF provides grants and technical assistance to NGOs, FBOs and government facilities to establish and provide VCT services, and brands these sites "ANGAZA" (meaning "shed light " in Kiswahili). AMREF also provides services that guarantee quality VCT. Over 65% of sub-grantees are FBOs. In 2005, AMREF introduced and integrated PMTCT services to six of the facilities that provide VCT 'as a pilot' PMTCT initiative. A slow start marked the implementation of this program and by the third quarter, 1,717 women (out of the 15,000) had received PMTCT services. AMREF shall continue to support theses sites and ensure the services are integrated into routine Reproductive Child Health Services (RCHS). The PMTCT program will not expand to new sites in FY 06/07 and mechanism will be instituted to transfer the support of these of facilities to Elisabeth Glaser pediatric AIDS Foundation (EGPAF).

In FY06 AMREF aims to have 9,500 women in target sites receive HIV counseling and testing results and 703 women receive a complete course of ARV prophylaxis. AMREF will build the capacity of 175 service providers through training in its state of the art training facility at AMREF headquarters. AMREF will use and help evaluate the new USG counseling and testing provider materials being finalized at the end of 2005, and will help MOH update PMTCT counseling and testing guidelines.

AMREF PMTCT program will work with the MOH and stakeholders to ensure that the majority of women attending AMREF supported facilities have increased access to PMTCT services consistent with the MOH approach. Pregnant and women attending ANC, labor wards and postnatal clinics will be offered counseling and testing in an "opt-out" approach. The AMREF PMTCT program will continue to promote point of service rapid testing with same day results (Capillus, Determine). This will contribute to increasing the uptake of not only testing but also ART prophylaxis for PMTCT. AMREF will continue using its innovative demand creation branding 'ANGAZA' to promote PMTCT messages for the targeted populations. Finally supportive supervision in PMTCT using community own resource persons (CORPS) will be carried out for appropriate referrals to Post Test Clubs. Several commodities will be procured to enable sites to provide quality services including, HIV test kits, antiseptics, swabs, vacutainers, infant feeding demonstration sets and supplies for infection prevention.

Currently, the MOH advocates the use of single dose (SD) Nevirapine. This approach is simple, has the least cost and is easy to implement. The program will make sure it accesses the AXIOS NVP donation program and make sure its sites do not run out of NVP tablets and syrup. The PMTCT program will continue to promote and advocate this approach and work with the MOH in its move to explore and adopt more efficacious regimens. AMREF will also work with MOH to look at possibilities of new initiatives to adopt more optimal ARV regimen that are more efficacious and address the health of the HIV infected mom (as advocated by WHO). All efforts will be made to link HIV positive mothers to sites that provide care and treatment including ARV services. PMTCT sites will be strengthened to be able to provide basic services and make appropriate referrals for preventive therapy, management of opportunistic infections and work-up for ART. Site strengthening will include growth monitoring equipment such as weighing scales and length boards at the RCH clinics. Babies born to HIV positive mothers will be followed up and those that showing clinical signs of pediatric HIV complications, fail to thrive or are found to be HIV positive will be referred so that they can get the additional services. The project will ensure

availability of cotrimoxazole drugs and the possibility of providing fluconazole will be explored. Counseling and referrals for infant feeding will be promoted using the national guidelines. Establishment of HIV diagnosis for infants and children will be in line with MOH recommendations. Strong efforts will be made to follow HIV-exposed infants with care and diagnosis. PCR for early HIV diagnosis will be utilized as soon as it is operational at a nearby zonal referral facility to assist with HIV diagnosis in babies.

All PMTCT sites will have appropriate educational materials including pamphlets and brochures. They will also be equipped with TV sets, and have video tapes all with appropriate PMTCT messages either from local or international sources. Couples counseling will receive special attention this time around, especially given sero-discordant rates and the need for family-centered approach for Care and Treatment. Family planning options for positives (concordant and discordant) will be made available including male & female condoms and demonstration items that go with them.

The program will ensure proper documentation and record keeping will be facilitated by providing the sites with record books and cabinets. AMREF will be work with the MOH to support the paper based reporting as well as the electronic version of the system. Monitoring the quality of the PMTCT service will be done through supportive supervision as well as periodic anonymous and client exit surveys. AMREF will work with other partners to carryout mid-term evaluation of the PMTCT program in FY06.

PMTCT is an entry point to HIV prevention, care and treatment is linked to many initiatives that AMREF and other partners are implementing. In particular: palliative care and Post test clubs, ARVs, and care and treatment. Other services include: education and legal, psychosocial and nutrition will continuously be accessible through use of post-test support groups.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	6	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	803	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	175	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	10,860	☐

Target Populations:

Infants

Pregnant women

Women (including women of reproductive age) (Parent: Adults)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Iringa

Kagera

Mara

Ruvuma

Njombe

Makete

Karagwe

Biharamulo

Bunda

Songea Rural

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Bugando Medical Centre
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3485
Planned Funds:
Activity Narrative: As part of the USG strategy to support the national effort of decentralization and geographical focus, USG has established a cooperative agreement with Bugando Medical Centre (BMC) hospital to facilitate PMCT rapid scale-up and to build the capacity of the hospital to provide technical assistance for zones in FY06. Though this strategy was initiated in FY05 due to delayed funds, this activity will be carried out in FY06 with FY05 funds.

In FY06, Bugando Medical Centre will establish a Centre of Excellence for expansion of PMTCT services in the lake zone of Tanzania mainland covering six regions; Mwanza, Kagera, Mara, Shinyanga, Tabora and Kigoma. BMC FY06 plans include the improvement of Reproductive and Child Health Services (RCHS) for the provision of prevention of mother to child transmission of HIV infection in new and existing PMTCT sites within target regions. BMC will enhance the continuum of HIV/AIDS prevention, treatment, and care services for people living with HIV/AIDS (PLHA) through the network model by linking PMTCT services with other initiatives. BMC will also support the focal regions to improve laboratory services at the zonal level; and provide a basic health care package to HIV positive pregnant women and establish priority referral systems to care and treatment clinics for HIV + eligible pregnant women.

With these funds Bugando medical centre will provide PMTCT training for at least 50 health care workers (including refresher training and continuing medical education) and support Regional and Districts Health Management Teams to strengthen and improve logistic systems to ensure regular supplies of health supplies for PMTCT services.

This support will contribute to the PEPFAR prevention goal by significantly increasing the number of women accessing PMTCT within the lake Zones; thereby reducing vertical transmission. This activity will identify the HIV sero positive women that require care and treatment and will significantly enhance the number of individuals on treatment through referral directly into ART programs in particularly PMTCT+.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	6	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	403	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	50	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	8,400	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Kagera

Kigoma

Mara

Mwanza

Shinyanga

Tabora

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Mnazi Mmoja Referral Hospital
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	3488
Planned Funds:	

Activity Narrative: Mnazi Mmoja hospital (MMH) is linked to the College of Health Sciences as a teaching hospital as well as serving as a referral Hospital for both Islands of Unguja and Pemba and identified to be among the centers of excellence in Tanzania. As part of the USG strategy to support the national effort of decentralization and geographical focus, USG has established cooperative agreement with MMH in FY05. The focus and strategy of USG in FY06 is to facilitate PMCT rapid scale up and to build the capacity of the referral hospital to provide technical assistance for zones. Though this strategy was initiated in FY05 due to delayed funds, this activity will be carried out in FY06 with FY05 funds.

In FY06 MMH will be establishing a Centre of Excellence for expansion to PMTCT services in Zanzibar covering all five regions in the Islands of Unguja and Pemba. This will include the improvement of the Reproductive and Child Health Services (RCHS) to ensure the prevision of quality PMTCT. This will be done through provision of technical assistance and close supportive supervision. MMH will play a leading role in enhancing the provision of care and treatment for HIV sero-positive mother-infant-pair through the network model and linking PMTCT services with other initiatives; including the provision of a basic care package to HIV sero-positive pregnant women and referrals of eligible HIV+ pregnant women to antiretroviral therapy ART services.

MMH will train national trainers of trainers (TOT) to support and scale up the national PMTCT training plan and provide direct technical assistance for the zonal training efforts. This funding will also go to support regional and district health management teams to strengthen and improve logistics systems in order to ensure regular supplies and commodities for quality, safe and clean deliveries. MMH will play a role in reinforcing the zonal PMTCT coordination and will facilitate monthly zonal PMTCT committees meetings. In addition, MMH will enhance and strengthen the PMTCT services in the hospital, training/retraining up to 30 service providers in FY2006 and 50 in FY2007 and establishing quality assurance system within the PMTCT services at facility level through supportive supervision and refresher training throughout the island.

This activity will contribute to the PEPFAR prevention goals and will increase significantly the number of pregnant women accessing PMTCT and thereafter will reduce mother to child transmission of HIV. HIV sero-positive pregnant women identified through this programs will be referred to care and treatment programs and thereby will contribute to PEPFAR care and treatment goals.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards	50	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑

Target Populations:

People living with HIV/AIDS

Pregnant women

HIV positive infants (0-5 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3501
Planned Funds:
Activity Narrative:

B5

In FY05 MOH has expanded PMTCT services with both government and FBOs from 33 sites in 10 regions to 67 sites in 15 regions, and integrated the PMTCT services within routine reproductive and child health care services. Out of the 67, the USG directly funds 57 sites. Among other achievements, the MOH has renovated hospitals to ensure confidential counseling and testing and procured supplies and equipment to ensure safe and clean deliveries. In addition, with the USG support the MOH has trained 108 trainers of trainers (TOT) and 636 service providers and deployed them within 46 new sites. Moreover, with FY05 funds 31,337 pregnant women were counseled and tested in FY05 and national guidelines were printed and distributed to 84 implementing districts to ensure quality service provision. Furthermore, with the USG funds the MOH has carried out community sensitization in 9 regions and developed information, education and communication materials and disseminated these materials to 33 implementing sites in 9 regions.

Despite these achievement, the PMTCT programs have faced challenges including, low nevirapine (NVP) uptake, poor partner involvement, poor mother-infant follow up, lack of comprehensive care and treatment for mother-infant and stigma and discrimination against HIV sero-positive women. Additional challenges in FY 05 included coordination of the multiple implementing partners', inadequate human resources and low access to antiretroviral (ARV) for HIV sero-positive mothers and infants.

To overcome these challenges the MOH strategy in FY06 is to strengthen PMTCT national systems and to continue with the geographical coverage. The system strengthening will include the finalization of the national PMTCT monitoring system (MS); this system will ensure accurate and quality data collection. The finalization process will include revising the current ANC and labour and delivery registers, monthly summary forms and instructions. The MS application component will also be upgraded and installed at the central office and thereafter will be expanded to a few selected districts. Up to 25 trainers will be trained to scale up the system at district level by the end of the FY06. To ensure quality service the MOH in close collaboration with USG technical team will revise and update the current PMTCT guidelines, and will develop a quality assurance system including supportive supervision tools. Furthermore, with FY06 funds, the MOH is planning the development of a 5 year PMTCT strategy and evaluation plan and will carry out annual program review by August FY06.

To increase service uptake, adherence and to reduce stigma and discriminations against HIV sero-positive mothers-infant pairs the PMTCT coordination unit, in close collaboration with the National AIDS Program, will design effective community sensitization activities including development and printing of IEC materials and intensive community campaigns. These activities will be carried out within the implementation regions and district.

With the FY06 funds the MOH will adapt the WHO/USG PMTCT generic training package. This activity will include the formation of a technical working group which will consist of bi/multilateral, NGO, FBO and the USG will play a technical role. The current national training manuals will be reviewed and analyzed and thereafter harmonized with the WHO/USG generic package, field tested and rolled out.

To ensure effective overall program coordination, in FY06 MOH will organize and facilitate quarterly partner coordination meetings and PMTCT technical subcommittee annually at national level. Regional/district level, national PMTCT coordination unit will continue working closely with the Regional/District AIDS and Reproductive

Child-health Coordinators.

To increase service availability and geographical coverage, the MOH objective is to establish PMTCT services within 25 district hospitals by September 2007. To achieve this objective, MOH will carry out facility based needs assessment, train and deploy at least 100 service providers, renovate facilities to ensure counseling and testing and sensitize 50 service supervisors and health management personnel. MOH will also procure supplies and equipment including delivery kits and protective care and test kits/reagents to ensure safe and clean deliveries.

With FY06 funds, the MOH will provide PMTCT services to 85,200 women who will be counseled and tested. The USG support will significantly increase the number of women accessing PMTCT at the national level and will directly contribute to the overall reduction of mother to child transmission and will contribute to EP prevention goal. This activity will contribute to the PEPFAR care and treatment as they identify HIV sero-positive women, children and their families that require care and treatment and will be referred to ART programs.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	82	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	1,940	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	100	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	98,400	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health - Zanzibar, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3503
Planned Funds:
Activity Narrative: Zanzibar is a separate Republic with a separate Ministry of Health and has a population of 1 million with estimated 2% prevalence and 10,000 of women delivery annual; 98% of pregnant women are registered with ANC. Zanzibar situation is different from the mainland, there are only 9 hospitals in the island, the plan is to reach 100% geographical coverage by 2007 and provide counseling and testing for 80% pregnant women attending ANC. There is a strong commitment from MOH to reduce the transmission of mother to child.

B5

USG support has been a cornerstone for the initiation of PMTCT/PMTCT+ services in Zanzibar. In FY05, Zanzibar AIDS Control Program (ZACP) has established full functioning PMTCT Coordinating unit and appointed national coordinator and two zonal coordinators. Furthermore ZACP has trained and deployed 60 PMTCT service providers and established three PMTCT services, two referral hospitals and a health centre. As a result a total of 1,012 pregnant women received counseling and testing for PMTCT. In addition, ZACP with close collaboration with the USG has carried out a baseline assessment for Behavior Communication for Change (BCC) and initiated the development of national PMTCT guidelines and training package.

The overall ZACP objective is to scale up PMTCT services and reach 80% of pregnant women in order to provide quality PMTCT and PMTCT+. With this objective, ZACP's proposed activities for FY06 are to strengthen the quality of existing PMTCT services and to expand the services to additional 6 health facilities by August 2006.

The FY06 funding will directly support training for service providers and program supervisors as well as renovation of counseling and testing rooms, basic laboratory, antenatal clinics and labour and delivery wards. In addition, basic protective gear and supplies will be procured to ensure safe and clean delivery. To ensure effective national program coordination this funding will also go to support the training and deployment of supporting personnel within the PMTCT coordinating unit. The role of the coordination unit is to oversee the national program and provide technical assistance for the regions and districts to expand services. The PMTCT national unit will conduct quarterly meetings to ensure partner coordination at national level and will carry out mid-term program review in collaboration with the USG technical team by the end of the fiscal year.

The proposed activities in FY06 also include the training of 120 service providers. In addition, 1200 health workers, community leaders, traditional birth attendance (TBA) and traditional healers will be sensitize to decrease stigma and discrimination associated with the disease. To ensure accurate quality data collection ZACP, in close collaboration with USG technical team will develop and institutionalize a national PMTCT monitoring system (MS). Up to three data managers will be trained on the new PMTCT MS and 30 PMTCT service providers will be oriented. Furthermore, ZACP FY06 plans also include the development of quality control system including supportive supervision tools. To improve and ensure the provision of comprehensive care for HIV sero-positive mother and infants, ZACP will develop effective follow-up and referral system.

To promote the service availability, increase uptake and to address stigma associated with the disease, ZACP will use this funds to develop effective strategies including information, education and communication material. These materials will be printed and disseminated within the implementing zones.

With FY06 funds the ZACP will reach 9800 pregnant women which will account 70% of the new ANC attendees in the implementing sites and will provide a minimum

package of PMTCT. In addition, 598 mother-child-pairs will receive nevirapine (NVP) prophylaxis. As part of implementation of the network model, USG will provide direct assistance to ZACP in the introduction and the implementation of care and treatment services within this facility in order to provide comprehensive care for eligible HIV positive mothers and infant.

USG support will significantly increase the number of women accessing PMTCT services in urban and rural population and thereafter will contribute the national and the PEPFAR strategy to reduce mother to child transmission of HIV infection. This activity will identify the HIV+ women, children and members of families that require care and treatment and will enhance the number of individuals on treatment through priority referrals and networks to the ART program.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	12	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	598	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	150	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	9,800	☐

Target Populations:

Infants

Pregnant women

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Kusini Pemba (Pemba South)

Kaskazini Pemba (Pemba North)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: University Research Corporation, LLC
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3510
Planned Funds: [redacted]
Activity Narrative: URC's Quality Assurance Project (QAP) finalized the integrated set of job aids on infant feeding counseling in the context of HIV/AIDS by seeking input from all key stakeholders in Tanzania and technical reviewers around the world. A high-level of consensus-building and acceptance of the materials was achieved. Subsequently over 300,000 copies of the materials were printed and distributed within Tanzania.

B5

QAP designed a job aids based training on infant feeding counseling in the context of HIV/AIDS. This consists of Training of Trainers, and transfer training. The training is targeted for health workers in RCH, and Maternity and Pediatrics Departments in facilities ranging from regional hospitals to dispensaries. The training curriculum is based on the drafts of the nationally adapted WHO/UNAIDS/UNICEF manual: Breastfeeding Management and HIV and Infant Feeding. The course has been adapted to provide technical updates on international guidelines on infant feeding in the era of HIV, train providers on effective use of the job aids for counseling all mothers on positioning and attachment, exclusive breastfeeding, and steps in counseling an HIV positive mother to assist her to make informed choices on infant feeding options. Training with job aids allows for consistency in messages and reduces training time.

QAP trained 60 trainers on infant feeding from all the regional and district hospitals in 3 regions - Morogoro, Tanga, and Kilimanjaro. Prior to the job aids based training there was a pool of 24 graduates of the WHO/UNAIDS/UNICEF course on HIV and infant feeding in Tanzania; only a few had been actively training. The trainers used the job aids to conduct transfer training of staff in-facility and in the peripheral facilities (health centers and dispensaries) in all districts in a given region. More than 180 providers were trained using the job aids during Phase I.

In all regions direct planning with pMTCT providers (MoH, EGPAF, AXIOS, Columbia) resulted in a high-level of cooperation for the training. Invitations to the trainings were channeled through the partners for sites supported by them.

With FY06 funding URC will conduct the following activities: (1) a workshop with national partners to review the training experience in Phase I; and (2) revision of the training strategy and curricula to center on a whole facility approach. The following components are being developed: 4 day training for Infant Feeding Counseling; orientation to providers; sensitization for administrators.

URC will also consolidate training achievements in the 3 regions: update the trainers with revised packages and facilitate in-facility transfer training in regional hospitals and the district hospitals where pMTCT services are provided, provide technical support to improve supervision, put M&E plan in place, and scale up the job aids based training to include Dar es Salaam, Iringa, Mwanza, Tabora, and Mtwara regions.

QAP will also continue working closely with all pMTCT service providers (MoH, Medecins du Monde, AMREF, Columbia University, EGPAF and sub-grantees AXIOS Foundation and EngenderHealth). We aim to provide technical support to pMTCT partners so that counseling with the job aids becomes part and parcel of service delivery at all pMTCT sites. Based on consensus-building and a concerted effort in forging partnerships, all of these partners have requested the job aids based training on infant feeding for the trainers/supervisors from their sites. Partners have noted and are concerned about the poor quality of infant feeding counseling and the need to address the high prevalence of mixed feeding.

During FY06 we will conduct training as requested by Medecins du Monde in Kagera

Region. MDM is supporting training to involve all district hospitals. We will also conduct training as requested by AMREF for staff from their 6 sites. This training will take place in Dar es Salaam and will include trainers from Amana Hospital. The supervised transfer training will include providers at health centers in Ilala District. A monitoring and evaluation plan is being devised and will be put in place. The M&E plan will fit into routine tracking of pMTCT service delivery. We will also provide technical support to trained facilities to improve supervision, and conduct in-depth evaluation of the impact of the job aids on counselors' skills and mothers' knowledge and behavior.

In addition to these activities, URC will assess the possibility of developing complementary materials to be used during routine group health talks at RCH clinics (flipcharts, posters and a video), developing flipchart training materials for in-facility training, and introducing the job aids and training into the pre-service environment (certificate and diploma nursing schools).

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑

Target Populations:

Public health care workers

Private health care workers

Coverage Areas

Dar es Salaam

Iringa

Kagera

Kilimanjaro

Morogoro

Mtwara

Mwanza

Tabora

Tanga

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 3518
Planned Funds: [redacted] B5
Activity Narrative: During the next fiscal year, HHS/CDC will continue to collaborate closely with the Government of Tanzania, Ministry of Health (MOH), and other key partners to further strengthen technical and program capacity for implementing the Emergency Plan. This will include the establishment and expansion of quality-assured national systems in the areas of surveillance, prevention of mother to child transmission (PMTCT), laboratory services, blood safety and blood transfusion, antiretroviral treatment, care and TB/HIV programs.

HHS/CDC provides direct technical support for all of its HIV/AIDS programs through US and Tanzania based organizations, which manage and implement in-country activities. These activities are funded through cooperative agreements and are performed at the field level in direct partnership and collaboration with Tanzanian governmental and non-governmental organizations. The non-governmental implementing partners have considerable experience in the field of HIV/AIDS and have established offices in Tanzania to carry out these activities. The technical assistance (TA) and support provided by HHS/CDC through our cooperative agreements will ensure a long-term sustainable system for providing HIV/AIDS services to Tanzanians.

In FY06, this funding will support the in-country PMTCT program staff and fund TA from CDC Headquarters. TA will be provided to support the roll out of the PMTCT monitoring system on the mainland; to the MOH and Zanzibar Aids Control Programme (ZACP) for the adaptation of the PMTCT training curriculum on both the mainland and Zanzibar; and for the development of quality assurance methods such as supportive supervision for all programs. In-country program staff will work with the MOH to develop national PMTCT strategies and protocols, support the national PMTCT implementation plan by helping the MOH/ZACP develop an annual work plan and to conduct site visits to observe service provision and monitor cooperative agreements to ensure appropriate program implementation.

Emphasis Areas	% Of Effort
Human Resources	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of *PMTCT services according to national or international standards*		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: International Rescue Committee
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 4904
Planned Funds: [redacted] B5
Activity Narrative: The activity is related to Counseling and Testing.

Refugees in Tanzania are among the most restricted in the African Great Lakes region. They are not allowed to travel beyond 4km from camp and rely entirely upon services provided by implementing partners of the United Nations High Commission for Refugees (UNHCR) for their livelihoods. With 2006 funding the International Rescue Committee (IRC) will provide PMTCT services to a population of more than 75,000 refugees and approximately 4,000 local Tanzanians in the Kibondo district of Tanzania.

According to 2003 Sentinel Surveillance information, the prevalence of HIV among refugees in the Kibondo area is between 3.0% and 4.8%. In 2004, a total of 4,462 pregnant mothers were counseled and tested (99% of antenatal clients). A total of 46 were HIV positive, and all accepted ARV prophylaxis. In the first 6 months of 2005, 1,801 antenatal mothers and 1,478 (88%) spouses were counseled and tested. The PMTCT program has also significantly increased demand for overall VCT services in the camp by raising awareness and decreasing stigma. Further funding will be critical in providing services to all refugees at risk from MTCT in Kibondo and will significantly contribute to data collection critical for strategic decision-making, both in Tanzania and Burundi.

IRC has provided services to refugees in Tanzania since 1996. It is UNHCR's main implementing partner for health in Kibondo, serving the three largest camps in the area: Karago, Mtendeli, and Nduta, as well as providing health services at the Kibirizi transit site. IRC also takes referrals from the other two camps in Kibondo--Kanembwa and Mkugwa--and from the border transit points. IRC started the PMTCT program in 2004 with USG funds. Currently, four service outlet sites provide the minimum package of PMTCT services according to national standards. Each has a VCT site specifically targeting the pregnant women and their spouses under the PMTCT Program. Based on the number of clients served in 2004 and 2005, approximately 3,000 to 3,500 women are expected to receive PMTCT services in 2006.

IRC provides comprehensive services including: counseling and testing for both mothers and their spouses, provision of Nevirapine tablets to the mothers found positive at 36 weeks of gestation, conducting modified delivery practice - non rupturing of membranes, no episiotomies during delivery, and provision of nevirapine syrup to the newborn babies. Counseling on infant feeding is provided during the antenatal period, and mothers who opt not to breastfeed are supported with infant formula. IRC utilizes community outreach activities to raise awareness of HIV/AIDS and the importance of minimizing the vertical transmission of HIV from mothers to their newborn babies. Community sensitization by community health workers and community and religious leaders are promoted regularly. When a client tests positive, he/she is encouraged to join a post-test club. Health workers provide treatment for opportunistic infections, and refugees are supported with supplemental food rations. Male involvement is emphasized through awareness campaigns and male clubs in an effort to fight stigma and enhance partner support in caring for the newborns delivered by HIV-positive mothers.

IRC will improve the availability of rapid test kits and train eight additional HIV counselors to address staff turnover and improve counseling capacity. There will be two new counselors per each PMTCT site. IRC will provide supplies for the PMTCT program including procurement of ARVs (Nevirapine tablets for HIV-positive mothers and syrup for newborn babies of these mothers), syringes, safety boxes, sterile

gloves, antiseptics and other essential supplies. IRC will also improve the supply of the drugs to prevent and treat opportunistic infections.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	4	☐
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	50	☐
Number of health workers trained in the provision of PMTCT services according to national or international standards	20	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	3,000	☐

Target Populations:

Mobile populations (Parent: Most at risk populations)

Refugees/internally displaced persons (Parent: Mobile populations)

Key Legislative Issues

Gender

Wrap Arounds

Stigma and discrimination

Coverage Areas

Kigoma

Kibondo

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	University of Medicine and Dentistry, New Jersey
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	4906
Planned Funds:	[redacted]

B5

Activity Narrative: A key component of the USG strategy is to support the national PMTCT programs in Tanzania and Zanzibar by developing and institutionalizing sustainable, efficient and quality systems including monitoring system. This strategy includes the development, implementation and evaluation of a national PMTCT training curriculum and revising and updating the national PMTCT guidelines.

Through a series of debriefing and consultative meetings between Ministry of Health mainland and Zanzibar, WHO and USG, there is a growing consensus regarding the need to adapt the WHO/USG PMTCT Generic Training Package for mainland Tanzania and at the same time review and update national PMTCT guidelines. In addition, as Zanzibar began PMTCT services in FY05 without specific guidelines and training manuals, the Zanzibar AIDS Control Program (ZACP) has identified the development of a national PMTCT training package and guidelines as priorities for their program.

In FY05, FXB, in close collaboration with USG, began providing technical assistance to the Zanzibar PMTCT Coordinating Unit to initiate the development of PMTCT policy guidelines and an in-service training package. Thus far, FXB has assisted the MOHSW to work closely with the newly-formed Technical Working Group (TWG) in Zanzibar. The TWG, consists of bi/multilateral and NGO partners and ensure that the content of the training package and guidelines are directly responsive to the needs and context of Zanzibar. The primary role of the TWG is to provide oversight and coordination in the curriculum and policy guidelines development process. FXB with close collaboration with the USG PMTCT team has developed a draft training strategy and curriculum. FXB has conducted an in-country consultation with the PMTCT Technical Working Group (TWG) to ensure that the draft policy guidelines and curriculum are current and relevant for Zanzibar and the training of service providers.

The current PMTCT guidelines in Tanzania, which are also used in Zanzibar, were developed in 2001, prior to the availability of ART and before international recommendations for combination PMTCT prophylaxis and based on single-dose nevirapine or short-course AZT. FXB has carried out in-depth analysis of the guidelines and found that it is crucial to update the counseling and testing section and include content on stigma and discrimination and home-based care. The FY06, funding will therefore support the updating of the national PMTCT guidelines for Tanzania and Zanzibar by August 2006. The updated guidelines will be based on the recent WHO PMTCT guidelines and will reflect options for PMTCT prophylaxis and care and treatment including ARV for HIV sero-positive pregnant women.

This funding will also support the finalization of the national training packages, which will address the basic training needs of PMTCT service providers and will include: participant and trainer manuals, presentation booklet, wall charts and pocket guide and flipcharts for counseling and health education. The wall charts, pocket guide and flipcharts will be made available in both English and Kiswahili. This training package will be supported through a training roll-out plan that complements and suggests courses to update and refresh basic content and to fulfill the unique needs for additional training by sub-sets of PMTCT service providers, including nurses, midwives, counselors, laboratory technicians and physicians. Nationally, an estimated 300 PMTCT service providers will be trained in FY06 with this training package including national Trainers-of-Trainers (TOT).

In order to develop the content of each module/chapter of the curriculum and guidelines, FXB will employ and assign technical leads and provide technical assistance for the in-country TWG. The content will then be reviewed and the draft will be pilot- tested to assure reliability, applicability and suitability, by healthcare services

providers. Finally, the training package components will be revised based on the pilot test outcomes and submitted to the MOH for final approval and production.

FY 06 funding will also go to evaluate the effectiveness of the training provision and to develop a basic training follow-up system to ensure quality service provision. FXB will also provide ongoing direct technical assistance for the overall national PMTCT training efforts at the national level.

The USG contributes to over 80% of the national PMTCT expansion and service provision in Tanzania. As the PMTCT program continues to scale-up and with PMTCT becoming an important entry point for care and treatment, USG in country team and the MOH have identified a mid-term program review as a high priority. This review would assess, coverage, quality of the program, key issues related to integration with care and treatment and coordination among USG partners and additional partners in the national effort.

This review will be critical for strengthening the USG PMTCT/PMTCT-Plus program; establishing mechanisms for quality assurance, promoting better planning for upcoming COP cycles, and helping Tanzania Government and USG accelerate towards their stated goals of 80% program coverage by 2008. This review would be carried out in conjunction with the USG HQ PMTCT/Pediatric, TWG, and PMTCT national committee. FXB's role will be to coordinate the overall activity, plan, design and facilitate in close collaboration with the USG and government of Tanzania.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national or international standards		☑
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national or international standards	50	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑

Target Populations:

Public health care workers

Private health care workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas:

National

Table 3.3.02: Program Planning Overview

Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: *02*

Total Planned Funding for Program Area: [redacted]

B5

Program Area Context:

In FY06, the USG program will build upon the success of its existing AB prevention activities. Results from the 2003-04 Tanzania HIV/AIDS Indicator Survey show that Tanzania is making progress in key prevention indicators, as evidenced by an increase in age at first sexual intercourse among women and men.

The USG is currently implementing an AB program that operates on multiple levels: improving the national level coordination of behavior change activities and messages, supporting behavior change through media campaigns and community level interventions through NGOs and FBOs, and weaving prevention messages and skill-building throughout the prevention/care continuum. Through these activities, a number of key results have been achieved in promoting AB messages, including reaching 2.7 million individuals through 108 community programs and training 1,748 individuals to provide HIV/AIDS education on AB prevention.

The USG will continue to expand its portfolio to fill programmatic gaps, while initiating activities to proactively address challenges. The USG team recently undertook an extensive strategic planning process to identify the program's barriers and to develop a strategic vision for AB. This exercise identified lapses in documentation of best practices and the overall coordination of interventions. Though youth focused programs are providing increased national coverage, many key target audiences continue to be under-served, and a number of important social norms, such as partner reduction/faithfulness, need further emphasis.

A number of strategic activities have been identified to build on the USG program's successes while addressing barriers and gaps. Coordinating and maximizing the contribution of all USG efforts, including the growing number of local sub-grantees and the large number of central awardees, has proven to be a challenge. In FY06, this will be addressed by utilizing an existing USG youth program that will be expanded to take a national-level coordination role. This will enable the USG to track each partner's efforts while ensuring that all partners have the capacity to implement and evaluate effective behavior change communication programs.

A new youth AB program will broaden the impact of the USG's AB efforts. This will include activities to specifically address the need for stronger community level interventions and work with influencers/gatekeepers (i.e. parents, teachers). Lessons from USG efforts in FY04 and FY05 will be built upon in FY06 to strengthen local involvement through community programs focusing on capacity building among young boys and girls and their influencers utilizing skill building workshops and peer support groups promoting AB behavioral choices. A direct partnership with the Ministry of Education will expand coverage to the under-served primary school population, and build the life skills of both teachers and students.

A new intervention in FY06 targeting men will address the "Be Faithful" aspect of the AB platform by specifically addressing male social norms through a community-based Tanzania specific 'Zero Grazing' intervention. This activity will identify factors that influence multiple partnering in Tanzania. It will also engage men in promoting fidelity among their peers as well as address social norms to discourage multiple partnering and cross-generational sexual practices.

Mass media programs will be utilized to link AB prevention messages to community level efforts. The efficiencies and reach of mass media is an important part of an overall mix of communications approach. Reinforcing mass media with activities that build skills through community interventions targeting the individual in promoting behavior change will be a key emphasis throughout the program's FY06 portfolio. This comprehensive USG effort will train 15,026 individuals in implementation of AB prevention programs and target over four million individuals with A, AB or B interventions.

Program Area Target:

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	4,451,192
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	1,634,742
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	15,026

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Kikundi Huduma Majumbani
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3374
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in treatment (MRH, MRMO, Rukwa), counseling and testing (MRH, MRMO, Rukwa), and palliative care (KIHUMBE, HJFMRI)

B5

Kikundi Hunduma Majumbani (KIHUMBE) has worked in close concert with the Mbeya Regional AIDS Control program since 1991, augmenting MOH prevention efforts through out the Mbeya Region. KIHUMBE continues to be at the forefront of prevention education in the region and is poised to begin to support other smaller groups in providing fact based, AB messages. In FY06, KIHUMBE will be concentrating its efforts strictly in the 36 wards of the Mbeya municipality where it is now part of a capacity building program of a Mbeya Network (Network) of other NGO's and FBO's in the region, all with similar missions and programs supporting community education. Technical assistance and training will be provided to groups throughout the region with FY06 funds, and will expand the impact of this program beyond the urban setting.

This local NGO will expand on previous AB education programs with a deliberate intent of working with the theme of "Know the Facts" specifically by producing new dramas, songs and other communication tools to inform individuals about gender and legal rights in addition to messages on prevention through AB. The Evangelical Lutheran Church of Tanzania (ELCT) through their Local Community Confidence Building program will conduct a training program for KIHUMBE and the other Network members. The training will teach organizations how to sensitize communities on the legal rights of PLWHA and OVC. The ELCT's Local Community Confidence Building has provided education in legal literacy as part of their platform for the past two years and uses local legal organizations and firms in the training to provide up-to-date factual information and assistance in understanding the laws and issues that affect OVCs and PLWHA. KIHUMBE and the Mbeya Network consider inclusion of legal rights education as part of any prevention platform as a reinforcement of empowering people, especially young girls and women.

The 20 well-trained members of the KIHUMBE drama group will support the production of 40 education programs that range from drama and music presentations to audience dialogues and personal testimonies. These productions will reach approximately 100,000 individuals within their communities. The education presentations will not only focus on AB messages and gender and legal rights; but will also include messages on VCT and the importance of knowing one's serostatus. This will serve as a link between community prevention programs, counseling and testing at Mbeya public health facilities nearby and palliative services, including support programs for PLWHA, provided by KIHUMBE and Network member organizations.

As a follow up and reinforcement of messages provided as part of community programming, KIHUMBE will also undertake at least 20 targeted educational presentations at primary and secondary schools. Through this activity they anticipate reaching an audience of 20,000, providing a chance to complement their community focused programs and reach the same youth in several venues for reinforcement of AB messages. In addition, this will provide an additional tool for school counselors and teachers to use to supplement HIV education and prevention efforts in their classrooms. Currently, Students Partnership Worldwide (SPW) has had its college bound volunteers working in many of the primary and secondary schools in Mbeya providing fact based, HIV education about HIV/AIDS and AB. As these volunteers head for colleges and universities, these primary and secondary schools will have no specific HIV/AIDS educational programs between September and January. KIHUMBE will span this gap at these schools and will build upon the excellent work of SPW student volunteers.

KIHUMBE will also take advantage of Radio Mbeya, which presently broadcasts only within the municipality. They will produce 30 radio programs which will be broadcast every other week and will include drama, testimonies, and music as part of public service announcements further promoting the "Know the Facts" campaign.

KIHUMBE will closely support members of the Network in their various educational events and instructing them on how to tailor each program to suit the given audience. KIHUMBE will conduct two trainings for the members of the various groups in the Network to up-date and reinforce their skills and creativity in presenting AB messages to youth and young adults. Up to 40 members of Network organizations will be trained by KIHUMBE in effective implementation of AB programs. Combined, the Network members will undertake 24 to 36 presentations by September 2007 with an average audience of 500 or a total target of 18,000. The Network members outside of the Mbeya Municipality who benefit from this training and will be able to better design and present programs relevant to their rural communities.

Funding will support transport of drama group members and educational personnel to communities and schools for events, cost of conducting the events, educational material for distribution, costs associated with advertising and development of new material, program planning, and the training of other Network members in improved AB messaging and ongoing technical assistance and support to these groups.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	118,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	20,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	40	☐

Target Populations:

Adults

Faith-based organizations

Teachers (Parent: Host country government workers)

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Key Legislative Issues

Stigma and discrimination

Gender

Coverage Areas

Mbeya

Rukwa

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National AIDS Control Program Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3381
Planned Funds: [redacted]
Activity Narrative: This activity is linked to activities in Other Prevention and other Abstinence and Be Faithful activities.

B5

The Tanzania Youth Awareness Trust Fund (TAYOA) program is an important component of the NACP and USG's approach to reaching youth with Abstinence messages for children attending Madras, Sunday schools and other religious studies. In FY05, the NACP run TAYOA "Helpline" program took a total of 98,000-recorded calls and more than 170,000 questions on abstinence and faithfulness, counseling and testing, ART, VCT, PMTCT and general HIV/AIDS questions. The frequently asked questions were compiled in an audio-visual presentation and disseminated to schools and out of school youth through the National HIV/AIDS Helpline Clubs. TAYOA will scale up and continue supporting 30 Helpline Clubs in primary schools, secondary schools, institutions of higher education and communities to reach 600,000 youth in Dar es Salaam, Coast region and Zanzibar in FY06.

In FY06 TAYOA will also produce a series of dramas, skits and debates that center around abstinence and faithfulness themes; and are based on the Ministry of Education and Culture's (MOEC) Life Planning Skills behavior change program (see MOEC activity narrative for more information on this program). The Life Planning Skills program promotes abstinence until marriage and is funded in part by the Melinda and Bill Gates Foundation. It uses a series of events that attract students to discuss AB related issues.

In the rural coastline area along mainland Tanzania and in parts of Zanzibar TAYOA will train 20,000 peer educators, community leaders and community theater groups to produce AB educational dramas. TAYOA will also produce music that promotes the rights of young girls and discourages early marriage, initiation ceremonies that push young people to have sex, young girls having sex with older men, female genital mutilation, and stigma and discrimination.

TAYOA will also partner with 6 religious schools to introduce monthly magazines that will be produced and disseminated locally by Parents School Committees, students and religious leaders. The monthly magazines will address HIV/AIDS issues with an emphasis on AB messages and will be disseminated in churches, mosques and strategic locales such as bus stands, markets and health centers. With USG funds, TAYOA will reach an estimated 600,000 youths mainly supported by young peers who will be attending editorial monthly meetings to discuss the content and topics of the messages that will be shared.

The National AIDS Helpline Clubs will collaborate and network with 10 FBOs and 16 NGOs, as well as the private sector partners that are members of the AIDS Business Coalition. The Helpline will also produce and disseminate 1,000 T-shirts with AB messages, 3,000 car stickers, 2,000 flyers, and 3,000 posters during national and local festivals and national events in collaboration with these partners.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	500,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	100,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	400	☐

Target Populations:

Adults

Business community/private sector

Faith-based organizations

Policy makers (Parent: Host country government workers)

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Caregivers (of OVC and PLWHAs)

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Key Legislative Issues

Gender

Volunteers

Stigma and discrimination

Coverage Areas

Dar es Salaam

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

COAST

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Academy for Educational Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3425
Planned Funds: [redacted] B5
Activity Narrative: This activity is linked to activities in AB (new TBD that was formerly BBC, Youthnet, Male Involvement TBD and OP under TCI, Police and PharmAccess.)

AED works through a locally registered organization, Tanzania Marketing and Communications Incorporated (T-MARC) that is dedicated to promoting healthy behaviors through increased access to HIV/AIDS products and information. In addition to activities described under 'Other Prevention', T-MARC will focus on behavior change communications that promote abstinence and be faithful (AB) messages. These interventions will include interpersonal communications, peer education programs and other activities to provide support to young people to strengthen their ability to abstain or delay their sexual debut, and with adult males to discourage multiple partners in sexual relationships to reduce the risk of HIV/AIDS infections. AED will specifically focus prevention efforts on neglected "B" interventions with adult males through partner reduction messages and strategies. AED's efforts in AB will reach 1,000,000 individuals by September of 2007.

Tanzania has an HIV prevalence rate of around 7% (among 15-19 year olds), and the vast majority of these infections occur through heterosexual transmission. A delay in the age of sexual debut and the reduction of partners can have a dramatic impact on prevalence rates. This has been shown in both Uganda and Thailand and similar data is now emerging from Zambia and Ethiopia. The 2005 Tanzania HIV/AIDS Indicator Survey identifies some positive trends; median age at first sex has increased while the number of concurrent partners has decreased. It is reported that 5% of married women and 24% of married men had more than 1 partner in the 12 months before the survey. Still, never-married women and men, aged 15-24 have had sex with a non-cohabitating partner in the last 12 months (33% and 40% respectively). There is much work to be done if the epidemic is to be curbed and appropriate messages that capitalize on the increasingly safer sexual behavior in Tanzania will be very important.

AED will strategically address the behavior change trends in Tanzania by focusing on two broad behavior change targets. The first target includes young people, primarily in the age group of 19 to 24, who are sexually active. AED will develop key messages that seek to reemphasize to the target audience that the primary risk of transmission for HIV/AIDS is, in fact, through unsafe sex. Messages will clearly state that they are in control when it comes to this risk. AED will also continue to counter the myth that looking healthy or attractive is an indicator of someone's negative HIV status. With concurrent partnerships viewed as a key driver in Tanzania's epidemic, the campaign will stress the benefits of being faithful to one uninfected partner and the risk of having multiple partners. Messages will be focused on largely adult male groups that trend towards multiple-partners, such as truckers, miners, migrant workers and men in uniform. These more targeted efforts will be focused in the following areas: Dar es Salaam, Iringa, Mbeya, Shinyanga, Mwanza, and Arusha. These areas are all in high prevalence regions and lie along major transport corridors including large tea estates and mines in which the target audience can be effectively reached.

The overall mix of approaches, based on best practices, is to complement the efficiencies and reach of mass media with interpersonal and community level support. First, in collaboration with a new TBD, mass media will be used to: 1) reach a broad cross-section of the population with key messages to strengthen the benefits associated with being faithful, 2) change the image of multi-partner behavior from desirable to undesirable, and 3) shift the perceived social norm around the acceptability of multi-partner behavior, in order to harness social support and

empower individuals to challenge risky social norms. While broadcast media will reach a broad cross-section of the population, IPC will be used to strengthen messages and to provide people with more targeted messages, and an opportunity to assess their own risk. These efforts will include: printed materials and job aids to be distributed at the grassroots level, through NGOs and faith-based organizations; mobile cinema to reach villagers beyond the reach of mass media; and experiential, face-to-face, events and performances, including street drama and other entertainment, incorporating the campaigns key message themes. Mass media messages will be sensitive to not moralize to or stigmatize men, women or people who are HIV positive and will also provide a rallying call for faith-based leaders.

The campaign will also reach out to and through faith-based organizations to strengthen their ability to create and deliver messages to their constituents to encourage being faithful and reducing partners through a "zero grazing" campaign similar to Uganda's, to promote reduction of multiple partners. Activities for the faith-based communities will include seminars and conferences, and the development and dissemination of materials and toolkits to enable faith-based leaders to provide accurate and effective messages to their congregations. Faith leaders will also be provided with training modules and materials (i.e., the anti-stigma toolkit).

At the community level, messages will be disseminated through interpersonal channels using lead NGOs in targeted regions. Special emphasis will be placed on getting AB messages to people attending VCT and ante natal clinics. A special effort will be placed on reaching young men through commercial outlets, such as bars, and retail outlets. The campaign will also reach out to young adults through a variety of interpersonal channels directly and through various partners using evidence-based approaches, including working with student peer educators through established NGOs

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	1,000,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Target Populations:

Adults

Community leaders

Community-based organizations

Faith-based organizations

Military personnel (Parent: Most at risk populations)

Mobile populations (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Lake Tanganyika Catchment Reforestation and Education Project
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3430
Planned Funds:
Activity Narrative: This activity links to Palliative Care (TACARE) and Other Prevention/Transport Corridor.

B5

The Jane Goodall Institute has been implementing the TACARE (Lake Tanganyika Catchment Reforestation and Education) Project since 1994 in the Kigoma region of western Tanzania. Although this region has relatively low prevalence rates (less than 5%) it risks future increases as it borders both Burundi and the Democratic Republic of the Congo (DRC) and hosts nearly 400,000 refugees. Prevalence rates in the DRC are unknown but Burundi has an estimated overall prevalence rate of 10% with higher rates in urban areas. After years of turmoil, Burundi is entering a time of reconciliation and peace and it is anticipated that there will be much greater cross-border interactions. Burundi's capital is less than a day away from the Tanzanian border by public transport and it could become the most readily accessible urban market for goods and services for Tanzanians in the Kigoma region. TACARE could play an important role in keeping prevalence rates from climbing quickly in Kigoma.

TACARE's activities will focus on communities surrounding the Gombe National Reserve. TACARE is currently receiving USG support for natural resource management activities, reproductive health funding to support family planning activities, as well as Emergency Plan funding to support prevention and care activities. TACARE is the only provider of these services in this catchment area and works closely with government to link with, and augment primary health care. In USG consultations with government, TACARE was named as a critical partner in *reaching these remote and underserved communities.*

TACARE received FY 05 Emergency Plan funds to initiate prevention, abstinence, and be faithful messages for youth. To meet program objectives, TACARE leveraged "roots and shoots", an educational methodology established by Dr. Jane Goodall to focus on humanitarian and environmental initiatives with young people via classrooms, facilities, and community settings to reach 2600 youth with AB messages. Employing communications and training activities, including local media (theater, songs, role plays) and mobile (boat) video materials, roots and shoots staff engaged youth to dispel myths, provide correct information, and promote, in particular, abstinence until marriage.

In FY 06 TACARE will focus its AB work on youth and has requested additional technical support from other organizations in the region. TACARE will train 250 youth from the "roots and shoots" network in AB prevention. In FY06, the USG will facilitate another organization (possibly the American Red Cross Track 1 program or other USG partners) to work with TACARE to improve the technical content of their training, expand the reach of the program, and to exchange lessons learned in youth programming. This will be an important linkage for TACARE, which is a proven partner in community mobilization and education but does not have a history of providing HIV education. TACARE anticipates reaching 5,000 youth through the expansion of the "roots and shoots" network, and expects to reach several thousands of people indirectly through the engagement of community leaders and schools.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	5,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	2,600	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	250	☐

Target Populations:

Children and youth (non-OVC)

Coverage Areas

Kigoma

Table 3.3.02: Activities by Funding Mechanism

Mechanism: USAID TBD (former BBC)
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3452
Planned Funds:
Activity Narrative: This activity is also linked to activities in ARV Services, Counseling and Testing, Other Prevention and other Abstinence and Be Faithful activities.

B5

This is a new TBD (formerly an activity associated with the BBC World Service Trust). BBC began implementing a mass media radio campaign to deliver demonstrable improvements in knowledge, attitudes and behaviors relating to HIV/AIDS in July 2005. The project uses entertainment to promote messages about reducing people's risk of infection, increasing the number of Tanzanians seeking treatment, and reducing stigma and discrimination. The project was designed to run for 3.5 years and consists of a variety of radio formats that have broad appeal but are also flexible enough that they address issues that concern specific groups of people. The BBC has provided the USG with programming that rapidly adapts messages to incorporate emerging issues. These messages clearly target youth and other appropriate populations; but BBC has also been a major component of the USG portfolio that reaches out to men with a strong message about being faithful.

BBC will use a similar approach to its programs in Nigeria, Angola, India, and Cambodia; where it has implemented large scale health campaigns that are based on a 'production partnership' model. 'Production partnership' entails forging an alliance between government ministries and public and private broadcasters to create highly synergistic campaigns that benefit both public health and broadcasting objectives. In exchange for training and capacity building, local broadcasters donate airtime for all of the campaign's outputs. In Tanzania, AB focused broadcasts will be delivered in Kiswahili under the guidance of the NACP and TACAIDS; and will be complemented by community level activities that are conducted by AED. Some of the broadcasters involved in the production partnership include: Radio Tanzania Dar es Salaam with a strong rural audience; and Radio Free Africa and Radio One which cover 75% of the country on FM and AM, with significant audiences in both urban and rural areas.

Radio is the most popular media outlet in Tanzania. In a 2002 survey, 81% of respondents claimed to have listened to radio within the past day. The popularity of radio will allow the new TBD to reach at least 10,000,000 Tanzanians (one third of the national population) with important messages regarding comprehensive services across the prevention-to-care continuum.

This new TBD will build on BBC's FY05 programming achievements to specifically promote AB messages and link them throughout the continuum of care in FY06. In an ongoing effort to promote effective abstinence, faithfulness and partner reduction messages to youth, this activity will try to address societal norms for each of these messages. USG support for the TBD for AB will support a variety of media formats in FY06:
1) Six radio spots (30 – 60 seconds) and three mini-dramas (60 – 120 seconds) for segmented audiences will be produced and broadcasted frequently on partner radio stations through donated time.
2) A weekly radio drama will deepen the linkages of all messages, enabling modeling of relevant life skills and positive behavior change. The drama series formula is an excellent vehicle through which to explore human relationships, life skills, and societal norms. The characters of the drama will show the benefits of adopting certain behaviors and demonstrate that change is possible, increasing the sense of self-efficacy necessary for the adoption and sustaining of new behaviors. A key component to the drama is a follow-up interactive discussion program to be broadcast after each episode which will be linked with the Youth Help Line also funded by the USG (see NACP AB activity narrative).

3) A discussion program focusing specifically on men will be produced and broadcast twice weekly. This program will draw on the experience gained by the BBC WST in Cambodia, where it has been producing radio programming for men for several years and will work closely with, and support, the new male involvement project (see "To Be Determined Male Involvement" AB activity narrative). The program will cross generational lines and will feature discussion with men about how they approach relationships, sex, fatherhood, work and personal development. Over 50 episodes will be produced.
4) Training of radio broadcasters to increase quality programming.

The flexibility of community-based radio communications allows the weaving of multi-pronged messages into programming. Working together with NACP, TACAIDS, and other Emergency Plan partners to assure messages are appropriate, support policies, and are linked to services. The new TBD will work to strengthen links between local radio broadcasters and GOT thus enabling more effective health campaigning by increasing media skills in the Government sector and by working closely with local broadcasters to enhance their commitment and capacity to produce quality health programming. This activity, local radio broadcasters and GOT are developing a strong working relationship to provide a mechanism that will be responsive to Tanzanians needs for information across the full spectrum of prevention, care and treatment issues within the Emergency Plan.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Indirect Targets

In FY06 under AB funding, the BBC WST will produce a variety a media outputs which are not captured in the direct targets: Six radio spots, 3 mini dramas, 1 training workshop for broadcast produces, 22 call-in shows, 15 radio dramas, and 50 episodes of a men's discussion program focusing on "B" messaging. All of these outputs are augmented by community program activities undertaken by the five Track 1 partners, AED, Youthnet and Africare.

Target Populations:

Adults

Business community/private sector

Commercial sex workers (Parent: Most at risk populations)

Community leaders

Community-based organizations

Faith-based organizations

Military personnel (Parent: Most at risk populations)

Mobile populations (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

People living with HIV/AIDS

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Stigma and discrimination

Gender

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: YouthNet
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3466
Planned Funds:

B5

Activity Narrative: To date, YouthNet/Tanzania (YN/T) has directly reached over 2.25 million young people and 750,000 community members with AB focused HIV prevention messages through the work of more than 35 sub-grants in Iringa and Dar es Salaam Regions. YouthNet has developed its sub-partners skills in behavior change communication, faith-based prevention approaches, youth participation, monitoring and evaluation, and report writing. YouthNet will build upon their activities in 2005 by continuing to expand its geographically focused work and broaden its response through greater emphasis on: 1) gender issues; 2) livelihood projects through linkages with existing programs, and 3) orphans and vulnerable youth. This project will use AB prevention strategies that focus on younger youth (10-14) for abstinence messages and older youth for preparing to be faithful messages, and faithfulness messages for married youth.

YouthNet will conduct activities that will support BCC efforts for HIV prevention through sub-grantees. In FY06 YouthNet's sub-grantees will reach more youth with HIV prevention skills and messages, younger youth sports programs and intensification of work with youth groups and peer to peer programs. YouthNet will also continue to support and collaborate with youth radio and TV programs such as Mambo Elimu to include AB messages that are designed for younger youth. YouthNet will also support its sub-grantees in creating and disseminating effective print materials.

Under the Ishi Campaign, YN/T will strengthen existing HIV Prevention Resource Centers to provide information on HIV education; continue capacity building efforts for Youth Advisory Groups (YAGs) and support and guide YAG outreach, mobilization, and awareness raising activities. YouthNet will also open new Prevention Resource Centers at four additional sites where it will introduce evidence-based components of its gender initiative; conduct Boy and Girl Power conferences focusing on gender issues and HIV infection; initiate a parent and youth communication project; and continue limited mass media efforts, particularly using radio targeted to support Ishi efforts.

YouthNet will enhance the capacity of faith based institutions that are already implementing youth AB projects and will enable additional faith based institutions to implement youth prevention programs. It will couple capacity building with grants to faith based institutions in Dar Es Salaam and Iringa. YouthNet will also help build an interfaith network in Dar Es Salaam and will strengthen an existing network in Iringa. These institutions will be provided with supportive supervisions in monitoring; translating, disseminating, and promoting use of the Christian family life education guide; field testing the Muslim family life education guide; and developing a core team of counselors from young faith leaders to implement psychosocial support activities. YouthNet will also conduct a PLA exercise in two regions to guide the work of faith based institutions. YN/T will also expand its activities to Zanzibar, subsuming existing Africare AB activities that end April 30, 2006.

YouthNet's YEC will meet quarterly to contribute to program and plan special events. YEC will organize monthly meetings to share information; will be provided with training opportunities to help youth participate more meaningfully in programs. YouthNet and YEC will develop IEC materials on youth leadership with AB messages and continue to develop collaborative efforts with Ishi YAGs, YouthNet YEC and interns.

YouthNet will also play an important role for the USG team by coordinating and providing technical leadership to the five ABY Track 1 grantees that are working in

Tanzania through monthly meetings. YouthNet will also continue to coordinate and lead other youth-serving organizations through quarterly Coordinating Committee for Youth Programs meetings. YouthNet will play a key role for the USG by disseminating and promoting tools that have been tested and translated around the world; providing trainings on state-of-the-art peer education that maximizes behavior change; addressing gender through programs; tailoring programs to meet the special needs of young men and women; and CCYP and ABY forums. YouthNet will continue to create important linkages with wrap-around programs that serve youth, such as: reproductive health education (for younger youth, focus on changing bodies and life skills), gender, policy, and livelihood programs.

YouthNet will also continue to conduct supervisory M&E visits to sub-grantee programs while providing technical assistance in using M&E packages and, as a follow-up to the larger Iringa Youth Behavior baseline survey conducted in 2003-04, undertake a Behavioral Surveillance Survey (BSS).

Behavioral Surveillance Surveys (BSS) are designed to track trends in HIV/AIDS knowledge, attitudes, and risk behavior in selected segments of a region or community. They are small-scale and low-cost surveys that can be undertaken more frequently and can be used in combination with other process data to enable program managers to plan and implement interventions that are responsive to trends in risk behavior and to evaluate the interventions' intermediate outcomes.

To implement the survey Youthnet will conduct a training to build internal and partner capacity, conduct the BSS and write and disseminate the data synthesis and programmatic recommendations by the close of the program. The BSS will focus on a subset of youth in YN/T's geographic focus areas. Selection criteria will include epidemiologic data, prevention programming underway, and feasibility. Sample size would vary according to the specific measurement objectives but will likely not exceed 300 – 400 youth. YN/T anticipates spending approximately $150,000 on BSS training and surveying.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	1,325,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	1,125,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	1,050	☐

Indirect Targets

OVC: While not a direct focus of YOUTHNET's work, YOUTHNET anticipates reaching OVCs with HIV prevention messages and skills through its program and through links to OVC projects. We will not be serving OVCs directly through programs or training providers in caring for OVCs.
Policy: YOUTHNET will not provide direct TA in policy development, though given that policy is relevant to YOUTHNET's work, policy will be considered.

Target Populations:

Adults

Street youth (Parent: Most at risk populations)

Orphans and vulnerable children

Children and youth (non-OVC)

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Wrap Arounds

Coverage Areas

Dar es Salaam

Iringa

Mbeya

Morogoro

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American Red Cross
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3472
Planned Funds:
Activity Narrative: This activity is one of Tanzania's five Track 1 Abstinence and Be Faithful for Youth (ABY) partners. This activity also relates to activities in Abstinence and Be Faithful (YouthNet/FHI, ADRA, IYF, Salesian Missions, and World Vision).

The American Red Cross (prime partner) and Tanzanian Red Cross (sub-partner) Societies are collaborating on the "Together We Can" (TWC) program, which uses a proven youth HIV/AIDS peer education methodology to reduce the incidence of HIV among 10-to-24 year old youth. The TWC program emphasizes: community mobilization/participation, IEC material design, capacity building of the Tanzanian Red Cross Society (TRCS) and its network of community volunteers and the development of networks with other groups working with youth. In addition the program emphasizes linkages and referrals to health and youth related services including the Ministry of Education. Other emphasizes include quality assurance and supportive supervision of staff and volunteers.

The TWC program is working in the Kigoma Urban, Kigoma Rural, Kasulu and Kibondo districts in the Kigoma region of Tanzania. The five-year project, which began in 2004, aims to reach 100,000 youth in the period from April 2006 to March 2007 *through direct peer education and mass mobilization approaches.* TRCS will work with and through its established Kigoma branches to train volunteer peer educators using the skills-based TWC methodology and to mobilize communities to adopt safer norms and behaviors related to HIV infection. The program targets girls, boys, primary school students, secondary school students, and out of school youth (target population) and aims to have gender equity in the number of youth reached (key legislative issue). TRCS' TWC program consists of a proven skills-based peer education methodology that uses games, role plays and other interactive methods in both small group and one-on-one settings to teach youth to: learn correct information about HIV/AIDS; examine their personal behavior to determine their risk; learn effective strategies to reduce their risk and that of their peers; and develop skills to help maintain these safer sexual practices. The TWC curriculum also teaches youth to examine stigma and discrimination against People Living with HIV/AIDS (PLHAs) and offers ways in which youth can support PLHAs in their communities. TRCS and its Kigoma branches will also promote dialogue on delaying and abstaining from sexual activity by empowering existing groups of Red Cross volunteers, adults, community leaders, religious leaders, teachers and volunteer youth peer educators (target populations) to facilitate a variety of community mobilization activities. Such activities as mass communication campaigns, theater, sports, and music festivals will complement and reinforce Kigoma regional campaigns to promote abstinence, HIV behavior change and stigma reduction.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	150,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	240	☐

Target Populations:

Adults

Community leaders

Non-governmental organizations/private voluntary organizations

Teachers (Parent: Host country government workers)

Volunteers

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kigoma

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Youth
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 3492
Planned Funds: [redacted] B5
Activity Narrative: This activity is linked to Family Health International/AB and Family Health International/Other Prevention (these activities are under the program name "YouthNet") and Youth TBD/Other Prevention. It targets younger youth (aged 10 – 14) for AB interventions to maintain protective behaviors, promote secondary abstinence, and builds life-skills for faithfulness in marriage.

The 2005 Tanzania HIV/AIDS Indicator Survey (THIS) found that 11% of women and men, aged 15 to 17, had had sex before the age of 15. In addition, 26% of women and 29% of men aged 15 to 19 had had sex in the 12 months preceding the survey and 53% of these women and 95% of these men had had multiple partners in that period. Although this data applies to youth older than the target age group of this activity it, is clear that young people in Tanzania are entering a period in their lives where they will be faced with critical decisions. They will be making decisions amidst a significant proportion of their peers that are placing themselves at high risk.

This activity will be funded through a competitive procurement that will be solicited as early as possible in FY06. Bidders will be asked to build on the work of YouthNet, a youth prevention program that is currently implemented by Family Health International and funded by the USG (see relevant activity narratives) as well as other successful youth efforts in Tanzania. YouthNet is a global cooperative agreement which comes to an end September, 2006. YouthNet's current government partner is the Tanzania's President's Office. This arrangement, vis-à-vis TACAIDS role as a national coordinating body, will be revisited with government before the procurement is released. The activity will lead the USG's effort to continue expansion of its youth programming while coordinating the efforts in the AB and Other Prevention portfolios. Funding will launch new services as well as support existing indigenous organizations to expand geographic coverage, improve quality, and increase range of AB interventions through coordination.

Three key strategies will be employed: 1) behavior change communication (BCC); 2) engagement of the faith community; and 3) youth participation and leadership. BCC efforts will include inter-personal, community, and media interventions. Based on currently successful efforts it is anticipated that activities could include: continued support for the Ishi campaign, a TACAIDS initiated national umbrella for youth media programming; continued strengthening of HIV Prevention Resource Centers; peer education; life skills education; parent/youth communication skills building; and dissemination and utilization of materials developed under YouthNet and other initiatives.

Engagement of the faith community will be anchored on a YouthNet initiated effort to create an inter-faith network for youth programming. Support to the network would include technical assistance, strengthening of monitoring and supervision capacity, use of the Christian Family Life Education Guide (developed under YouthNet) and a similar document under development for the Muslim community, and proceed with a pilot concept of preparing youth faith leaders to provide psychosocial support to their peers. Faith organizations will also be provided with the skills to work with adults, to improve their communication skills with their children and be encouraged to provide leadership for the modification of social norms that put children at risk of HIV infection.

Youth participation and leadership efforts will emphasize capacity building of Youth Advisory Groups, initiated under TACAIDS's Ishi program and present in every region, to fulfill their mandate of outreach, mobilization, and awareness raising. Through

other youth groups, the skills of individual youths will be built to not only communicate correct information regarding HIV/AIDS but they will also be provided with strategies for motivating their peers to make safe choices, be a voice for youth to opinion leaders, policy makers, parents, and teachers; and identify situations in which youth are at particular risk (i.e. environments of alcohol utilization) and develop strategies for avoiding those situations.

Another important element of the program will be to assist TACAIDS to coordinate youth programming. This includes facilitating, under USG guidance, coordination across USG partners, including Track 1, as well as exploring the possibility of creating, under the auspices of TACAIDS, a coordinating body for youth serving organizations. This group could facilitate coordination and networking, rolling-out of national guidance, sharing of lessons-learned and new materials, advocacy, and capacity building. It would be a portion of a larger effort under this activity to build the capacity of indigenous youth serving organizations.
In all areas, bidders will be requested to propose additional innovative ideas and proven strategies. In addition, they will be required to address contextual issues such as stigma and discrimination, gender, wrap-arounds, livelihoods, and links with OVC programming. While this activity will not be able to provide these services directly, they will be expected to link with other organizations providing these services in the same target areas. Sub-granting will be undertaken based on mapping of existing services) and focus on filling gaps. Bidders will be encourage to include the collection of baseline information regarding the views of parents, community and religious leaders and other gatekeepers regarding attitudes towards AB as well as risk perceptions as a means of improving programming. This information as well as lessons-learned will be shared with other USG partners to inform the content of advocacy, policy and legislative efforts. This 5-year effort will be subject to a mid-term and final evaluation.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	500,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	200,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	50	☐

Target Populations:

Adults

Street youth (Parent: Most at risk populations)

Orphans and vulnerable children

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Education

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Adventist Development and Relief Agency
USG Agency:	U.S. Agency for International Development
Funding Source:	N/A
Program Area:	*Abstinence and Be Faithful Programs*
Budget Code:	HVAB
Program Area Code:	02
Activity ID:	4859
Planned Funds:	
Activity Narrative:	This activity is one of Tanzania's five Track 1 Abstinence and Be Faithful for Youth (ABY) partners. This activity also relates to activities in Abstinence and Be Faithful (YouthNet/FHI, ARC, IYF, Salesian Missions, and World Vision). The ADRA Abstinence and Behavioral Change for the Youth (ABY) project will target Tanzanian youth (10–24 years of age) in three regions: Mara, Mwanza and Kilimanjaro. The project will focus its efforts on scaling up skills-based HIV education with parental involvement; facilitating a community discourse on healthy norms and risky behaviours; and reinforcing the role of parents and other protective influences. *In FY06, ADRA will spread AB messages to youth through a network of local* partners. ADRA will provide its partners with a training of trainers course, curriculum, and materials for a cadre of trainers from FBOs, CBOs and schools. Educators will then be trained and will be able to share messages about abstinence, fidelity and partner reduction, as well as avoidance of harmful behaviors such as coercive and transactional sex with youth.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	175,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	1,004	☐

Indirect Targets

ADRA will reach over 175,000 youth directly; and 1,000,000 youth through mass media.

Target Populations:

Street youth (Parent: Most at risk populations)

Orphans and vulnerable children

People living with HIV/AIDS

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Coverage Areas

Kilimanjaro

Mara

Mwanza

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: International Youth Foundation
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4860
Planned Funds:
Activity Narrative: *This activity is one of Tanzania's five Track 1 Abstinence and Be Faithful for Youth* (ABY) partners. This activity also relates to activities in Abstinence and Be Faithful (YouthNet/FHI, ADRA, ARC, Salesian Missions, and World Vision).

Regular Activity Narrative (5,950 character limit): 3777
This activity is one of Tanzania's five Track 1 Abstinence and Be Faithful for Youth (ABY) partners. This activity also relates to activities in Abstinence and Be Faithful (YouthNet/FHI, ADRA, ARC, Salesian Missions, and World Vision).

The Empowering African Young People Initiative (ABY) is an alliance of seven global youth organizations. In Tanzania, the ABY program will be implemented by six local partner affiliates as direct IYF sub-grantees: Tanzania Red Cross Society (TRCS); Tanzania Scouts Association (TSA); Tanzania Girls Guides Associations (TGGA); Kuleana Centre for Children's Rights; Young Men's Christian Association (TYWCA); and Tanzania Young Women's Christian Association (TYWCA).

This activity has several different components. The first component is to scale up skills-based peer education. The six program affiliates will continue to conduct skills based trainings at national and district level using a harmonized curriculum. Specific targets include boys and girls, out-of-school youth, street youth and refugees/internally displaced persons. Five thousand young people will be targeted for training as Peer Educators; where as 55,000 more will be reached through one-to-one and one-to-group interactions as well as by outreach. The three affiliates or sub-partners that have ongoing Life Planning Skills interventions intend to orient and train a minimum of 12 TOT, 30 trainers and 150 Life Planning Skills facilitators (for more information on Life Planning Skills, see the Ministry of Education and Culture's AB activity description). Functional drama groups will be re-oriented and trained and new ones developed. Consequently, six music, dance and drama outreach events are planned as well as 48 video shows, all designed to deliver BCC messages, incorporate audience feed back and provide opportunity for discussion. The dissemination of age and culturally appropriate BCC materials will be done in conjunction with outreach activities.

The second component involves stimulating broad-based community discourse on healthy norms and risky behaviors. The partners will continue to participate in national, district and community level coordination committees and meetings. Key influential leaders including faith leaders, political leaders and community resource persons will continue to be targeted for sensitization, mobilization and advocacy on ABY HIV prevention. Through the activity's third component, reinforcing the role of parents and other influential adults, four sub-partners will select and train adult partner affiliate members on ABY HIV prevention, parent-to-child communication and mentoring. These activity components will reach 12,000 adults.

The fourth and final component will aim to reduce the incidents of sexual coercion and exploitation of young people, and address the key legislative issues relating to gender, stigma and discrimination. The sub-partners will continue working with community advocacy on identified risk areas, risk behaviors and prevalent vulnerabilities amongst young people, including intergenerational and trans-generational sex, in the districts in which they will be working. They will also maintain linkages with previously identified and available referral interventions including youth-friendly VCT centers for young people, and advertise these through peer-peer approaches, outreach and meetings with key influential leaders and community members.

In all these components, the Empowering African Young People Initiative will seek to focus especially on younger youth, girls and young women, and young people in especially difficult and vulnerable circumstances. IYF will not only sub-grant but will continue to provide the needed capacity building for the local sub-partners to effectively achieve the stated goals

Emphasis Areas	*% Of Effort*
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	55,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	22,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	5,000	☐

Target Populations:

Adults

Community leaders

Street youth (Parent: Most at risk populations)

Refugees/internally displaced persons (Parent: Mobile populations)

Orphans and vulnerable children

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Key Legislative Issues

Gender

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Kagera

Kilimanjaro

Mbeya

Mtwara

Mwanza

Pwani

Ruvuma

Shinyanga

Singida

Tabora

Kaskazini Unguja (Zanzibar North)

Bagamoyo

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Education and Culture, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4863
Planned Funds:
Activity Narrative: This activity is related to other Abstinence and Be Faithful activities.

B5

The Ministry of Education and Culture (MOEC) has a total of 14,257 primary schools implementing the Life Planning Skills program in Tanzania. This national program has the potential to reach 1,315 schools in Mtwara and Ruvuma regions by 2007 and will reach youth aged 10-19 years with important HIV/AIDS prevention and abstinence messages that are age and gender appropriate and is expected to reach 25,000 children by September 2007. The program is aimed at developing the knowledge and skills that are necessary for youth to make informed decisions regarding abstinence and sexual and reproductive health.

The USG will support the scaling up of this program that was introduced in secondary schools by MOEC in 2002. The program will be implemented in 32 primary schools as a pilot project in two regions of Ruvuma and Mtwara. These two underserved regions have high rates of STIs, severe truancy problems, and higher rates of teenage pregnancy and dropouts. The MOEC will provide prevention education that emphasizes AB messages, encourages interactive and entertaining education, and integrates HIV/AIDS counseling services, gender, stigma and discrimination in extracurricular activities.

The MOEC will initiate the implementation of the Life Planning Skills program by conducting a training of trainer's course that will teach 320 trainers. The 320 trainers will then train a total of 640-school faculties in Ruvuma and Mtwara. The teacher training will provide teachers with the skills that will be necessary to instruct students using the Life Planning Skills curriculum. The MOEC estimates that it will reach a total of 25,000 students grade three through seven in the two regions. The Life Planning Skills curriculum provided to the 640 teachers will also be captured in a published curriculum with Abstinence messages. Roughly 20,000 copies of the Life Planning Skills curriculum supported by USG will be distributed to trainers, teachers and students.

The MOEC will also establish 16 school clubs, 32 youth talk shows, and other school events at the local and national levels. Some of these events will be MOEC sponsored inter-school competitions that will provide fora for addressing AB messages and HIV/AIDS prevention issues. The MOEC in collaboration with faith-based institutions will teach youth in schools and school clubs that early sexual activity can lead to STIs and HIV infection. A selected number of youth will also be called upon to participate in Council Multi-sectoral HIV/AIDS committee (CMAC) meetings to represent their issues that will later be discussed during monthly meeting as support to the goals of the National Multi-sectoral Strategic Framework on HIV/AIDS (NMSF). To facilitate this process, the MOEC will hold three sensitization meetings at the district level for key community, village leaders, faith based leaders and other opinion and decision makers within the community. This will familiarize the attendees on integrating AB youth programs into their CMACs. The MOEC anticipates reaching a total of 100,000 people in two regions through these meetings.

The MOEC will build on its school-based program with a wide-reaching mass media component. Nearly 3,500 free-play radios will be purchased with USG support and will be placed in the youth clubs and some strategically within communities. The radios will allow community members to listen to health education programs and AB messages that will be broadcast each week. Both youth and the community members will be encouraged to discuss documents and disseminate emerging AB messages and HIV/AIDS issues in their communities that have been covered by the radio programs. IEC materials with abstinence and behavior change messages will be developed to complement the programs and the materials will be disseminated to

schools, health centers and youth clubs.

In the following years, the MOEC will begin to integrate parent-child and teacher-parents communication initiatives in schools. The MOEC will start planning new fora for communication that will encourage parents; teachers and children to discuss HIV/AIDS related social norms and AB messages. MOEC through USG support will also integrate the school Life Planning Skills training programs into district level health plans that guide the operation of the CMACs.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	100,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	25,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	640	☐

Target Populations:

Community leaders

Faith-based organizations

Policy makers (Parent: Host country government workers)

Teachers (Parent: Host country government workers)

Primary school students (Parent: Children and youth (non-OVC))

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Mtwara

Ruvuma

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	US Peace Corps
USG Agency:	Peace Corps
Funding Source:	GAC (GHAI account)
Program Area:	Abstinence and Be Faithful Programs
Budget Code:	HVAB
Program Area Code:	02
Activity ID:	4868
Planned Funds:	

Activity Narrative: Peace Corps Tanzania directly implements Emergency Plan activities through the actions of its 110 Peace Corps Volunteers in 15 of 21 regions on mainland Tanzania. PC/T implements an integrated HIV/AIDS program where all Volunteers in country are encouraged to implement HIV/AIDs activities. Volunteer are involved in three projects for PC/T that gives them opportunity to do activities related to AB. The projects include the Education project that brings in secondary school Volunteer teachers to teach mathematics and science, the Environment project that places Volunteers in communities to assist with better natural resources management (including farming practices) and the Health Education project that brings Volunteers into communities to work as health educators. Volunteers have opportunities to work with teachers and in-and-out-of-school youth in both primary and secondary schools and with other community based organizations (CBOs) such as women's groups.

B5

In FY05, the Peace Corps implemented its HIV/AIDs program with "Other Prevention" as its main program area, by directly reaching community groups with HIV/AIDS awareness information and Life Skills. Volunteers also trained different community groups to build their capacity to train others and conduct other awareness activities.

In FY06, the Peace Corps is planning to spend 33.3% of its prevention budget on programs that are focused on abstinence and/or being faithful. Peace Corps Volunteers will specifically target youth in primary schools in its AB program. The rationale for this approach is that in Tanzania the primary school enrollment rate is 90% while enrollment in secondary schools is 5.8%. The average age of those completing primary school is 15 years. Schools provide a critical opportunity to provide correct information on HIV/AIDS prevention to youth especially since for most children, primary school is the only formal training they will receive in life. The Life Skills focus is to help youth learn to assess healthy life choices that are appropriate for them to avoid being infected by HIV.

This AB program will allow Volunteers and their host country national (HCN) counterparts to work together to reach 13,000 primary school youth. The primary school youth will be reached through: Volunteers facilitating classroom sessions; strategically placing question and answer boxes; and conducting extra curricular activities like health clubs, sports and field trips.

Volunteers and their HCN counterparts will also conduct trainings for school teachers, who in turn will teach youth on HIV/AIDS awareness and life skills information. The Volunteers will provide training for 200 primary schools teachers to help them gain confidence in teaching HIV/AIDs related curriculum that is focused on AB, teaching life skills, and starting up and maintaining awareness activities in schools e.g., with peer educator groups. Volunteers will also train 66 peer educators in primary schools that have shown to be very effective in reaching their peers with health information.

PC/T will conduct workshops for all of the first year Volunteers and their host country counterparts to impart them with the skills needed to conduct Emergency Plan programs. They will be trained on monitoring and reporting and Volunteers will be introduced to VAST grants (that will be supplemented with Emergency Plan funds). Volunteers will be taught how to access the grants which they will be able to use to fund trainings and other awareness activities in schools and communities.

Training materials such as videos, manuals, posters and books will supplement the Peace Corps AB programs. The materials will be developed or purchased by Peace

Corps to be used by Volunteers and HCN counterparts around Tanzania.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	13,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	0	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	266	☐

Target Populations:

Community leaders

Teachers (Parent: Host country government workers)

Volunteers

Children and youth (non-OVC)

Key Legislative Issues

Volunteers

Coverage Areas

Mtwara

Ruvuma

Arusha

Dodoma

Iringa

Kagera

Kilimanjaro

Lindi

Manyara

Mara

Mbeya

Morogoro

Mwanza

Singida

Tanga

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Salesian Mission
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4882
Planned Funds:
Activity Narrative: The Salesian Missions "Life Choices Program", is a Track 1 ABY program that aims to teach youth to avoid being infected with HIV/AIDS through healthy behaviors. The Life Choices Program reaches youth through peer education programs and peer outreach and is led by trainers and selected 'adolescent opinion formers'. These opinion formers, or peer educators, will be equipped as agents to spread AB messages in their communities. Life skills will also be taught by youth center trainers and will be reinforced by parents and parishes. Youth that live in communities impacted by HIV/AIDS will receive life skills training, be taught AB messages and be coached to take responsibility for their health. The Salesian Missions program will also administer outreach programs for at risk youth. Programs for these youth will be tailored to include information that addresses difficult decisions they make about their reproductive health.

The Life Choices Program will be taught by trainers to both youth and their parents or caregivers. Trainers will introduce youth ages 10-19 to the Life Choices curriculum at ten Salesian of Don Bosco youth centers. Classes will be taught in group meetings during and after school through formal classroom sessions, weekend sessions and sessions during school leave. An estimated 1,000 youth will be trained in each of the ten youth centers, reaching a total of 10,000 youth in 2006. Outreach programs that operate out of the ten youth centers and target at risk youth, orphans and vulnerable children and street youth will also share the Life Choices curriculum. The outreach programs will reach an additional 2,840 youth.

Trainers will also teach the Life Choices approach to parents and caregivers, to facilitate discussion with their children on how to avoid being infected with HIV/AIDS. Sessions for parents and caregivers will be organized four times a year and a minimum of 15 parents will be recruited for each session; thus, a minimum of 600 adults will be reached through the ten youth centers in 2006. The parent/caregiver sessions will focus on factual information and on parent to child communication. Issues and solutions arising from the sessions will be recorded and followed-up on by the trainers to better support a social environment for youth behavior change.

Salesian Missions will also increase the peer to peer outreach through voluntary peer educators. Peer educators will be selected based on their commitment to volunteer for HIV/AIDS prevention activities and on the rapport that exists between them and their peers. Youth who demonstrate leadership skills and are motivated to change their behavior will be identified and given more training sessions to support facilitating Life Choices education among fellow students at youth centers. Peer educators will also be selected from the entire spectrum of youth social niches and cliques to ensure that high risk groups of youth are reached, regardless of social standing. Youth will also be reached via church groups, choir groups or through catechism classes. Out of school youth, street children and OVC will also be reached through peers that are in similar situations. Peer educators will create activity plans after being trained and will be provided with program materials to initiate peer education activities.

Region-specific Life Choices materials and curriculum will also be developed within the first four months of 2006. The development teams will consist of the local Program Manager, public health professionals, social workers, and existing staff members. Each team will come up with recommendations for tailoring a set of audio visual and printed materials. Materials will be tailored to include local terminology, cultural beliefs, gender, sexual violence, drugs and alcohol abuse, and stigma reduction messages, as appropriate. The educational materials will also be field tested in 2006. In 2005, the Trainer's Manual was developed and abbreviated versions of it will be used to create

materials to support different program activities. Parts of the trainer's manual will be translated and handouts will be printed for each adolescent trained and peer educators will be supplied with handbooks to facilitate their outreach work.

Life Choices trainers will link with leaders of the communities, parishes, youth and the respective District's AIDS Control management to facilitate the peer educators and assist them in monitoring peer education activities. Salesian Missions has already trained 240 peer educators in 2005 and these educators will be expected to reach roughly 24,000 of their peers in 2006. The Life Choices trainers and community mobilizers will also hold wider events for communities and parishes. At least four events that focus on behavior change will be held that will reach around 2,000 community members. Community participation will be spearheaded by community mobilization leaders. Nearly 1,000 people will be trained to be community mobilization leaders; and will organize the community events that focus on learning more about your own health while promoting linkages between the community and established VCT centers that are operated by other organizations. More specifically, messages will be provided at the events about knowing your HIV status if you have been exposed to HIV and seeking treatment for STIs. A radio show on HIV prevention will also be developed for play on existing stations owned by the Diocese that have ongoing broadcasts that are designed for young listeners. Salesian Missions estimates that it will be able to reach thousands of Tanzanians through these radio shows.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	38,840	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	15,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	1,060	☐

Target Populations:

Adults

Street youth (Parent: Most at risk populations)

Orphans and vulnerable children

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Coverage Areas

Dar es Salaam

Dodoma

Iringa

Kilimanjaro

Shinyanga

Table 3.3.02: Activities by Funding Mechanism

Mechanism: TBD-FBO Initiative
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4883
Planned Funds:
Activity Narrative: This activity is related to other Abstinence and Be Faithful activities.

B5

Several of the USG's supported Faith-based partners are already promoting abstinence and faithfulness through social, spiritual, and psychological change interventions. The USG will continue to capitalize on these partnerships through a coalition that will be set up as an umbrella grant mechanism through the HIV/AIDS Faith Based Initiative (HAFI). Through HAFI the USG will provide support to the Tanzania Muslim Council, (BAKWATA), the Christian Council of Tanzania (CCT) and the Tanzania Episcopal Conference (TEC). The TEC, CCT and BAKWATA coalition in 2004 jointly conducted 12 training programs for 2,100 clergy, Imams and other religious leaders and implemented HIV/AIDS activities that specifically target their respective religious communities.

TEC, CCT and BAKWATA through HAFI play an integral role in building the capacity among the coalition partners for delivering HIV/AIDS prevention, care and support services; through community mobilization, IEC materials and capacity building in advocating abstinence for school youths and faithfulness for older youths who are sexually active. Key messages will seek to reassure the target audience that the primary risk of transmission for HIV/AIDS is through unsafe sex. The FY06 activities will begin with rapid, participatory, community-driven assessments in eight regions that have a high HIV prevalence. These assessments will include working with the faith-based organizations, private sector and community groups in the selected sites. A sub-set of program sites will be selected as a result of the assessment for program implementation working through community groups and other USG partners.

The USG will continue to support TEC, CCT and BAKWATA to improve an existing interfaith-based resource and information center for youth ages 10-24 years old. The aim is to enable youth access to AB information as well as spiritual and health related information (on reproductive health, gender, rights and social norms). Charity and humanitarian organizations from different denominations/sects provide support in the form of publications, teaching and counseling services on regular basis in small Christian communities, Madrasa and Youth clubs. This coalition will work to attract and increase the number of interfaith organizations that will collaborate to advocate and promote abstinence and faithfulness messages in communities. In FY06, this FBO coalition will target Madrasa, seminary schools, Nuns, Imams, Sheiks and other stakeholders such as the business HIV/AIDS coalition groups, charities and humanitarian organizations with different AB messages to support the resource centre and in developing AB messages. Messages will include themes such as: "AIDS is not a sin: Get facts! Get tested!" or "Sex can wait until marriage" messages. The messages will be developed to instill confidence and resistance to peer pressure and to promote parent and child communications and community initiatives in developing social norms.

The coalition will produce 10 feature articles, 20 advertisements, and 10 radio and television spots in the Faith based media campaigns. In local Kiswahili weekly newspapers, question and answers articles will be jointly answered by Sheikhs and Clergies and will be also be offered as "pullouts" during Muslim or Christian national events or celebrations. Articles and radio programs will explore AB issues; activities for youth, fidelity, partner reduction, stigma, discrimination, HIV/AIDS counseling and testing and other safer behaviors will be promoted by HAFI. Messages will be tailored to be age appropriate. Illustrations and pictures supported by specific Abstinence messages will focus on younger youth between the ages of 6-10.
For older youths living in rural areas a variety of low literate literatures of AB Kiswahili messages will be produced in a tabloid format to be disseminated at the grassroots'

level through the existing networks within HAFI.HAFI in collaboration with other interfaith media organizations and the HIV/AIDS business group will also produce a package of traditionally appropriate HIV/AIDS prevention messages based on AB. The exercise will be expected to produce 50 HIV/AIDS audio and visual "kaswida" (Muslim gospel songs) with AB messages that target rural areas where the majority of youths have limited or no access to accurate HIV/AIDS information. The target is to reach one third of the national population in rural communities previously not targeted.

HAFI will also link with other regional and Community based HIV/AIDS prevention partners to educate the public on getting the AB messages across through interpersonal channels to encourage the public to reduce stigma and discrimination against people living with HIV/AIDS and promote gender equality. In addition to these activities, HAFI will help document and disseminate best practices and lessons learned nationally through Balm in Gilead support. Faith based media institutions together with other local media organizations will discuss the challenges and the strategies to address gaps and to develop linkages and collaborations to promote AB. 3000 youth and adults will be trained and they will in turn work directly with 6,000 people through peer-to-peer education, parent-to child education and with traditional leaders on HIV/AIDS prevention.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Needs Assessment	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	100,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	100,000	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	400	☐

Target Populations:

Business community/private sector

Community leaders

Community-based organizations

Faith-based organizations

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Arusha

Dodoma

Iringa

Kagera

Kigoma

Mwanza

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

COAST

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Table 3.3.02: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: World Vision International
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4885
Planned Funds:
Activity Narrative: This activity is one of Tanzania's five Track 1 Abstinence and Be Faithful for Youth (ABY) partners. This activity also relates to activities in Abstinence and Be Faithful (YouthNet/FHI, ADRA, IYF, Salesian Missions, and ARC).

The World Vision ARK (Abstinence and Risk Avoidance) program is a five year initiative implemented in partnership with Johns Hopkins Bloomberg School of Public Health, Center for Communications Programs (CCP) in Tanzania, Kenya and Haiti.

In Tanzania, World Vision is implementing activities in five districts (Monduli, Hai, Bukoba rural, Handeni and Karagwe) through partnerships with faith-based organizations, and national and regional civil society networks. World Vision operates through established district level Youth Advisory Groups (YAGs) that were set up by FHI/YouthNet's Ishi campaign (see YouthNet AB activity description for more information). World Vision and its partners will also operate through Parent Advisory Groups (PAGs). It will strengthen the capacity of the YAGs and PAGs to promote AB behaviors, and to form youth and parent action groups at ward and village levels. In FY06, this program will continue scaling-up its activities by expanding the YAGs and PAGs into new geographic areas.

The World Vision program has three main components. The first component is to strengthen youth capacity for AB behaviors. Five YAGs will be established, two existing YAGs will be strengthened, and 110 youth action groups will be established. The YAGs and youth action groups will provide participating youth with training in interpersonal communication, lifeskills and Transformational Development, and support to develop and roll out personal and group development plans. To support these groups, the program will adapt existing resource materials, develop and implement curriculum and materials for youth, and develop and implement a communication strategy. World Vision will also work to sensitize 10 youth service providers to AB, while encouraging youth to use services and refer their peers to VCT if they believe they should be tested. Out of school youth will be targeted through establishing and supporting AB programs and referrals for out of school youth. World Vision will aim to create incentives for volunteers for the outreach and YAG program.

World Vision will also increase the capacity of families and communities to promote AB behaviors. Five PAGS will be established, two existing PAGs will be strengthened, 60 parent action groups will be established, four District Advisory Committees will be established, and one existing DAC will be strengthened. Through these groups, 1,375 parents and five DACs will be oriented to and trained in transformational development, as well as creation and roll out of action plans. Forty community leaders, and 50 church leaders will be mobilized to form Community Care Coalitions. Fifty Common Ground Melting Pot meetings will be held between YAGs and PAGs at division, ward and village levels to stimulate dialogue between parents and youth regarding Adolescent Reproductive Health and Sexuality in relation to AB.

A number of products will be developed to support these parents and community members, specifically aiming to build skills in adult-youth communication around AB. World Vision will produce 3 curricula (1 for parents, 1 for 10-14, and 1 for 15-24), radio programming (4 radio spots followed by call-in sessions) and a toolkit (sharing materials across the program's countries and with key stakeholders where applicable). Finally, training and supervision will be conduct, which includes establishing a core team of 10 master trainers in each district (50 total), who will conduct downstream training for volunteers and action groups, followed by supportive supervision.

The third and final component is creating and supporting an enabling environment for AB behaviors. Twenty-five government actors will be sensitized at various levels (district, division, ward, village) to generate involvement in development planning for World Vision's AB activities, to provide input into the program's materials design, and to participate in the program's performance review. In addition, World Vision partners will receive technical assistance to plan, design, implement and monitor AB activities.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	43,852	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	25,142	☐
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	2,980	☐

Indirect Targets

While World Vision's primary audience is youth 10 to 24 years old, it is promoting peer education and one-on-one coaching that could benefit youth outside the target group (younger than 10 and older than 24) and parents and youth outside target areas. Additionally, the CBOs and FBOs that World Vision works with will also reach other populations outside the target groups and sites.

Target Populations:

Adults

Community leaders

Community-based organizations

Faith-based organizations

Teachers (Parent: Host country government workers)

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kagera

Kilimanjaro

Tanga

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Male Zero Grazing RFA
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4888
Planned Funds: [redacted] B5
Activity Narrative: This activity is linked to other activities in AB (see BBC and AED activity descriptions), as well as to activities in Other Prevention.

This new activity has multiple components aimed at influencing partnering behavior in Tanzania by explicitly engaging men in promoting fidelity as well as promoting social norms that discourage risky sexual behavior. Tanzania is in the midst of a generalized epidemic with prevalence at around 7%, and the vast majority of these infections occur through heterosexual transmission.

The 2005 Tanzania HIV/AIDS Indicator Survey found some positive trends. Median age at first sex has increased while the number of concurrent partners has decreased. However, much work needs to be done to curb the epidemic. It is reported that 5% of married women and 24% of married men had more than 1 partner in the 12 months before the survey. An even higher number of never-married women and men, aged 15-24 had sex with a non-cohabitating partner in the last 12 months (33% and 40% respectively). Nine percent of girls aged 15 to 19 who had sex with a non-cohabitating, non-marital partner in the last 12 months did so with men 10 years or more older than themselves. These partners are much more likely to be infected and facilitate transfer to the younger generation. Alcohol seems to play a limited role as a risk factor for this kind of high risk sex.

When looking at best practices, evidence is emerging that partner reduction appears to have played a role in the dramatic declines in prevalence in both Uganda and Thailand. Similar data is also coming from Zambia and Ethiopia. Its also seems that the greatest impact is achieved when partner reduction occurs among older, married men.

The goal of this activity is to identify factors that influence multiple partnering in Tanzania, and implement activities that explicitly engage men in promoting fidelity among their peers as well as promote social norms that discourage multiple partnering. Interventions will work with and reach out to sexually active adult men and will likely, in later stages, reach out to younger men as well based on lessons-learned during the first year of implementation.

This 4 year activity will be undertaken following a competed Request for Application (RFA). The RFA design will be developed in collaboration with senior technical assistance from O/GAC and USG agencies while the interventions themselves will be subject to mid-term and final evaluations. Although the detailed elements of this activity will only be determined at the end of the bidding process, the activity will be undertaken in 2 phases.

The first phase of this activity will be a detailed situational assessment (emphasis area: needs assessment) of sexual partnering in higher prevalence areas of Tanzania. Issues to be identified will include: societal norms and expectations regarding masculinity and sexual behavior; types of partners; situations in which multiple partnering occurs; barriers/facilitators of multiple partnering; avenues for reaching men; influencers in men's lives and avenues for influencing social norms around partnering; and strategies for addressing partner reduction in the context of polygamy. The findings of this assessment will drive the content of interventions and activities, will directly address gender norms and inequalities, and will be shared through national stakeholder events as well as at USG partner meetings.

Implementation strategies for the second phase of this activity will include, but not be limited to: promoting do-able actions as well as building on behaviors that society

is willing to endorse; engaging male social networks and role-models; employing interpersonal methodologies that allow individuals to accurately assess their own personal risk (as most sexually active adults don't have large numbers of partners they may not realize their risk as part of a network); and promoting and facilitating mutual testing. Additional activities may include awareness raising around existing partnering norms; skills building of local institutions, particularly faith-based groups, regarding how to engage men in dialogue and behavior change; engaging male PLWAs that can testify about behaviors that put them at risk; and developing and reinforcing messages across avenues of intervention. Emphasis areas include community mobilization and participation, development of networks, linkages and referral systems, information education and communication, local organization capacity development and training.

Target populations of this activity include adult men who are sexually active and may, at later stages, include adult women who are regular female partners of adult men as well as young men who are nearing the age of sexual debut. Community leaders, religious leaders, Community-Based Organizations, Faith-Based Organizations and Non-Governmental Organizations will also be targeted with this activity. In year 1, this activity will train 50 individuals to promote HIV/AIDS prevention through reduction of multiple partnering and emphasis of positive social norms, and reach 2,500 individuals through community out-reach activities. Outcomes will include reduce social acceptance around sexual coercion; cross-generational relationships, and transactional sex as well as a reduction in number of sexual partners and increased levels of fidelity

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	2,500	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	50	☐

Target Populations:

Community leaders

Community-based organizations

Faith-based organizations

Non-governmental organizations/private voluntary organizations

Men (including men of reproductive age) (Parent: Adults)

Religious leaders

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 4950
Planned Funds: [redacted]
Activity Narrative: In FY06, HHS/CDC will continue to collaborate closely with the Government of Tanzania through the relevant Ministries of Health (MoH) /National AIDS Control Program (NACP), Ministry of Education and Culture (MOEC) and other key stakeholders to further strengthen technical and program capacity for implementing the Emergency Plan. In the efforts of rapidly scaling up other youth HIV/AIDS prevention activities USG will require technical assistance in the area of behavior change communication, Youth friendly services, abstinence and faithfulness programs targeting youth. The technical assistance will support county teams to develop and enhance prevention and AB interventions that are supported by the USG. The funding will also support in- country Youth program staff salary for FY 06.

B5

The TA will be provided on semi- annual basis to the Ministry of Education and Culture (MOEC), the NACP/TAYOA Helpline program, FHI/Youth Net, African Medical Research Foundation (AMREF), and the Ministry of Labor, Youth Development and Sports (MLYDS) to orient the implementers on IEC/BCC, ABY, Life skills on the technicalities of developing interagency HIV/AIDS programs that promote behavior change and complimented by abstinence messages for in and out of school youth.

The TA team will also visit a variety of youth program sites managed by the Government, NGOs and FBOs. More time will be spent in orienting/training NACP IEC/BCC technical officers on how to develop quality BCC materials tailored to different target groups, with a particular focus on youth HIV/AIDS BCC educational materials and quality assurance. Emphasis will be on assisting the key implementers to adopt the MARCH (Modeling and Reinforcement to Combat HIV) strategy; activities will include radio serial drama, community activities involving parents and FBOs, developing materials for prevention with HIV infected persons; provider delivered interventions to be used in care and treatment settings and TA for general population and youth activities. At the end of the site visits the team will provide feedback to stakeholders and discuss the recommendations set forward.

The team in collaboration with MOEC will also review the Life Planning Skills (LPS) guidelines and training manuals used by facilitators and student's manuals with the aim of identifying strength and weakness in reaching program goals. This TA will assess and determine the strategies for scaling up other youth approaches in HIV/AIDS education and youth programs. The technical working group of the MOEC, NACP, MLYDS and USG will consider quality of life planning skills guidelines aimed to reinforce and simultaneously address AB prevention benefits linking with other HIV/AIDS prevention strategies. The team will also assess the monitoring and evaluation tools used and assess the quality of LPS knowledge imparted to teachers and other stakeholders in implementing youth programs for behavior change.

Emphasis Areas	% Of Effort
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)		☑
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful		☑

Target Populations:

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.03: Program Planning Overview

Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03

Total Planned Funding for Program Area:

B5

Program Area Context:

HIV transmission through the transfusion of contaminated blood is a preventable public health problem and forms a key strategy in the prevention of HIV/AIDS within the USG Five Year Strategy, the Government of Tanzania's (GOT) HIV/AIDS policy, the National Multisectoral Strategic Framework (NMSF) 2003 – 2007, and the Health Sector Strategy on HIV/AIDS (HSS). The USG strategy involves a two-pronged approach: establishing seven zonal transfusion centers and a developing pool of voluntary, non-renumerated repeat blood donors.

Since 2001, the USG has worked with the MOH in improving the National Blood Transfusion Services (NBTS). In support of the national requirement for at least 500,000 blood units annually, the USG has strategically focused on the establishment of a sustainable, nationally coordinated blood transfusion service, developing infrastructure and capacity necessary for collection, processing, storage and distribution of safe blood and blood products. USG support in FY04 and FY05 has included the renovation and equipping of three zonal blood transfusion centers. Although these three centers are still ramping up, the have collected, processed and distributed a total of 5,645 blood units between January and June 2005. Renovation of four more blood transfusion centers to serve the remainder of Tanzania will be completed in FY06. The USG has also contributed to the formulation of policy and technical guidelines, protocols and manuals for the NBTS and the training of 224 health workers in blood donor recruitment counseling.

The USG is the major collaborator supporting the GOT's efforts for the strengthening of the blood transfusion services. Other donors complementing the USG efforts include the Norwegian Agency for Development Cooperation. They will support the establishment of a national training centre in Dodoma with technical support from the University of Bergen in Norway. The Japanese International Cooperation Agency supplements safe blood screening by providing test kits for HIV, hepatitis and syphilis.

In FY06, USG efforts will support completion of the remaining NBTS zonal blood transfusion centers and collection of 40,000 blood units. Primary efforts will move to focus on the recruiting and training of adequate staff to meet the human capacity requirements within the NBTS, increasing institutional capacity to manage resources effectively. Activities will also focus on introducing a monitoring and evaluation (M&E) system to maintain quality, efficiency and effectiveness of the NBTS. The USG will work with the MOH towards the establishment of an executive agency for oversight of the NBTS headquartered in Dar es Salaam. Initially key staff for fiscal management and M&E will be hired on a contract basis with Emergency Plan funds with the executive agency taking over personnel costs upon budget approval by Parliament. An effective M&E system will include the updating, printing and dissemination of M&E tools for blood transfusion services; developing monitoring tools for blood donor clubs; conducting field supervisory visits and biannual progress reviews to develop a detailed implementation plan for FY07.

Community mobilization supported by the USG has complemented development of NBTS capacity and significant gains have been made in the establishment of blood donor clubs for youth (Club 25) in 12 out of the 21 regions. Activities in FY06 will be expanded in coordination with the NBTS to a total of 120 clubs in these 12 regions surrounding the seven zonal blood transfusion centers. These community efforts will support the collection of 52,000 additional blood units. Emphasis will be placed on strategies to reduce the dependency on family replacement blood donors by creating a pool of young voluntary, non-renumerated donors. Combined, these efforts will support USG strategic goals of safe blood provided to all health facilities by 2008.

Program Area Target:

Number of service outlets/programs carrying out blood safety activities	20
Number of individuals trained in blood safety	219

Table 3.3.03: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National Blood Transfusion Services, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 3416
Planned Funds:
Activity Narrative: *Links to other program area activities include: ABY- TAYOA, Sanquin Consulting* Services, Laboratory infrastructure strengthening program

The Tanzania Ministry of Health National Blood transfusion Service (NBTS) is a recipient of a track 1 Emergency Plan funds for Rapid Strengthening of Blood Transfusion Services in the United Republic of Tanzania (Tanzania Mainland and Zanzibar). In FY06, MOH will print and disseminate to all 6 zonal centers, 12 regional centers, all 27 Tanzania red cross regional offices and 6 military hospitals the NBTS Policy Guidelines, Clinical guidelines for use of blood and blood products, NBTS regulations and standards that were finalized in FY05 and are in the final process of being approved. The NBTS will conduct public awareness activities that include dissemination of IEC materials addressing NBTS services, customers rights advocating the rights to free blood transfusion service to all patients in need will be conducted by all NBTS partners in their respective areas of operation. The USG will support the MOH to maintain and expand the operations in the newly renovated zonal blood transfusion centers in Mbeya, Mwanza and Moshi. These centers will be provided equipment, reagents and supplies for collecting, processing and distributing blood to the referral hospital and the regional hospitals within the catchment areas of the respective zones. These zonal centers will ensure that all blood units are screened for HIV, Syphilis Hepatitis B and Hepatitis C

Through USG support, the MoH plans to expand the infrastructure for collection, testing, storage and distribution of safe blood and blood products in Zanzibar, and the Western and Southern zones of Tanzania mainland. In FY06, renovation of zonal blood transfusion centers in Zanzibar, Mtwara and Tabora will be completed. With USG support, the MOH will focus on establishing an effective management and administrative system for the NBTS, building institutional capacity for collecting, processing and distributing adequate safe blood and blood products, providing technical assistance and oversight in addressing problems encountered in implementing the planned activities, support the recruitment and training of staff, establish mobile donation teams at each of the zonal blood transfusion centers, procure transport and blood donation equipment for mobile teams, develop Standard Operating Procedures (SOPs) for BTS activities, ensure regular supply of HIV test kits, monitor project and budget performance, and develop an effective monitoring and evaluation system for the NBTS. The MoH will ensure that the prepared tools for staff performance, yearly appraisal, preparation of annual budget and monthly and quarterly meetings and other systems are in place for standardization of management procedures at all levels.

The main role of Tanzania Red Cross Society (TRCS) in the NBTS is recruitment and retention of voluntary, non-remunerated, repeating blood donors from a low risk population. This includes, community education, pre-counseling, blood collection, temporary storage, transportation to regional/zonal NBTS sites and provision of post counseling. In FY06, More emphasis will be placed on community mobilization strategies to reduce the dependency on family replacement blood donors by creating a pool of voluntary young blood donors and motivating them to become regular repeating voluntary blood donors. It is estimated that the annual requirement of blood for transfusion in Tanzania is about 500,000 units per year. TRCS plans to strengthen its activities in 12 regional centers established in FY05 and collect 5,000 units of blood per region per year. This is equal to 60,000 units per year. TRCS will also expand its donor recruitment and blood donation activities to regions in which the zonal blood transfusion centers are based.

TRCS will print and disseminate National guidelines for blood donor clubs developed

by MOH with support from TRCS. Using these guidelines, TRCS will establish and maintain 120 blood donor clubs for in and out of school youths. Youths of ages between 15 and 18 years are targeted for HIV counseling and testing, HIV prevention through ABY messages and life skills interventions. The youths are also counseled on blood donation, those who agree to become regular donors are enrolled as members of blood donor clubs and are expected to donate up to 25 units of blood by the age of 25 years (Club 25). Incentives provided include promotional materials, recognition during annual blood donors day (June 14), support for sports and recreational activities and provision of mobile phone airtime for the first donation and/or when reaching a pre-determined number of blood units donated. The youth blood donor promotional activities are implemented in collaboration with Tanzania Youth Awareness Trust Fund (TAYOA). Study visits will be conducted to internationally recognized country on blood donor clubs management. TRCS will procure additional 48-blood donor coaches for fixed and mobile teams in 12 regions. Purchase one vehicle for blood collection in Pemba, and 14 additional motorbikes for counselors in 12 regions. This will make a total of 24 motorbikes to all 12 regions, 2 in each region. Transportation costs of blood from regions to zonal centers using public transport service. Training will be conducted for newly recruited blood donor staff (30 Blood donor recruiters, 24 blood donor counselors, and 15 Phlebotomists. Refresher courses to 72 staff for donor recruitment and retention will also be conducted in FY06.The NBTS will Conduct Program management workshop for 36 participants. (12 regional coordinators and 12 recruiters, 6 TRCS administrative personnel, 4 representatives from MoH.

In FY05 TRCS played a leading role in preparation and development of IEC materials, In FY06, the MoH in collaboration with TRCS and other partners will finalize, produce and disseminate IEC materials to workplaces, community centers, institutions of higher learning, schools, and to the general public during national/public events. Zonal and regional blood transfusion committees will be formed to support activities related to promotion of blood donation, community mobilization and ensure proper use of blood and blood products. The committees, chaired by Directors of Zonal Referral hospitals or regional medical officers, will develop a working relationship with national and local organizations providing services related to blood transfusion.

The final component of the activity will establish a monitoring and evaluation framework for the NBTS to ensure provision of good quality services. This will include the review updating, printing and dissemination of M&E tools for blood transfusion services; developing monitoring tools for blood donor clubs; conduct field supervisory visits on a quarterly basis and conduct biannual progress reviews and development of annual detailed implementation plan for FY07.

Major challenges faced include the delay by MOH to initiate the establishment of NBTS as a semi-autonomous executive agency, inadequate qualified and skilled staff, and the slow pace in initiating operations in the newly renovated zonal centers.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets/programs carrying out blood safety activities	20	☐
Number of individuals trained in blood safety	219	☐

Target Populations:

Adults

Business community/private sector

Community leaders

Community-based organizations

Faith-based organizations

International counterpart organizations

Military personnel (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Pregnant women

Children and youth (non-OVC)

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

University students (Parent: Children and youth (non-OVC))

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Volunteers

Stigma and discrimination

Coverage Areas:

National

Table 3.3.03: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Regional Procurement Support Office
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 3479
Planned Funds:
Activity Narrative: This activity is linked to blood safety (MoH/NBTS), Laboratory strengthening (MoH/Diagnostics) in the COP.

B5

In order to support the rapid strengthening of the National blood transfusion services (NBTS) in Tanzania, 2 more zonal blood transfusion service outlets will be renovated in Mtwara and Tabora to increase the number of service outlets that are collecting, processing and distributing blood in the country. The sites for renovation of these zonal blood transfusion centers have been identified and the architects and *contractors have conducted a feasibility study and renovations will begin in end of* FY05. The Regional Procurement Support Office (RPSO) in the US Consulate in Frankfurt has contracted with Landplan-Icon, a local architectural firm as consultants to the project. Landplan-Icon provides consultancy services to both MOH-NBTS in the mainland and the Zanzibar Blood Transfusion Service.

MOH has submitted quantities and specifications of equipment, furniture and other supplies required to outfit these 2 centers. In FY06, the Regional Procurement Support Office (RPSO) in the US Consulate in Frankfurt will procure these of equipment, furniture and supplies. RPSO will handle this procurement as it did the other previous procurements for the 3 zonal blood transfusion centers. In FY06 this will include negotiating maintenance and service contracts with suppliers of the technical equipment. In some cases it is significantly cost effective to rent than purchase large and high cost equipment. Conversely, it maybe more cost effective to purchase than rent small instruments. RPSO will procure the equipment and supplies and the Medical Stores Department (MSD) will handle storage and ultimate distribution to the centers.

After the centers are completed, equipped and outfitted the blood banks will support the MoH- NBTS to compete forming the hub of six zonal blood transfusion centers throughout the country that are collecting, processing and distributing safe blood and blood products.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Logistics	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets/programs carrying out blood safety activities		☑
Number of individuals trained in blood safety		☑

Target Populations:

Public health care workers

Coverage Areas

Mtwara

Tabora

Table 3.3.03: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Sanquin Consulting Services
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 3509
Planned Funds:
Activity Narrative: Link to other program area activities include: ABY- TAYOA, MOH/NBTS Laboratory infrastructure strengthening program

The Tanzania Ministry of Health National Blood Transfusion Service (NBTS) is a recipient of a track 1 Emergency Plan funds for Rapid Strengthening of Blood Transfusion Services in Tanzania Mainland and Zanzibar. Sanquin Consulting Services of the Netherlands is also a recipient of a track 1 Emergency Plan funds for providing technical support to MOH/NBTS in implementing its program for Rapid Strengthening of Blood Transfusion Services in Tanzania Mainland and Zanzibar.

In FY06 SCS will assist and advice in the assessment of the current situation and needs in the country, resulting in a plan of action, and selection of the blood safety reform groups or steering committees for the country. These committees will have country local experts under defined leadership of the national coordinator.

After the staff of the zonal centers have been appointed (September 2005), task forces will be established in the 3 zonal centers that are currently operating in Mwanza, Mbeya and Kilimanjaro. The task force will report to the implementation team that will be at the MoH. The training needs of the members of each of these groups, and appropriate staff at all levels will be assessed and SCS will organize specialized training courses that will be conducted locally and internationally. Training of staff in management skills will be done in the Sanquin WHO Collaborating center and Academic Institute for International Development of Transfusion Medicine in the Netherlands.

The activities of SCS will be primarily directed to an accepted project organization, which can then slowly evolve to an executive agency with full control, documenting all decisions, evaluations and improvements of plans. The availability of the infrastructure and equipment are two of the most important pre requisites for improvement of the current operations in each of the 3 zonal centers. SCS will provide guidance for other activities including, administrative and management structure organization; expansion of the infrastructure for collection, testing, storage and distribution of safe blood; setting up a logistics system for procurement and supply of commodities for the NBTS; and developing monitoring and evaluation systems for the NBTS.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets/programs carrying out blood safety activities		☑
Number of individuals trained in blood safety		☑

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
National AIDS control program staff (Parent: Host country government workers)
Policy makers (Parent: Host country government workers)
Host country government workers
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Other health care workders (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.03: Activities by Funding Mechanism

Mechanism:	Country staffing and TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Medical Transmission/Blood Safety
Budget Code:	HMBL
Program Area Code:	03
Activity ID:	5026
Planned Funds:	
Activity Narrative:	This activity is linked to blood safety (MoH/NBTS), Laboratory strengthening (MoH/Diagnostics) in the COP. HHS/CDC provides technical assistance and support to MOH-National Blood Transfusion Service (NBTS) and the Zanzibar Blood Transfusion Service (ZBTS) in *implementing activities funded through a central mechanism (track 1)* to MOH/NBTS and Sanquin Consulting Services. This technical assistance involves TDY visits from the project officer in Atlanta as well as in country site visits to zonal centers and regional centers operated by the Tanzania Red Cross Society and military hospitals operated by the Tanzania Peoples Defense Force.

B5

Emphasis Areas	% Of Effort
Human Resources	51 - 100
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Coverage Areas

Mtwara

Tabora

Table 3.3.04: Program Planning Overview

Program Area: Medical Transmission/Injection Safety
Budget Code: HMIN
Program Area Code: 04

Total Planned Funding for Program Area:

B5

Program Area Context:

The MOH in Tanzania is committed to ensuring safe, quality health care services to Tanzanians through the implementation of the Infection Prevention and Control-Injection Safety (IPC-IS) program. The USG supports the MOH's overall responsibility for achieving the three-step strategy recommended by WHO and the Safe Injection Global Network that includes: supporting behavior change for healthcare workers and patients to ensure safe injection practices, ensuring availability of equipment and supplies, and introducing safe management procedures for disposal of medical waste.

The MOH, through USG technical and financial support, has initiated a Universal Safe Precaution and Injection Safety program in five referral hospitals and 60 district facilities. Under this program, the MOH has developed, printed, and disseminated over 6,000 copies of National Infection Prevention and Control Injection Safety guidelines to these facilities. In addition, a total of 1,289 health workers have been trained in general IPC-IS, quantification/management of safety injection supplies and proper waste handling. This was augmented by direct USG support in procurement of safety equipment and over 3,500 safety boxes.

The MOH coordinates IPC-IS implementation through a stakeholder coordinating mechanism to support the MOH goal that all healthcare providers practice universal safety precautions across such services as blood safety, laboratory, VCT, and PMTCT services. The program establishes an environment where healthcare workers and patients are better protected from transmission of HIV/AIDS and other blood-borne pathogens via medical practices.

Other donors like the German Technical Cooperation and WHO have supported the initiation of the universal safe precautions program in Tanzania. It is believed that it will take the combined experience and long-term commitment of these donors, the MOH and the USG to build the significant capacity required to achieve the MOH goal. Key challenges include the need to further develop the Post Exposure Prophylaxis (PEP) policy and guidelines for healthcare workers, ensure continued quality training for healthcare workers in IPC-IS, and procurement of injection equipment with safety features, safety boxes for health facilities, and protective gear for waste handlers.

USG support in FY06 will focus on scaling up the IPC-IS program in Tanzania. Under the Emergency Plan, the USG will provide ongoing technical assistance and funding to the MOH for continued expansion of IPC-IS to five regional and 30 district health facilities. USG efforts have been coordinated with the MOH and other donors to maximize both geographic and programmatic coverage. Capacity strengthening of referral hospitals and zonal training centers in the application of and education in standard safety precautions, including waste management, will be a critical component of the USG's activities fostering long term sustainability. This will include the implementation of targeted advocacy and behavior change strategies.

During FY06 the IPC-IS program geographic coverage will be expanded to 70 additional new sites including 60 districts within ten regions. Critical priorities will be to decentralizing training to zonal training centers, developing a strategy for local production of injection equipment with safety features and finalizing the PEP policy and guidelines for healthcare workers. A total number of 4,550 healthcare workers will be trained and the USG will procure and distribute 70,300 safety boxes and over three million safe injection devices.

As part of Emergency Plan activities in FY06, the USG will conduct follow-up assessments in original pilot areas and collect baseline data in proposed expansion sites. This and future assessments will assist in determining impact and the level of implementation of IPC-IS training and commodity support, informing future program elements and approaches, ensuring national coverage by 2008.

Program Area Target:

Number of individuals trained in injection safety	9,740

Table 3.3.04: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	JHPIEGO
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Medical Transmission/Injection Safety
Budget Code:	HMIN
Program Area Code:	04
Activity ID:	3422
Planned Funds:	
Activity Narrative:	This activity is linked to other activities in Injection Safety, and to activities in Policy and Systems Strengthening.

B5

Transmission of infection continues to be a major problem in Tanzanian health care settings, affecting both the users of health services as well as health care workers. Improper infection prevention and control practices, including unsafe use of injections, continue to be a route for HIV transmission. Infection also remains one of the top five direct causes of maternal death in Tanzania. The Ministry of Health and other stakeholders in health sector acknowledge that infection prevention is one of the pre-requisites for ensuring safe health care delivery as well as protecting the population from infectious diseases, including HIV/AIDS. It is also essential to protecting the health workforce.

This infection prevention (IP) activity is a follow-on effort implemented by JHPIEGO in partnership and with the leadership of the Ministry of Health under the ACCESS program. During FY05, ACCESS supported the Ministry of Health in the dissemination of National Guidelines on Infection Prevention to 37 district and FBO facilities during training workshops on focused Antenatal care.

The first component of this activity is the production of a pocket guide containing the National Guidelines on Infection Prevention. ACCESS was to receive FY05 PEPFAR funding to create the pocket guide by simplifying the National guidelines and translating them into Swahili. However, due to delays in funding, simplifying the guidelines, translating them into Swahili, printing, and dissemination have not started. These actions will be carried over to ACCESS FY06 work-plan. The purpose of the pocket guides is to provide all healthcare service providers with basic infection prevention guidelines and safety precautions applicable in their day-to-day activities. Updates on injection safety will be one of the important components of the pocket guide.

Additional activity components for FY06 include developing, printing and disseminating an orientation package on infection prevention which will assist district supervisors, trainers and other resource people in their efforts to orient policy makers at the district level and health providers to the IP guidelines. The orientation package aims at facilitating the updates on infection prevention Standard Precaution practices at district and other levels of health care system.

To benefit health workers at health centers and dispensaries in Tanzania, the orientation package will be translated into Swahili. Sufficient copies will be produced so that it is available in every district, as well as one per large health facility including FBO facilities. The pocket guide will be distributed widely so that all peripheral health facilities as well as some Village Health Management Committees will be reached.

Two trainers from 37 districts where ACCESS in collaboration with the MOH introduced focused ANC in FY05 will be given an update on IP and Injection Safety and oriented on the use of the Swahili Infection Prevention Orientation Package. This training session will also equip trainers with advocacy skills for them to advocate for infection prevention among Council Health Management Teams (CHMTs). Advocacy training will include advocating for the allocation of resources to conduct orientation sessions on infection prevention and injection safety as well as to see to it that standard precautions feature in district comprehensive health plans. Trainers will in turn conduct orientation of service providers in their own districts to complete the training cascade, resulting in over three hundred seventy individuals being trained in infection prevention and injection safety. ACCESS together with the MOH will

follow-up with trainers to support them as they carry out these orientations. It is expected that over 2000 providers will be reached with the Swahili pocket guide on Infection Prevention in at least 37 districts. A follow-up tool will be developed for use by the supervisors.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in injection safety	370	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Policy makers (Parent: Host country government workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Kagera

Kigoma

Kilimanjaro

Manyara

Mara

Mbeya

Morogoro

Mtwara

Mwanza

Ruvuma

Shinyanga

Singida

Tabora

Tanga

COAST

Table 3.3.04: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: John Snow, Inc.
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Medical Transmission/Injection Safety
Budget Code: HMIN
Program Area Code: 04
Activity ID: 3441
Planned Funds:
Activity Narrative: Link to other activities include: IS/JHIPEGO, IS/JSI, Policy and Systems Strengthening

John Snow, Inc. (JSI) has been contracted by CDC to provide technical assistance to Ministry of Health in implementing a program on Infection Prevention Control and Injection Safety (IPC- IS). JSI is a public health management consulting firm dedicated to providing quality technical and managerial assistance to public and environmental health programs around the world. JSI has been one of only a few key international players that has significantly contribute to country – level and global leadership in decreasing unsafe injections through policy development, supply management, country assessment and development of local injection strategies, plan and programs.

This activity consists of several different components involved in promoting and implementing programs in injection safety, infection prevention and waste management.

The first component of this activity is to develop and implement a safe injection strategy that focuses on ensuring the availability of injection safety devices, personal protective equipment (PPE), supplies, and related commodities at service delivery points through commodity procurement and delivery. The goal of this component will be to ensure timely provision of sufficient quantities of injection safety commodities to designated MMIS project sites, and to build-in efforts for sustainable provision of commodities after the life of the project. A total of 3,543,225 injections with safety devises, 70,300 safety boxes and 320 needle cutters will be procured and distributed.

The second component of this activity aims to improve the safe disposal of used medical devises through medical injection safety (MIS) effort that focus on training and capacity building of logisticians and waste handlers. This component will provide support to 35 new sites in 30 districts within ten regions for FY 06. A total of 700 logisticians and waste handlers will be trained (ten from each site) by September 2007. The strategy is to build capacity of regional and district hospitals and Zonal Training Centers (ZTCs) on medical injection safety through training. John Snow Incorporation (JSI) will support the MOH to accomplish harmonization of training materials with in country programs and partners for adaptation and use at the national level. The goal is to improve the level of knowledge, attitudes, and practices on injection safety-infection prevention and control among all logisticians and waste handlers engaged in the health care delivery system. Supportive supervision activities with district-level and other supervisory staff will be implemented to reinforce and assess injection safety and-infection prevention and control practices among healthcare service providers, store keepers and waste handlers.

The third component is to continue developing and implement targeted advocacy and behavior change strategies (BCC -IEC) that will improve injection safety - infection prevention and control (IS - IPC) practices, including reducing unnecessary use of injections. This component will promote safe and necessary injections as a social and professional norm among the populations targeted for intervention, including health care workers and waste handlers.

The fourth component is to provide technical assistance to the Ministry of Health (MOH) to establish a sustainable and safe health care waste management system. The strategy for the overall activity is to develop and strengthen systems to support proper disposal of healthcare wastes. Appropriate policies will be established and

adequate resources will be present to ensure the success of this component.

The fifth component is to provide technical assistance to the MOH on developing policies and management guidelines for Post Exposure Prophylaxis (PEP) for health care workers.

The final component of this activity will link to the MOH activity in this program area *(refer to the MOH/IS activity narrative for more information). In collaboration with* the MOH, JSI will conduct Monitoring and Evaluation of Injection Safety - Infection Prevention and Control activities. The goal is to track progress of the different activity components and the activity as a whole through monthly work plan *monitoring and reporting. Monitoring and evaluation activities include conducting* follow-up health facility assessments in original pilot areas and to conduct baseline assessments in expansion areas. Technical support will be provided to MOH to develop and translate tools and methodologies for measuring user satisfaction and acceptability. Behavior Change and Communication (BCC) evaluation tools will be created and adapted to local contexts in order to conduct BCC evaluations in target areas.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Human Resources	10 - 50
Training	10 - 50
Information, Education and Communication	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals trained in injection safety	700	☐

Target Populations:

Store Keepers
Waste Handlers

Key Legislative Issues

Wrap Arounds

Coverage Areas

Dar es Salaam

Kilimanjaro

Dodoma

Iringa

Iringa Rural

Iringa Urban

Kagera

Bukoba Urban

Hai

Moshi Urban

Mwanga

Morogoro

Morogoro Rural

Morogoro Urban

Mwanza

Misungwi

Nyamagana

Kwimba

Ilemela

Ruvuma

Songea Rural

Songea Urban

Tanga

Lushoto

COAST

Kibaha

Bagamoyo

Mkuranga

Rufiji

Same

Muheza

Table 3.3.04: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHA1 account)
Program Area: Medical Transmission/Injection Safety
Budget Code: HMIN
Program Area Code: 04
Activity ID: 3500
Planned Funds:
Activity Narrative: Link to other activities include: IS/JHIPEGO, IS/JSI, Policy and Systems Strengthening

B5

The program started as a Ministry of Health (MOH) activity in year 2004 and later John Snow Inc (JSI) through a central cooperative agreement has been contracted by CDC to provide technical support in the implementation of the program. MOH and JSI activities are complementary and support one joint work plan. The USG funding for Medical Injection Safety through MOH will provides opportunity for sustainable inclusion in the government budgeting in future.

This activity consists of several different components involved in promoting and implementing programs in injection safety, infection prevention and waste management.

The first component of this activity specifically aims to improve medical injection safety (MIS) through training and capacity building of health care workers and other personnel like logisticians and waste handlers. This activity will provide support to 35 new sites in 30 districts within ten regions by FY 06. A total of 8400 health workers will be trained by September 2007. The strategy is to build capacity of regional and district hospitals and Zonal Training Centers (ZTCs) on medical injection safety through training. This will be accomplished by harmonizing training materials with in country programs and partners for adaptation and use at the national level. The goal is to improve the level of knowledge, attitudes, and practices on injection safety-infection prevention and control among all cadres of staff engaged in health service delivery. Supportive supervision activities with district-level and other supervisory staff will be implemented to reinforce and assess injection safety and-infection prevention and control practices among prescribes and frontline healthcare service providers.

The second component of this activity is to establish a sustainable and safe health care waste management system. The strategy for this component is to develop and strengthen systems to support proper disposal of healthcare wastes. Appropriate policies will be established and adequate resources will be present to ensure success of this component.

The third component is to improve healthcare worker safety through effective injection safety - infection prevention and control practices including effective needle-stick prevention. Health care workers will be encouraged to adhere to injection safety and infection prevention and control policies and management guidelines. This component will promote the application of standard precautions in medical settings, including infection prevention and control practices in order to reduce the risk of the transmission of infections including HIV/AIDS and other blood borne pathogens among health care workers. This component will also lobby for vaccination of healthcare workers at risk of hepatitis - B infection with the hepatitis B vaccine series (three doses). This activity component will also develop policies and management guidelines for Post Exposure Prophylaxis (PEP) for health care workers.

The fourth component will promote public - private partnerships to implement a global communication and advocacy strategy to leverage and coordinate support for injection safety and infection prevention and control. This activity component will involve developing strategies to improve injection safety and infection prevention and control practices in the private sector. The component will also include conducting four (on quarterly basis) stakeholders coordination forum (SCF) meetings on quality improvement, infection prevention and control, and injection safety. Program findings and lessons learnt will be shared at international conferences within and

outside Africa.

The final component of this activity will link to the John Snow Incorporation (JSI) activity in this program area (see *JSI Injection Safety* activity narrative for more information). This partner (JSI – Making Medical Injection Safe) in collaboration with the MOH will conduct Monitoring and Evaluation of Injection Safety - Infection Prevention and Control activities. The goal is to track progress of the different activity components and the activity as a whole through monthly work plan monitoring and reporting. Monitoring and evaluation activities will include conducting follow-up health facility assessments in original pilot areas and to conduct baseline assessments in expansion areas. With the technical support from JSI, tools and methodologies for measuring user satisfaction and acceptability will be developed, translated and distributed.

Also Behavior Change Communication (BCC) evaluation tools will be created and adapted to local contexts in order to conduct BCC evaluations in target areas. Supportive supervisory systems on injection safety and infection prevention and control will be established in Zonal training centers and two national staff members will be trained on Data Management skills in order for the program to have a well established data collection, storage, aggregation and reporting system in place.

Emphasis Areas	**% Of Effort**
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100
Human Resources	10 - 50
Logistics	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals trained in injection safety	8,400	☐

Target Populations:

Public health care workers

Private health care workers

Key Legislative Issues

Wrap Arounds

Coverage Areas

Dar es Salaam

Kilimanjaro

Mwanza

Dodoma

Dodoma Urban

Iringa

Iringa Rural

Iringa Urban

Kagera

Bukoba Urban

Hai

Moshi Urban

Mwanga

Same

Morogoro

Morogoro Rural

Morogoro Urban

Misungwi

Nyamagana

Kwimba

Ilemela

Ruvuma

Songea Rural

Songea Urban

Tanga

Muheza

Lushoto

COAST

Kibaha

Bagamoyo

Mkuranga

Rufiji

Table 3.3.05: Program Planning Overview

Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05

Total Planned Funding for Program Area:

B5

Program Area Context:

The Government of Tanzania (GOT) and USG remain committed to a comprehensive prevention program. Prevention is considered a fundamental component of all services and there is a strong conviction that emphasis should be placed on assuring that linkages are actively promoted throughout the continuum of care. Given the continuing level of stigma and discrimination compared to the increased level of HIV awareness among Tanzanians, specific emphasis needs to be placed on combating negative social norms and supporting individual behavior change. In order to assure these linkages, activities included in this section will support, and are supported by, activities in the AB, VCT, PMTCT, care, and treatment sections.

While Tanzania is experiencing a generalized HIV epidemic, Geographic Information Systems (GIS) mapping and regional prevalence statistics support the need to more effectively target most at risk populations (MARPS), including the uniformed services, agricultural workers, commercial sex workers, truckers and communities along the transport corridors. Significant progress has been made by the Tanzania Commission on AIDS and the National AIDS Control Programme in the development of the national HIV/AIDS Communications Strategy, which is nearly finalized. This strategy is vital to assure the coordination of behavior change activities and messages, support best practices, and ensuring that prevention messages and skill building is woven throughout the prevention to care continuum. While approximately 57 million condoms were distributed in Tanzania over the last year, the availability of condoms continues to be a challenge, particularly due to stock-outs in the public sector. As identified in the USG Five Year Strategy, targeted behavior change and condom distribution to reduce transmission in MARPS, including prevention messages to PLWHAs and specific work place interventions will be emphasized.

USG assistance to prevention programming is substantial. In FY06, this will continue to include the training of health care workers in provision of youth friendly services targeting at risk youth and the established national youth HIV/AIDS helpline. In years past, the USG has been the largest supporter of condom social marketing and provided technical assistance to GOT in developing a national strategy to guide this marketing. This strategy is being developed with all stakeholders and will be instrumental in tracking and harmonizing the distribution of condoms throughout the public and commercial sector and social marketing programs (Global Fund Round 4, KfW Entwicklungsbank, the Royal Netherlands Embassy, and Marie Stopes Tanzania are now major contributors). A USG contractor is preparing to launch a new socially marketed condom brand targeted to MARPS in conjunction with and linked to other USG supported behavior change interventions which will continue into FY06.

In FY06, the USG portfolio is refocusing to target MARPS more effectively. The interventions that target communities surrounding major transport centers and uniformed services are being scaled up. Focused behavior change communications will include peer education programs, interpersonal communications, and other activities that directly interface with MARP target groups in high HIV transmission areas, including bars, guesthouses and other locations where alcohol is served. Activities focusing on at risk youth will contain many of the elements above and will include the training of teachers and gatekeepers in support of these interventions. In total, USG efforts in FY06 will support 10,583 condom service outlets, the training of 2,629 individuals in promoting HIV prevention with over five million individuals reached through community based programs. The activities in FY06 build upon existing programs and are being expanded to emphasize stronger linkages throughout the continuum of services, enhancing the comprehensive nature of HIV prevention efforts in Tanzania.

Program Area Target:

Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	5,378,900
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	2,629
Number of targeted condom service outlets	10,583

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National AIDS Control Program Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 3377
Planned Funds:
Activity Narrative: This activity is related to the following activities in Other Prevention: Youth net, Peace Corps and Youth TBD. It is also related to the following activities in AB: FBO and MOEC.

B5

The Tanzania Youth Awareness Trust Fund (TAYOA) proposes to scale up and continue supporting National AIDS Helpline Services in different institutions and communities in 9 municipalities of Dar es Salaam, Zanzibar and Coast region. Since they started operating two years ago, the Helpline Services have recorded more than 170,000 frequently asked questions from more than 98,000 callers regarding information on HIV/AIDS and HIV/AIDS prevention. The Services facilitate personal risk perception and promote comprehensive prevention measures through outreach activities. HIV/AIDS Helpline Services are located in both urban and rural areas.

Using FY 06 USG funds, the Helpline Services will be able to increase their capacity in rural areas and reach an additional 75,000 callers annually. The helpline will also leverage its network with private sector collaborating partners from TTCL, VODACOM, MOBITEL, ZANTEL and CELTEL to reach rural areas. Helpline Services will ensure that callers will receive accurate and consistent basic information about HIV/AIDS and related issues. It is expected that the frequently asked questions will be compiled in the form of audio tapes to be disseminated in 10, 000 families, 25 institutions, 50 schools and through the National HIV/AIDS Helpline Service Clubs located in urban and rural areas.

Outreach activities conducted by the National AIDS Helpline Services will raise awareness of youth personal risk behaviors through community based youth groups and increase at-risk youth access of youth friendly reproductive health services with condom access and STI treatment. The Helpline Services also plan to promote public dialogue that will discuss about broad prevention messages, such as making responsible decisions regarding their sexual and reproductive health, and reducing multiple partners.

The National Helpline Services also plans to intensify and promote gender equality through responsible parenthood, focusing on men in particular. TAYOA will train 200 peer educators, 29 community leaders and community theater groups in Zanzibar, Coast region and Dar es Salaam to produce comprehensive HIV/AIDS prevention educational materials. Though the integration of entertainment such as dramas, sports, and music, TAYOA will be engaged in mobilizing communities to adapt safer norms and behaviors related to HIV/AIDS infections by promoting the correct and consistent use of condoms, discouraging teenage pregnancies, and promoting life planning skills. TAYOA will also promote dialogue on delaying sexual activity through empowering adults and opinion leaders to facilitate a variety of community mobilization campaign activities that will complement and reinforce HIV behavior change.

The National AIDS Helpline Services through the support of USG will provide HIV/AIDS Behavior Change Communication tools that will build upon other HIV prevention messages within the broader context of youth reproductive health. The National AIDS Helpline services will use mass media, community mobilization methods, parent child communication initiatives, dramas, soap operas and other traditional low literacy tailored materials to focus on broad-based age-appropriate HIV/AIDS prevention

The National AIDS Helpline Services in collaborations with local HIV/AIDS Business Coalition will produce and disseminate 500 T-shirts 750 car stickers, 500 flyers, and

1,000 posters with broad-based prevention, stigma reduction and anti-discrimination messages. These materials will be disseminated during local and national events where prevention, VCT and Youth Friendly services will be discussed. These activities are jointly organized with other HIV/AIDS prevention, care and treatment services

This activity will be implemented through collaboration with the National Aids Control Program (NACP), and will aim to reduce risky sexual behavior, by presenting prevention messages linked with AB information that are responsive to cultural realities. It will support institutional and community structures that support youth in making responsible and healthy decisions in addressing HIV/AIDS prevention. Targeted organizations include primary schools, secondary schools, institutions of higher education and other organizations working with youths aged 7-24 years, as well as organizations supporting out of school youth. The program target is to reach 600,000 youth with broad based prevention messages.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	600,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	400	☐
Number of targeted condom service outlets	400	☐

Target Populations:

Adults

Business community/private sector

Faith-based organizations

Most at risk populations

Street youth (Parent: Most at risk populations)

Policy makers (Parent: Host country government workers)

Children and youth (non-OVC)

Religious leaders

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Dar es Salaam

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

COAST

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mbeya Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 3387
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in CT (MRH and MRMO), treatment (MRH and MRMO), and other prevention (AED, Central Contraceptive Procurement and FHI/Transport Corridor Initiative).

B5

The Mbeya Regional Medical Office (MRMO), through its Regional AIDS Control Programme (MRACP), is responsible for implementing a wide range of prevention programs within its region. In FY05, the MRMO was supported under Emergency Plan funding to refocus efforts on most at risk populations along the trade routes in its region. Situated along the Trans-African Highway, at the junction between Malawi and Zambia, Mbeya Municipality and its surrounding communities contribute to a large percentage of the overall HIV infected population in Tanzania. Prevalence in the population along the trade routes averages around 12% according to data from NGOs and FBOs providing VCT services but can range as high as 68% among bar workers (high incidence cohort studies, Mbeya Medical Research Programme).

Recently the MRMO and the Mbeya Referral Hospital conducted their own HIV sensitization campaigns targeting health care workers in an effort to encourage those who are HIV positive to access treatment. Part of this sensitization included a blind screening of health workers to determine the HIV prevalence in this work force. They found that 12% of those tested were sero-positive, higher than the general population nationally though in line with that for Mbeya (prevalence in the general population nationally is 7%, Tanzania HIV/AIDS Indicator Survey 2003-2004). This has caused great concern regarding the ability of the health care system in Mbeya to maintain its required human resources. The MRMO and the Mbeya Referral hospital have designed a work place program to sensitize and educate this high-risk population.

The MRACP has been undertaking both general and targeted prevention programs with technical support from the German Technical Cooperation (GTZ) for over eight years. GTZ has assisted in developing the capacity of the MRACP in not only designing and implementing such programs but also undertaking evaluations to determine impacts of these interventions. In FY06, with support from USG funds, the MRMO and MRACP will continue to implement prevention activities in high transmission areas though peer-educator programs targeting not only females but also local and transient males. Activities under FY05 USG support have just been initiated and results on the number reached and impact will not be available until March 2006. Current plans for prevention will include training and support of peer outreach workers, provision of educational materials on safe behavior practices, support of community meetings and production of local radio spots and billboard messages targeting the behaviors associated with risk along the transport corridor. Condom distribution through nationally supported programs and USAID partners will complement this outreach. Activities will also provide information on the nearest counseling and testing centers and treatment available in the region. Evaluation of FY05 activities will guide the MRACP on making modifications to this intervention as they move into FY06.

Similar approaches will be taken with the health care workers with the establishment of a peer educator program. Workshops will be conducted in each district with participation by both public and private facilities and to include health center and dispensary personnel. Whenever possible, such programs addressing personal behavior will be used to complement professional behavior such as injection safety education supported at the national level. Information on the availability of treatment and the offering of counseling and testing will be part of all workshops. Monitoring of the number of health care workers accessing treatment will be compared to the

current prevalence rate.

Programs for the population along the transport corridor will target a total of 400,000 individuals with those targeting health care workers estimated to reach 4,000 individuals. Funding under this submission will support community programs (20) and workshops (10), training of peer educators (40), continued support of those educators, media campaigns, reprinting of educational materials and detailed data collection and analysis to determine impact.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	404,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	40	☐
Number of targeted condom service outlets		☑

Target Populations:

Commercial sex workers (Parent: Most at risk populations)

Most at risk populations

Truck drivers (Parent: Mobile populations)

Partners/clients of CSW (Parent: Most at risk populations)

Public health care workers

Private health care workers

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Mbeya

Table 3.3.05: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	PharmAccess
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Other Prevention Activities
Budget Code:	HVOP
Program Area Code:	05
Activity ID:	3392
Planned Funds:	

B5

Activity Narrative: This activity also relates to activities in PMTCT (PharmAccess), counseling and testing (PharmAccess), other prevention (AED and Central Contraceptive Procurement).

As with many militaries in Africa, HIV prevalence among uniformed personnel in Tanzania is estimated to be higher than that of the general population (seven percent, Tanzania HIV/AIDS Indicator Survey 2003-2004). Continued aggressive measures are needed to address this mostly young and sexually-active portion of the population which represents a high-risk group which can serve as a bridge for HIV transmission to the population at-large. This activity will support ongoing efforts, started under FY05, by the Tanzanian Peoples Defense Forces (TPDF) with assistance from PharmAccess, to provide prevention, education and condom distribution services to military personnel and to communities surrounding military posts including the military health facilities.

An HIV/AIDS education program, based on adapted life-skills modules, was developed for the TPDF in FY05 and will be utilized through the TPDF basic training centers for recruits. A unique aspect to the military is that all recruits must be HIV-negative in order to be able join the military services, as well as to be able to serve on military duty outside of Tanzania (such as in UN-supported peace keeping operations). Thus, this HIV testing requirement is an excellent opportunity for monitoring baseline HIV prevalence and annual HIV incidences, which, in turn, will allow objective evaluation of the effectiveness of these prevention programs over the course of the service members' service in the TPDF.

USG funding will support the initial training of 100 peer educators, at least two per camp. In addition, another 145 peer educators, who already trained in FY05, will receive much-needed refresher training. The peer educators will be supported in continued prevention/outreach efforts throughout their period of military service. In addition, special attention will be directed this year to 14 camps of the National Services. This "branch" of service is under the TPDF and includes individuals ranging from 18 to 22 years of age who enlist for a two-year, pre-service training. These young adults are removed from family and other support mechanisms, and are often exposed to high-risk populations such as commercial sex workers, putting them at greater risk of infection. Efforts within the TPDF will continue to focus on the 16 TPDF basic training, special detachment and border camps where service members are stationed outside their residential areas for periods which usually range from six to 24 months (or longer).

Condom distribution and education services will be incorporated through prevention efforts and as part of VCT services at post/camp treatment clinics, basic training centers and special detachment and border camps. Condoms will be obtained through USAID/AED and national procurement efforts which will also assist in distribution. Their cost is not included in this budget.

It is expected that this activity will reach a target of approximately 4,000 recruits at basic training centers; 3,000-4,000 men and women under the National Services; and a total of approximately 200,000 service members, their dependents and surrounding community members by September 2007. Prevention outreach will be linked to counseling and testing and PMTCT activities in support of the continuum of care.

The TPDF and PharmAccess, a large not-for-profit organization based out of the Netherlands, have developed a strong working relationship over the past four years in the area of health service provision. Expansion of prevention services in FY06 will

ensure a close linkage of military implementation to national strategies and programs. Funding for the TPDF through PharmAccess will provide much needed technical support, management assistance and M&E for all TPDF activities in this COP.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	208,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	245	☐
Number of targeted condom service outlets	30	☐

Target Populations:

Adults

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Key Legislative Issues

Addressing male norms and behaviors

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Academy for Educational Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 3424
Planned Funds: [redacted]

B5

Activity Narrative: This activity relates to several activities in Other Prevention, and also relates to activities in Abstinence and Being Faithful and in Policy Analysis and Systems Strengthening.

In years past, the USG has been the largest supporter of condom social marketing in Tanzania. At the end of FY04, a competitive procurement process identified a new USG contractor for condom social marketing; this shift in implementing partners resulted in significant transitional challenges causing slower than hoped for implementation. In FY05, the new contractor AED incorporated a locally registered organization, Tanzania Marketing and Communications (T-MARC) Incorporated. This locally controlled social marketing organization is dedicated to increasing access to marketed HIV/AIDS products through an emphasis on communications focused on changing the corresponding risky behaviors, especially in most at risk populations (MARPS).

T-MARC's approach is to build partnerships with the commercial sector, NGOs, FBOs, CBOs and the public sector in a comprehensive effort to change risky behaviors and generate demand for an affordable and accessible range of HIV/AIDS preventive products, starting with condoms. Reaching full market potential relies on targeted market segmentation, whereby all sectors play critical roles. However, such reach can only be achieved through a strong foundation of behavior change communications at national and community level that focus on changing critical behaviors in the population.

Approximately 57 million condoms were distributed in Tanzania over the last year yet the availability of condoms continues to be a challenge, largely due to stock-outs in the public sector. T-MARC will increase the supply of condoms and other HIV/AIDS preventive commodities by supporting partners in the private, NGO, and public sectors to introduce new products and brands that meet the needs and desires of MARP target groups. T-MARC has recently launched a newly branded female condom in Tanzania, and is in the process of conducting market research to launch a newly branded male condom; both of these products will be oriented to key target groups, especially along high transmission transport corridors. T-MARC and its partners are targeting 10,000 condom-service outlets in FY06.

T-MARC will increase the demand for condoms and other HIV/AIDS preventive products through coordinated, research-based communications campaigns that focus on the need for changing underlying behaviors in coordination with, yet separate from, promoting product sales. T-MARC, in conjunction with partners, will implement focused behavior change communications that will include peer education programs, interpersonal communications (IPC), training in prevention and condom use and other activities that directly interface with MARP target groups in high HIV transmission areas, especially along the high transmission transport corridors. Success will be measured by increasing, compared to baseline, the percent of target group adult men and women who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those surveyed who have had sex with such a partner in the last 12 months.

T-MARC will work with its commercial distribution partners to fund additional sales and promotional personnel as long as necessary to ensure coverage and education in outlets and non-traditional outlets such as bars, nightclubs, hotels, and kiosks visited by the target groups. T-MARC will also support brokering deals with institutional buyers and ensure distribution of female condoms to retail outlets in areas frequented by commercial sex workers, as well as educational interventions to focus

on correct use and underlying behaviors.

While combating a generalized epidemic, GIS mapping and regional prevalence statistics in Tanzania support the need to more effectively target MARPS, especially along transport corridors. T-MARC's commercial partners will focus distribution efforts in urban markets, thus T-MARC proposes to use matching funds to bolster coverage in high-transmission areas and workplaces, thereby increasing access and behavior change interventions in these areas. In addition, T-MARC will assist the AIDS Business Coalition in Tanzania with materials development for work place programs.

In promoting the increased use of condoms in Tanzania, T-MARC will support a variety of interventions to change underlying behaviors and to increase access and acceptability of condom use among the target groups. T-MARC will provide direct promotional support for donated products, and use matching funds to provide promotional support for non-donated products. The free public sector condoms will receive promotional support indirectly through generic promotion programs. Condom use promotion programs will comprise a mix of activities that will include radio advertising, outdoor advertising (particularly along the major transport corridors), point-of-sale promotion, experiential communications, peer group (interpersonal communications) programs largely implemented by partner NGOs, and public relations.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	3,000,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	100,000	☐
Number of targeted condom service outlets	500	☐

Target Populations:

Adults

Commercial sex workers (Parent: Most at risk populations)

Community leaders

Most at risk populations

Military personnel (Parent: Most at risk populations)

Truck drivers (Parent: Mobile populations)

People living with HIV/AIDS

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism:	YouthNet
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Other Prevention Activities
Budget Code:	HVOP
Program Area Code:	05
Activity ID:	3465
Planned Funds:	
Activity Narrative:	This activity is related to other activities in Other Prevention, and to activities in AB and OVC.

B5

With FY 04 and 05 Emergency Plan funds, FHI's YouthNet/Tanzania (YN/T) has reached over 2.25 million youth and 750,000 community members with HIV prevention messages, primarily focused on AB. This has been achieved through direct programming and through more than 35 sub-grants to NGOs in Iringa and Dar es Salaam Regions. The regions in which YN/T works are situated along a major transport route, and thus have high HIV prevalence rates. In addition, these regions each have a large urban center; as urban youth tend to initiate sexual activity earlier and tend to engage in higher-risk sexual behaviour, an AB only program may not adequately address their prevention needs. YN/T will use other prevention funds for more comprehensive HIV prevention messages to these older youth.

With USG support, YN/T has developed skills in behavior change communication, faith-based prevention approaches, youth participation, monitoring and evaluation, and report writing. Building upon activities from FY05, YN/T in FY 06 will expand its intensive, geographically focused work in Iringa and Dar es Salaam to incorporate two other at-risk areas, Morogoro and Mbeya, thereby continuing the focus along this major high transmission corridor. YN/T will also expand its activities to Zanzibar, as they will also subsume the existing Africare activity for other prevention as that agreement ends April 30, 2006. The intention is to continue supporting activities in Zanzibar until the newly competed youth TBD mechanism is in place.

YN/T has played a Technical Leadership role globally and in Tanzania, and in FY 06, it proposes to scale up activities with youth-serving organizations nationwide, such as Track 1 ABY partners and the Government of Tanzania. Additionally, YN/T proposes to broaden the thematic reach of its program by emphasizing various themes, including key legislative issues, critical to the success of HIV prevention among youth. These include gender issues, livelihood projects through linkages with other existing programs and orphans and vulnerable children.

YN/T's three main strategies focus on community based behavior change, developing youth participation and leadership, and technical assistance. YN/T will support Behavior Change activities for HIV prevention for older youth, both in- and out-of-school. Through multiple grant mechanisms, YN/T plans to reach more youth with "ABC and beyond" HIV prevention skills and messages, through partners such as IDYDC's older youth sport program and curriculum.

Other activity components will include expanded work with youth groups, expanded support for specific youth camps; and collaboration with Mambo Elimu and a new TBD activity (formerly BBC WST) to develop age-appropriate, targeted ABC messages. YN/T will also support the creation and distribution of print materials, such as the popular "Si Mchezo!" magazine, which includes articles on youth, gender, reproductive health, HIV/AIDS, STIs, and violence prevention. YN/T will work with peer-education programs to disseminate and promote use of these new materials. YN/T will also use its existing grants mechanisms to support projects that reach and improve skills of youth communities that have not been reached to date.

Under the national Ishi Campaign, funds will be used to deliver targeted comprehensive prevention messages. Existing Ishi-supported HIV Prevention Resource Centers (PIRCs) will be supported through this campaign and will continue to offer comprehensive information and HIV education, as well as strengthen links to services such as VCT. The PIRCs will conduct men and women's discussion groups to

promote positive roles, responsibilities, and behaviors. They will continue capacity building efforts for Youth Advisory Groups (YAGs) and continue to support and guide YAG outreach, mobilization, and awareness-raising activities. The Campaign will introduce evidence-based components of the "Program H" gender initiative, a program that fosters gender equity and promotes changing social norms related to gender and sexual behavior. The Campaign will also consist of limited mass media efforts, particularly using radio and some billboards, targeted to support Ishi efforts. Prevention messages designed for and targeting older youth will be comprehensive.

YN/T will additionally promote youth participation and leadership through its Youth Executive Council (YEC), and through a collaborative effort with the YEC, Ishi YAGs, and interns. Projects that focus on reduction of youth vulnerability will be supported. This will be done through youth participation training to community members, which will result in the development of youth friendly policies and plans. YNT will document its experiences in this area in order to facilitate experience sharing forums among OVC partners also working to promote youth participation and leadership.

Under its technical leadership role, YN/T will promote the use of global tools, such as its Youth Participation Guide, which seeks to increase the level of meaningful youth participation in reproductive health and HIV/AIDS programming at an institutional and programmatic level. The tools will be tested and translated for the Tanzanian context. Other activity components will include trainings on state-of-the-art of peer education, which will maximize outcomes for youth behavior change, and addressing gender issues by tailoring programs to meet the special needs of young men and women.

Continued and new efforts will be directed to creating linkages with other programs in reproductive health, gender, policy, and livelihood issues as important crosscutting themes throughout all YN/T and ISHI project activities.

YN/T will train 620 individuals to deliver comprehensive prevention messages. Nine hundred and twenty thousand individuals will be reached through the various activity components implemented by YN/T and ISHI.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	920,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	620	☐
Number of targeted condom service outlets		☑

Indirect Targets

OVC: While not a direct focus of YN/T's work, YN/T anticipates reaching OVCs with HIV prevention messages and skills through its program and through links to OVC projects. It will not be serving OVCs directly but will work through programs or training providers that care for OVCs.
Policy: YN/T will not provide direct TA in policy development, though given that policy is relevant to YN/T's work, policy will be considered.

Target Populations:

Adults

Community leaders

Street youth (Parent: Most at risk populations)

Orphans and vulnerable children

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Wrap Arounds

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Dar es Salaam

Iringa

Mbeya

Morogoro

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Peace Corps
USG Agency: Peace Corps
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 3497
Planned Funds:

B5

Activity Narrative: This activity relates to activities in Abstinence and Be Faithful, Palliative Care: Basic Health Care and Support and Orphans and Vulnerable Children.

Peace Corps Tanzania (PC/T) directly implements Emergency Plan activities through the actions of its 110 Peace Corps Volunteers in 15 of 21 regions on mainland Tanzania. PC/T implements an integrated HIV/AIDS program where all Volunteers in country, irrespective of their project assignment, are encouraged to implement HIV/AIDS activities. In FY05, PC/T implemented its HIV/AIDS program with "Other Prevention" as its main program area, by directly reaching community groups and their members with HIV/AIDS awareness information and Life Skills. Volunteers have worked with teachers and in-and-out-of-school youth in both primary and secondary schools and with other community based organizations (CBOs) such as women's groups and their members. Volunteers also trained different community groups to build their capacity to train others and conduct other awareness activities.

With FY06 'Other Prevention' funds, PC/T will specifically target youth in secondary schools, teachers and other community members. A recent behavioral survey stated that the Iringa region in Tanzania is.... "One of the regions with a high prevalence rate of HIV/ AIDS in Tanzania, 14%" Some of the findings of the study include: that the median age at first intercourse was 18 and 20 years for girls and boys respectively in rural areas and 18 years for both sexes in urban settings. This is the age when most youth are either out of school or are enrolled in secondary schools, thus there is a need to target these youth. Through collaboration with the Ministry of Education and Culture in Tanzania, PC/T has also been asked to work with teachers as an affected group as, "Over 3,000 teachers are said to have died due to HIV/AIDS in 2004." PC/T implements a Life Skills approach which helps people to learn to assess healthy life choices that are appropriate for them to avoid being infected by HIV.

In FY06, PC/T will directly reach 27,000 secondary school youth through Volunteers' actions. Some of these actions include: facilitating classroom sessions, strategically placing question and answer boxes, and conducting extra-curricular activities like health clubs, sports and field trips focusing on HIV/AIDS prevention. Volunteers and their Host Country National (HCN) counterparts will also reach 400 teachers with HIV/AIDS awareness activities and Life Skills trainings to enable them to assess life's risks and to make healthy choices. About 3,000 community members will be reached with HIV/AIDS awareness information through: large community awareness meetings, community drama activities and video shows. PC/T will continue to provide training to help build capacity on HIV/AIDS awareness and Life Skills information. The planned capacity building activities are to train 400 teachers in secondary schools in order for them to gain confidence to teach HIV/AIDS subjects and Life Skills, but also reproductive health and the correct and consistent use of condoms. Capacity building activities will also to enable these teachers to gain the skills required to initiate and maintain HIV/AIDS awareness activities in schools. Volunteers will train 134 peer educators in secondary schools and 100 out of school youth through community theatre, games and community mobilization activities.

PC/T will conduct workshops for all first year Volunteers and their HCN counterparts to give them the capacity needed to conduct Emergency Plan program activities. Volunteers can also access Emergency Plan monies through VAST grants to fund trainings and other awareness activities. PC/T will develop and acquire the needed materials for conducting the planned activities using Emergency Plan funds.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	27,400	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	534	☐
Number of targeted condom service outlets		☑

Target Populations:

Adults

Community leaders

Teachers (Parent: Host country government workers)

Volunteers

Children and youth (non-OVC)

Primary school students (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Key Legislative Issues

Gender

Stigma and discrimination

Volunteers

Coverage Areas

Dodoma

Iringa

Kagera

Kilimanjaro

Lindi

Manyara

Mara

Morogoro

Mtwara

Mwanza

Ruvuma

Singida

Tanga

Arusha

Mbeya

Table 3.3.05: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Central Contraceptive Procurement
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 3508
Planned Funds:
Activity Narrative: This activity is related to other activities in Other Prevention.

B5

The condom social marketing program in Tanzania has evolved from one that *targeted the general public, to one focusing more specifically on most at risk* populations (MARPS, and thus high transmission sales areas). In the public sector, condoms are available free to the public in clinic settings.

Estimates by the Government of Tanzania place overall need for condoms at over 100 million per year. In 2005, 57 million condoms were distributed in Tanzania through a combination of social marketing programs, the public sector, and commercial sector sales. A significant gap exists between unmet need and sales/distribution figures. Thus procurement, targeting most at risk populations and high transmission areas, to help fill these requirements is an imperative.

In FY06 field support will be utilized to procure condoms and provide logistical support to increase by approximately 20 million the number of available condoms in the country. These condoms will be used to support a number of Emergency Plan partners targeting MARPS. These include PharmAccess providing condoms to the military, a new Police program initiative providing condoms to the police, and to support the new Transport Corridor initiative focusing on mobile populations along at-risk transport corridors. Procurement will also supply condoms to the Tanzania Marketing and Communications (T-MARC) project, the USG's social marketing partner, who is set to launch a new condom targeted at MARPS. All distribution activities with these partners have been and will continue to be discussed with the National AIDS Control Program.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	20,000,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful		☑
Number of targeted condom service outlets		☑

Target Populations:

Adults
Business community/private sector
Commercial sex workers (Parent: Most at risk populations)
Community leaders
Community-based organizations
Faith-based organizations
Most at risk populations
Discordant couples (Parent: Most at risk populations)
Military personnel (Parent: Most at risk populations)
Mobile populations (Parent: Most at risk populations)
Truck drivers (Parent: Mobile populations)
Non-governmental organizations/private voluntary organizations
Partners/clients of CSW (Parent: Most at risk populations)

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Youth
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4844
Planned Funds:

B5

Activity Narrative: This activity is linked to Family Health International/AB and Family Health International/Other Prevention (these activities are under the program name "YouthNet") and Youth TBD/AB.

This activity targets youths aged 15–24 for comprehensive prevention interventions. The 2004 Tanzania HIV/AIDS Indicator Survey (THIS) found that 11% of women and 10% of men, aged 15 to 24, had had sex before the age of 15. In addition, 33% of women and almost 40% of men in the same age group had had sex in the 12 months preceding the survey. Over 35% of these women and 81% of these men had had multiple partners in that period. Only 44% of women and 49% of men demonstrated comprehensive knowledge of HIV/AIDS.

This activity will funded through a competitive procurement and will be awarded and implemented jointly with TBD Youth/AB. Bidders will be asked to build on the work of YouthNet, a youth prevention program currently implemented by Family Health International and funded by the USG (see relevant activity narratives) as well as other successful youth efforts in Tanzania. YouthNet is a global cooperative agreement which comes to an end in September 2006. YouthNet's current government partner is the President's Office, however this arrangement, vis-à-vis the Tanzanian Council on AIDS (TACAIDS)'s role as a national coordinating body, will be revisited with the government before the procurement is released. This activity will lead the USG's effort to continue expansion of its youth programming. Funding will launch new services as well as support existing indigenous organizations to expand geographic coverage, improve quality, and increase range of ABC for youth interventions.

Three key strategies will be employed: 1) behavior change communication for older in and out of school youth (BCC); 2) engagement of the faith community; and 3) youth participation and leadership. BCC efforts will include inter-personal, community, and media interventions. Anticipated activities include continued support for the Ishi campaign, which is a TACAIDS initiated national umbrella for youth media programming, continued strengthening of HIV Prevention Resource Centers, peer education, life skills education, youth camps, parent/youth communication skills building, and dissemination and utilization of age appropriate and targeted ABC materials developed under YouthNet and other initiatives.

Engagement of the faith community will be anchored on a YouthNet initiated effort to create an inter-faith network for youth programming. Support to the network would include technical assistance, strengthening of monitoring and supervision capacity, and comprehensive life-skills training. The network will also be supported with a pilot program preparing youth faith leaders to provide psychosocial support to their peers. Faith organizations will also be encouraged to provide leadership for the modification of social norms that put older youth and young adults at risk of HIV infection.

Youth participation and leadership efforts will emphasize capacity building of Youth Advisory Groups, initiated under TACAIDS's Ishi program and present in every region, to fulfill their mandate of outreach, mobilization, and awareness-raising. The skills of individual youths will be built to not only communicate correct information regarding HIV/AIDS but they will also be provided with strategies for motivating their peers to make safe choices, and to be a voice for youth to opinion leaders, policy makers, parents, and teachers. Individual youths will also be taught to identify situations in which they are at particular risk (i.e. environments of alcohol utilization) and to develop strategies for avoiding those situations.

Another important component of this activity will be to assist TACAIDS to coordinate youth programming. This includes facilitating, under USG guidance, coordination across USG partners, including Track 1, as well as exploring the possibility of creating, under the auspices of TACAIDS, a coordinating body for youth serving organizations. This group could facilitate coordination and networking, rolling-out of national guidance, sharing of lessons-learned and new materials, advocacy, and capacity building. This component would also build the capacity of indigenous youth serving organizations.

In all areas, bidders will be requested to propose additional innovative ideas and proven strategies with an emphasis, for this age group, on vulnerability reduction. In addition, they will be required to address contextual and key legislative issues such as stigma and discrimination, gender, wrap-arounds, livelihoods, and links with OVC programming. While this activity will not be able to provide these services directly, they will be expected to link with other organizations providing these services in the same target areas. Subgranting will be undertaken based on mapping of existing services (already being undertaken by YouthNet) and focus on filling gaps. Bidders will be encouraged to include the results of baseline assessments of parents, community and religious leaders and other gatekeepers regarding risk perceptions. This information as well as lessons-learned will be shared with other USG partners to inform the content of advocacy, policy and legislative efforts as well as improving youth programming overall.

This 5-year effort will be subject to a mid-term and final evaluation and possibly targeted behavioral surveillance to monitor trends of risk behaviors and youth infections over time.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	200,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	50	☐
Number of targeted condom service outlets		☑

Target Populations:

Adults

Orphans and vulnerable children

Children and youth (non-OVC)

Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: REDSO Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 4846
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in other prevention as well as activities in counseling and testing, PMTCT and OVC.

Geographic Information Systems (GIS) mapping and regional prevalence statistics support the need to more effectively target most at risk populations (MARPS), especially along transport corridors in Tanzania. The overall goal of the multi-sectoral Transport Corridor Initiative (TCI) is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable people in communities along major East African transport corridors. There is a high HIV transmission rate among members of mobile populations – drivers and their assistants, prostitutes, and members of the uniformed services, all of whom tend to congregate at stop-over sites – and the vulnerable populations of OVC and low income women in these host communities. Research demonstrates that truck drivers who travel these routes regularly will often have "steady" women partners in the community; these women will often have other regular partners in the host community thus serving as a "bridge" from the truck drivers to the larger community. The prevalence of transactional sexual behaviors involving not only community women but also orphaned children is also high, especially at cross-border stop-over sites where trucks can be held up for 2-3 days in customs clearance and where the poverty of the host communities is entrenched. Services at these high risk sites such as C&T, PMTCT and STI diagnosis and treatment tend to be fragmented at best and/or unavailable or unwelcoming to those in greatest need. Furthermore, studies show that all key audiences in these communities are highly transient and most drivers are foreigners and are generally "lost" to prevention and other interventions as they cross borders. The TCI targets these high risk mobile populations through interventions based at stop-over site communities that focus on regionally coordinated messages and new or improved services tailored to meet their needs. It thereby adds value by maximizing the effectiveness of MARP country level interventions and thus the results of country programs. The TCI is presently working in Kenya, Uganda, Rwanda, Djibouti and the Southern Sudan and in 2006 will initiate activities in Burundi, and the DRC.

In Tanzania in 2006, the TCI will focus on program development and launch implementation through existing Emergency Plan partners. This activity will begin with rapid, participatory, community-driven assessments in select stop-over sites along the Dar-Mbeya road (a North/South corridor inclusive of the regions with the highest prevalence), as well as other sites along the Dar-Burundi road. These assessments will include working with major trucking companies in Dar es Salaam, the transport union/association, relevant USAID/Tanzania Emergency Plan partners, the private sector and a broad array of community groups. Based on the assessment, a subset of program sites will be selected for program implementation. Where necessary, TCI will assist local providers and community organizations to integrate interventions such as syndromic STI diagnosis/treatment, reduction of high-risk alcohol use; stigma reduction and CT into ongoing service provision. In some instances, however, these local institutions may only need encouragement and skills-building to reach out to MARPS (e.g., by expanding CT hours, by inviting truckers to religious services) and to coordinate and collaborate efforts (e.g., in the provision of OVC services). Although they vary somewhat based on local context, TCI interventions include basic health services (risk reduction/prevention interventions including condom social marketing, C&T, syndromic STI diagnosis/treatment, home based care, referrals to other care and treatment services); alternative recreational activities (sports, faith services, fitness centers, men's discussion groups, adult education); PLHA and OVC interventions (education and health support, stigma reduction, income generation in small business and expanded agricultural production, linkages with Food for Peace and World Food

Program); and capacity building including training for local institutions.

These TCI program components will be supported with PEPFAR funding as appropriate as well as funding from the USAID/REDSO/ESA regional TCI program and private sector contributions. Targets for training of intervention implementers, numbers of participating sites, and people reached with prevention, care and mitigation support will be better established through the initial assessments and program design but it is anticipated that preliminary implementation activities will be introduced at the Port of Dar es Salaam and 5 select sites along the two identified transport corridors. The program will be implemented over five years and will be managed from TCI project headquarters in Nairobi with support from Tanzanian-based site coordinators. The program will be fully integrated with USG PEPFAR programming in Tanzania to both maximize synergistic benefits and contribution to Tanzania's PEPFAR results.

All planned interventions are in full compliance with pertinent Government of Tanzania priorities and guidelines. Partners will include USAID/Tanzanian Emergency Plan partners, local NGOs, CBOs, FBOs, chambers of commerce and businesses; local multisectoral government front-line ministries; national and regional organizations, and the USG Mission.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	51 - 100
Needs Assessment	10 - 50
Workplace Programs	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	1,000	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence *and/or being faithful*	200	☐
Number of targeted condom service outlets		☑

Target Populations:

Adults

Business community/private sector

Commercial sex workers (Parent: Most at risk populations)

Community leaders

Community-based organizations

Faith-based organizations

Military personnel (Parent: Most at risk populations)

Truck drivers (Parent: Mobile populations)

Orphans and vulnerable children

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Police Prevention Program
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 5003
Planned Funds:
Activity Narrative: This activity also relates to activities in Counseling and Testing.

B5

As with many uniformed forces in Africa, HIV prevalence among police forces personnel in Tanzania is estimated to be higher than that of the general population (prevalence 7% THIS 2004) though exact figures are not available. Aggressive measures are needed to address this high risk part of the population that can serve as a bridge for HIV transmission to the population at-large. The Police Forces currently employ approximately 15,000 men and women in 146 regional and district offices throughout the country, averaging 100 personnel per post. A small percentage of the forces are displaced from their families for temporary assignments to other districts placing them at greater risk. This activity support efforts by the Tanzanian Police Forces to provide prevention, education and condom distribution services to personnel serving in the police force and their dependents.

An HIV/AIDS education program, based on life-skills modules which were developed by the Tanzania Peoples Defense Forces (TPDF) in FY05, will be adapted for the police and will be utilized through the police training centers for newly recruited policemen and -women. Other prevention materials and approaches being used in East Africa, such as successful interventions with the police and prison systems in Kenya, will be reviewed and adapted for Tanzania. A HIV/Education Task Force will be formed to develop and adapt education and information materials. Materials will be distributed to all police stations targeting all personnel working for the police in Tanzania.

USG Funding will also support training of two servicemen and -women per Regional and District Police Office to become office peer educators, for a total of 300 individuals. Every Regional and District Police Office will be supported in the organization by an HIV/AIDS committee, led by peer educators. Once every two months the committees will organize HIV/AIDS information meetings for all personnel per office. Each meeting will have a dedicated theme, with a main focus on HIV/AIDS prevention. Materials and information to lead the discussion will be provided through this program. The peer educators and the HIV/AIDS committees will be supported in continued prevention/outreach efforts through provision of up to date educational materials, data collection tools, information on available linked services for VCT and treatment, and semi-annual workshops. Semi-annual workshops will discuss progress/challenges, and analyze implications of data collected as part of interventions and share lessons learned.

Special attention will be directed to those police units serving temporarily outside their home region, away from family and other support mechanisms, which puts them at greater risk of infection and infecting others. Condom distribution for HIV positive and high-risk police officers will be incorporated through prevention efforts. Condoms will be obtained and distributed through USAID/AED and national procurement efforts. Their cost is not included in this budget.

It is expected that these activities will reach a target of approximately 1,500 recruits during basic training and 17,000 men and women currently serving as part of the Police Forces and their spouses for a total of 18,500 by September 2007. Prevention programs will be linked to VCT and ART activities in support of the continuum of care. Prevention services in FY06 will ensure a close linkage of program implementation amongst the police forces to national strategies of targeting most at risk populations in Tanzania.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	18,500	☐
Number of individuals trained to promote HIV/AIDS prevention prevention through other behavior change beyond abstinence and/or being faithful	300	☐
Number of targeted condom service outlets	146	☐

Target Populations:

Adults

Key Legislative Issues

Stigma and discrimination

Coverage Areas:

National

Table 3.3.06: Program Planning Overview

Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06

Total Planned Funding for Program Area:

B5

Program Area Context:

The USG supports Tanzania's continuum of care model, which includes initiating, enhancing, and formalizing referral networks. This includes scaling up the full array of quality services for diagnosis and management of OI, cotrimoxazole prophylaxis, psychosocial and spiritual support, economic and nutrition interventions, legal support, and end-of-life care. The National AIDS Control Programme (NACP) presently maintains community programs in approximately 43 districts, serving over 12,000 PLWHA. In FY05, The Emergency Plan supported services to another 36,000 people in an additional 26 districts. Combined, the NACP and USG have trained 143 district home-based care (HBC) providers and 657 health center and dispensary level personnel in all service districts.

In FY05, National HBC guidelines were revised and a simple reference handbook developed and disseminated with USG assistance to all health facilities providing HIV care. A recent review by the USG of one of the larger HBC providers in Tanzania shows that this has not translated into a uniform package of services. Linkages between HBC services implemented at the community level and care and treatment programs at the district and regional levels will continue to be developed, strengthening a network model for care. With FY06 funding, the USG will work with national level providers and the NACP in ensuring countrywide implementation of the guidelines and standards for HBC services and establishment of a formal referral mechanism between health facilities and community providers.

In FY06, USG support will build further on existing relationships with NGOs and FBOs, expanding the services to reach 24,350 clients through 47 HBC service organizations. A total of 2,320 HBC providers will be trained in basic palliative services to support this expansion. Larger umbrella organizations will continue to provide technical assistance and funding to smaller local organizations, expanding services and strengthening linkages with clinical care. Efforts in FY06 will ensure that USG HBC partners are providing basic care packages, including cotrimoxazole prophylaxis, support for pain relief, end-of-life care, and counseling in healthy living choices/prevention for positives. In addition, Tanzania is one of the three target countries for the new USG malaria initiative and linkages with this new initiative will be used to enhance HBC services through provision of treated bed nets for PLWHA. Innovative programs will include the development of community agricultural plots for PLWHA. Some will serve as small income generating opportunities for PLWHA while food from others will be used to supplement dietary needs for HBC clients and patients initiating ART.

In FY06, as USG ART partners develop a more geographically focused approach to expansion of treatment, expansion of community based, palliative care services will follow this pattern. Organizations serving communities surrounding current and anticipated treatment facilities will be targeted for development or expansion. Support for improvement of clinic-based/hospital palliative services by the USG under Emergency Plan funding is being undertaken through ART partners, complementing the community-focused approach in this section. Programs providing HBC services to communities without access to quality facility based care and treatment will continue to be expanded in preparation for national ART coverage. FY06 USG funding will also include treatment adherence counseling for ART patients in some sites as a means to enhance patient follow up at their homes.

It is clear in Tanzania that the role of HBC is becoming even more important as the numbers of people on treatment expand and HBC increasingly becomes a way to help support and monitor drug adherence. Activities in this program area contribute towards this integrated network model developing community services in support of clinical care, in line with the USG Five Year Strategy.

Program Area Target:

Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	152
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	54,850
Number of individuals trained to provide HIV-related palliative care (including TB/HIV)	

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Kikundi Kuduma Majumbani
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3375
Planned Funds:
Activity Narrative: This activity also relates to activities in palliative care (HJFMRI), OVC (HJFMRI, KIHUMBE), treatment (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices), and counseling and testing (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices),

B5

Kikundi Hunduma Majumbani (KIHUMBE) is a large, local NGO which has been serving the needs of PLWHA in the Mbeya Municipality's 36 wards and surrounding rural wards since 1991. It has one of the more comprehensive care and support programs in the region, linking its clients to the continuum of care through direct association with treatment facilities and by coordinating with a new Mbeya Network of NGOs and FBOs, supported by the Henry M. Jackson Foundation Medical Research International, Inc., to maximize coverage. With FY05 funding, KIHUMBE expanded their Community Home Base Care (CHBC) volunteer staff to 85 trained individuals. In FY06, KIHUMBE will provide continued support and refresher education to its current staff promoting quality care and continued improvement in services as well as expansion of the types of services offered to include ART adherence counseling and treatment follow up.

KIHUMBE has been partnering with the Mbeya Referral Hospital since before large-scale ART was initiated. Not only do they serve as an excellent referral mechanism for patients to the ART Care and Treatment Clinic (CTC) but support back referrals by the hospital to aid in patient support when they return home. Referrals between the CTC and KIHUMBE are facilitated by a social worker placed at the CTC specifically for this purpose. As the treatment population has expanded, so has the roll KIHUMBE, and other similar NGOs and FBOs, must play.

KIHUMBE's basic care package for PLWHA includes provision of non-prescription medication, psychosocial counseling, education on healthy living choices for positives, provision of situation appropriate basic commodities and nutritional support and counseling. Medical officers volunteering for KIHUMBE expand its capacity to provide prescription medications following a medical examination at home. This includes the use of cotrimoxazole prophylaxis as a preventive intervention. In FY06, produce from their agricultural plot initiated with FY04 funding will continue to be used to supplement dietary needs of their clients as part of their nutritional counseling. As treatment has been introduced in the Municipality, KIHUMBE has found that as the health of clients on treatment improves, so do their requirements to support the increase in energy they experience. KIHUMBE will begin to provide produce grown on its plot to these clients on a prescription basis for a three to six month period as treatment is initiated.

Since its inception, KIHUMBE has worked with the Mbeya Regional Medical Office (MRMO), the local MOH office responsible for supporting overall regional training in home based care (HBC), to ensure regional coverage in developing capacity in HBC. As a continuation of this collaboration, KIHUMBE has been designated by the Mbeya Network of NGOs and FBOs to train volunteer CHBC providers from these other organizations. Individual volunteers to be trained will meet basic education requirements of having at least completed primary school and are able to read and write Kiswahili. Training in basic palliative care services for new volunteers in the Network will be conducted by KIHUMBE within the Municipality with the MRMO training members in the remainder of the region. The advanced ART training to be undertaken by KIHUMBE will expand on these basic skills for members through out the region. This training will focus on ART and TB treatment adherence, symptomatic monitoring and improved patient record keeping.

It is anticipated that a training module focusing solely on treatment adherence will be finalized by the MOH. As there is no established curriculum for the training of CHBC providers in treatment adherence, KIHUMBE's medical staff will work closely with the regional TB and ART experts at the MRMO and the Mbeya Referral Hospital to devise a six-day course to cover topics in adherence and basic patient monitoring using the national module as a base. A section on record keeping in this same training will include provision of tools and questionnaires to assist the CHBC volunteer on identifying signs of complications due to treatment and when patients need to be referred to the hospital. In addition to the training and care management forms, KIHUMBE and the MRMO are designing tools to monitor and evaluate the outcome of using CHBC providers as a means to enhance follow-up of patients on treatment.

Funding under this submission will support the provision of supplies for basic palliative services to 650 individuals in 500 households with over 150 of these clients on ART. It will also cover the development of the new training curriculum, training of 300 CHBC providers in ART and TB adherence and patient follow up and 200 care givers through at-home sessions in basic palliative support for the members of their household. Funds will also support the improvement of the organization's capacity, programmatic and administrative staff to assist the MRMO in monitoring the use of CHBC providers in treatment adherence and follow up.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	1	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	650	☐

Target Populations:

People living with HIV/AIDS

Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Mbeya

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Henry M. Jackson Foundation Medical Research International, Inc.
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3403
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in counseling and testing (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices) treatment (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices), palliative care (KIHUMBE), and OVC (HJFMRI, KIHUMBE).

B5

Scale up of ART in the Southern Highlands will not be sustainable if only reliant on facility based services. This in large part is due, but not limited, to inadequate infrastructure and capacity. As part of the comprehensive program set out in the Southern Highlands, NGOs, FBOs and community groups factor in as critical partners with MOH facilities to ensure integration of services from community to facility and back to the community. These groups not only aid in the acquisition of patients but can support ongoing patient monitoring and treatment adherence at home. As services and laboratory monitoring are improved at facilities, patient loads will increase and this will require strengthening community aspects of treatment and for community care organizations to begin to take on more significant role to include the development of their capacity to assist HIV+ individuals now on ART.

HJF Medical Research International (HJFMRI) is an arm of the not-for-profit, Henry M. Jackson Foundation based in Rockville, Maryland. HJFMRI was established in Tanzania to manage and provide technical assistance to HIV care initiatives in the Southern Highlands supported by Emergency Plan funding. As a locally based organization, HJFMRI has had two successful years in the Mbeya Municipality and the past year has been successful in augmentation of hospital care through expansion of palliative care services. Activities in FY05 helped found an Mbeya Network of NGOs and FBOs which have been active in providing services to community members in the region and the Southern Highlands from two years onwards.

The Mbeya Regional Medical Office (MRMO) will be mobilizing Emergency Plan funding in FY05 to improve the capacity of local NGO's, FBO's and CBO's in providing HBC services through training of new community home-based care (CHBC) providers in basic services. Activities in FY06 will expand this training under support of the MRMO, HJFMRI and Kikundi Hunduma Majumbani (KIHUMBE), a large, experienced local NGO, to include modules on ART and TB treatment adherence, symptomatic monitoring and improved patient record keeping. Many of the Network NGOs and FBOs will be targeted for this expanded training with 475 CHBC providers expected to be trained in both basic and the advanced palliative care skills. This will strengthen and expand their capacity in Mbeya and the nearby region of Rukwa in provision of such services to its communities. Member groups have been chosen based on current and/or potential capacity to support this advanced form of palliative care. Branches of these organizations have also been selected based on proximity to treatment sites and their catchment populations.

The basic care package provided by these organizations for PLWHA will include provision of non-prescription medication, psychosocial counseling, education on healthy living choices for positives, provision of situation appropriate basic commodities and nutritional support and counseling. These organizations are "assigned" medical expertise with ART trained clinicians through agreements with the nearest medical facility. These medical officers will assist the organizations to provide prescription medications to clients. This includes the use of cotrimoxazole prophylaxis as a preventive intervention. Combined, these organizations will care for a total of 5,000 patients, and increase of over 4,000 from the 900 targeted in FY05, all of whom will be linked to HIV Care and Treatment Centers (CTC) at District, Regional and/or Referral Hospitals for either basic clinical care or ART. The number of service providers in FY06 will be increasing from the nine supported in FY05 to a total of 17

(including branches of larger organizations). In addition, CHBC providers will offer informal training to 2,000 caregivers on skills necessary to assist in the support of the HIV positive members in their homes. Activities under this entry are designed specifically to address and monitor the continuum of care process in the Southern Highlands and Emergency Plan targets for both clinical care and ART.

FY06 EP funding will support technical oversight and management of the participating organizations. Funding will focus also on direct service provision through support of commodities for care (non-prescription medication and disposables), assistance in supporting community providers, training of caregivers, development of management capacity, support to expand on local IEC promotions, and training in income generating skills which can benefit patients/head of households who are temporarily unable to provide for their families due to burden HIV places on their households.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	18	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	5,000	☐

Target Populations:

People living with HIV/AIDS

Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Mbeya

Rukwa

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: CARE International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3427
Planned Funds:
Activity Narrative: This activity relates to the Care/Tumaini OVC activity supported by the USG.

B5

Palliative home-based care (HBC) pertains to provision of comprehensive HIV/AIDS care extended from the health facility to the patient's home, using a holistic approach in order to meet the needs of HIV-positive individuals and their caregivers in a range of environments. This activity will be the extension of an existing program, which will be re-competed during FY2006. The activity will also subsume the existing Africare activity for HBC in Zanzibar after that agreement ends March 31, 2006. The intention is to maintain the persons presently on HBC with the existing mechanisms (Care/Tumaini and Africare/Zanzibar), and then transfer them and the most effective subgrantees to the newly competed mechanism.

The proposed intervention for FY2006 has four major components, ranging from medical care to social support identified and served by different disciplines. The first component is clinical management, including early diagnosis, rational treatment, and planning for follow-up care of HIV-related illness. The second component is nursing care, including care to promote and maintain good health, hygiene, and nutrition. The third component is counseling and psycho-social/spiritual care, which includes reducing stress and anxiety, promoting positive living, and helping individuals to make informed decisions on HIV/AIDS, plan for the future, change behavior, and involve sexual partners in such decisions. The fourth component is provision of material support to the extent possible, and social support, which includes information and referral to support groups, welfare services, and legal advice for individuals and families, including surviving family members.

Through frontline volunteers, basic services will be provided, followed by the involvement, as needed, of nursing or supervisory support. Funding will support the procurement of HBC kits that include drugs for prevention and treatment of opportunistic infections and protective materials; community mobilization and participation to ensure the necessary expansion of home care and the regular and routine availability of support within each home; support to the human resources to build a strong team approach for HIV/AIDS care services; development of networks/linkages/referral systems to ensure a multi-disciplinary approach to meet the complex needs of PLWHAs; information, education, and communication to de-stigmatize the disease and promote care seeking; and infrastructure (renovation, equipment, supplies, and vehicles) necessary for implementation. Funds will also support creating linkages with other sectors and initiatives to ensure coordination, support, cost-effectiveness. Linkages will also help better meet the increasing demands for improved care and support; capacity building of community and faith-based organizations (CBOs/FBOs) to ensure quality provision of the elements of comprehensive care; and logistics systems for appropriate procurement, storage, distribution, and performance-monitoring of the HBC equipment, drugs, and supplies. In addition, funds will be used to assess the needs of PLWHA; train frontline staff in the provision of care, treat common symptoms and palliative care to adequately address all the components of the program; provide quality assurance and supportive supervision for medical and management needs of the HBC providers; and develop a strategic information system to track HBC patients and their needs, as well as all service providers. Tumaini will also focus on quality improvement in FY06 by the implementation of the new Tanzanian HBC guidelines. Both the strategic information tracking system and the quality improvement will be done with Pathfinder, NACP, and FHI. In addition, Tumaini and Pathfinder, along with FHI, will support the Palliative Care Association of Tanzania to strengthen the association and promote their linkage between HBC in Tanzania with the African Palliative Care Association (University of Cape Town, Sun Gardens Hospice in Pretoria, Hospice Uganda, and

Zimbabwe and Zambia home-based care programs).

The program will tap complementary programs in education, health, livelihoods and natural resources sectors across Tanzania in order to "wrap around" with the Tumaini program to support linkages between HIV/AIDS and other sectors. Further, Care/Tumaini programs will continue to be actively engaged at the community, village, district, and national levels in all sectors. There will be special attention paid to wrap around programming for income generation, education, and nutrition. To ensure a multi-disciplinary approach to the needs of PLWHAs, a minimum of four Alliance partners and 24 sub-grantees will be supported technically and financially to provide comprehensive HBC using a holistic approach. A total of 20,500 PLWHAs and affected families in five regions of Tanzania plus Zanzibar will be supported and transitioned to a newly competed mechanism. The planned targets will be attained through maximum family and community involvement to endure expanding service provision and the regular, routine availability of support within each home. Qualified supervisors and community-based volunteers will provide back-up support in a well-structured network. Further, to support the increased number of beneficiaries, Tumaini will also be re-designed to encourage direct referrals by community members to the large number of mobilized volunteers. Referral systems linking homes and the formal health care systems will be consolidated to ensure professional back-up.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	24	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	20,500	☐

Target Populations:

Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Stigma and discrimination

Gender

Wrap Arounds

Coverage Areas

Arusha

Dodoma

Iringa

Mwanza

Pwani

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Lake Tanganyika Catchment Reforestation and Education Project
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3429
Planned Funds: [redacted]
Activity Narrative: This activity links to Counseling and Testing (AMREF).

B5

The Jane Goodall Institute (JGI) has been implementing the TACARE (Lake Tanganyika Catch Reforestation and Education) Project since 1994 in the Kigoma region of western Tanzania. Although this region has relatively low prevalence rates (less than 5%) it borders both Burundi and the Democratic Republic of the Congo (DRC) and hosts nearly 400,000 refugees. While prevalence rates in the DRC are unknown, Burundi has an estimated overall prevalence of 10% with higher rates in urban areas. With Burundi entering a hoped for time of reconciliation and peace, it is anticipated that there will be much greater cross-border interactions, making Bujumbura, less than a day away by public transport, the most readily accessible urban market for goods and services for those in Kigoma.

The region is highly underserved in terms of testing, care, and treatment. ARVs are not yet available. Start-up is anticipated in FY06 although reach will be limited. Testing is currently only available in Kigoma town itself, a several hour drive from much of TACARE's catchment area. In FY06, through USG support, testing services should be expanded through mobile services but complete coverage is unlikely until FY 07. In this context of nascent clinical care, community support, particularly home-based care, positive living, and early management of opportunistic infections is critical.

TACARE's activities will focus on communities surrounding the Gombe National Reserve. TACARE is currently receiving USG support for prevention and care activities. TACARE is the only provider of these services in this catchment area and works closely with government of Tanzania to link with, and augment, primary health care. During USG consultations with government, TACARE was named a critical partner in reaching these remote and underserved communities.

Several years ago, as part of a strategic planning process, TACARE solicited from the communities it works with, their needs in order to protect the Gombe National Reserve. TACARE staff were surprised to note that the highest priority concern was the need for care and treatment services for ill adults. Even in a relatively low prevalence area such as Kigoma, communities were feeling a growing care burden and the need for assistance.

Subsequently, TACARE received FY 05 Emergency Plan funds to initiate care and support activities for those living with AIDS. Building on an existing infrastructure of community-based workers, TACARE has been able to identify, support, and refer hundreds of ill and at risk family members. These community agents, a long-established network of community volunteers, canvas entire communities providing various health related services. As such, they have an in-depth knowledge of the sexual behaviors of the adults in the communities they serve making them an ideal conduit for providing messages and home-based care services. As well, because they are in communities everyday, they can monitor and health and well-being of its members.

TACARE works very closely with the MOH to ensure that these outreach workers provide appropriate care and effectively refer both at risk as well as ill adults to testing and care. The curriculum for training follows MOH protocols and issued supplies comply with guidelines for appropriate care provision by non-medical personnel. MOH supervisors that oversee the community work also participate in the training to ensure mutual understanding of roles and responsibilities. Community agents provide basic support such as bathing, nutrition education, over-the-counter

pain medication, and Oral Rehydration Salts and actively promote testing. They also follow up with clients as to whether they actually accessed the service and provide emotional support if necessary. A large component of their work includes destigmatization. While initially meeting with some resistance, the community workers are now welcome and in fact looked to as reliable informants vis-à-vis HIV/AIDS.

Twenty-three community workers currently cover 24 villages. As the USG, through other sources, will be providing funds for further expansion, thereby increasing coverage for HBC services.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	250	☐

Target Populations:

Adults

People living with HIV/AIDS

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Kigoma

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Deloitte Touche Tohmatsu
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3445
Planned Funds:

B5

Activity Narrative: This activity is linked to activities in Palliative Care-Basic Care & Support (FHI, Tumaini, Pathfinder International) and to activities in Other Policy Systems (MSH/LMS).

The Rapid Funding Envelope (RFE) has been evaluated as an effective mechanism to get funding to small community-based organizations (CBOs) for urgent and innovative projects. It is funded by multiple donors (10), who provide funds for grants, with USG funding focused on the management of the program and funds, and on special program needs, such as palliative home-based care (HBC). During FY05, over $3.6 million was distributed to small organizations through the RFE. For FY06, Deloitte & Touche will receive additional grant funds in the Rapid Funding Envelope mechanism to manage HBC programs, and to make up to four special awards to NGOs and FBOs for building community capacity to respond to the needs of people living with HIV/AIDS (PLWHA).

The RFE leverages funds from the USG to provide funding for HBC programs. These activities will both help to develop the local response to PLWHA CBOs with the newly formed Council Multi-sectoral AIDS Committees for to greater sustainability, and assisting PLWHA to organize income generating activities, food security programs, etc.

Deloitte provides important technical assistance in proposal review and award monitoring; technical assistance to grantees in implementation and monitoring; and grants management in terms of financial management and monitoring. Also, the RFE allows for the rapid "piloting" and evaluation of innovative interventions that then can be transferred to other HBC programs as an effective practice.

Though the program has the potential to impact thousands of PLWHA and their families, the initiative will not report direct targets, since it is funding from other donors leveraged by the USG funding that will actually provide the grants. This USG funding is only for the management of the grants to cover palliative care.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑

Indirect Targets

Though the program has the potential to impact thousands of PLWHA and their families, the initiative will only report indirect targets of 5000, since it is funding from other donors that specifically provide for the actual grants. This USG funding is only for the management of the grants.

Target Populations:

Community leaders

Community-based organizations

Faith-based organizations

International counterpart organizations

Non-governmental organizations/private voluntary organizations

Volunteers

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

HIV positive children (6 - 14 years)

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3460
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in Orphans and Vulnerable Children, ARV Treatment, and Systems Strengthening.

B5

The main objective of this program area is to increase the capacity of community organizations (initially NGOs/CBOs/FBOs) to provide services in a continuum of care, with the focus on quality and sustained home-based care (HBC). This will be done through the coordinated efforts of all HBC providers, but with specific focus on HBC services provided through the Tumaini Strategic Alliance (Tumaini). Tumaini presently consists of six partners (CARE International, Family Health International, COUNSENUTH, Muhimbili University College of Health Sciences, Heifer International and Healthscope), though the activity will be re-competed during FY06.

Tumaini works in close partnership with Government of Tanzania health facilities, civil society, and community-based organizations who implement the program activities with continuous technical and management support from the program. The program focuses on the "continuum of care" concept linking individuals living with HIV and AIDS and their families, with access to care and anti-retroviral drugs and the social and community support activities, such as income generating activities and legal support. The project puts considerable emphasis on building long-term capacity within communities to adapt and cope with the effect of the HIV and AIDS pandemic.

The Tumaini Alliance presently works in five regions (Arusha, Coast, Dodoma, Iringa and Mwanza) through 23 sub-grantees, which include 12 FBOs, 9 CBOs, 1 NGO, and 1 private-for-profit institution. Through these sub-grantees Tumaini has been able to register and support a total of 9,145 PLHA (3,600 males and 5,545 females). In all cases the numbers exceeded the initial targets. In FY06, the target is to register and support 25,000 people with palliative care through home-based services provided by 30 sub-grantees in 5 regions in Tanzania.

FHI will continue to play a critical technical role to ensure that Tumaini supported sub-grantees understand and address, in a quality fashion, the various needs of PLWHA throughout the continuum of care. In addition, FHI will further support the NACP in updating, distributing and ensuring usage of HBC Service Guidelines and training manuals and standardized procedures for community HBC service providers. These Service Guidelines will form the basis for the quality control measures that FHI will provide. Support will also assist in developing reader-friendly local language reference materials for the community-based volunteers, as well as development of job aids for the volunteers and supervisors. Critical to the success of the Tumaini program will be the strengthened focus on effective referrals and linkages to other institutions that meet the comprehensive care needs of PLWHA, including health facilities (based on earlier success with the continuum of care approach in Mwanza, where 58% of clients attending the CTC in Bugando Referral Hospital are actively referred from Tumaini HBC program). Simple protocols will be developed to further assist implementers in establishing functional referral systems and networks. In addition, FHI will identify, document, and disseminate best practices in comprehensive care, develop appropriate methods to keep community-based volunteers motivated. The increase in targets under this project will require that considerable additional human resources will need to be trained and deployed. FHI will undertake intensive technical monitoring and supervision activities in the program, as well as provide monitoring and evaluation support.

Because the scope of FHI's work is to provide technical oversight, coordination, and quality control to other USG implementing partners who report the recipients in their

Indicators, no direct targets are submitted with the FHI entry. FHI's linkage with the Tumaini activity will support Tumaini's direct targets of 35,000 individuals with quality palliative care services, 250 persons trained to provide quality HIV palliative care, and 30 organizations/outlets providing HIV-related palliative care.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Dodoma

Iringa

Mwanza

Dar es Salaam

COAST

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Pathfinder International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 3468
Planned Funds:

B5

Activity Narrative: This activity aims to improve the health status and overall well-being of PLWHA and their families through community home-based care (CHBC) and support services. The program will contribute to a reduction of the impact of HIV/AIDS by strengthening the capacity of communities and local organizations to plan and implement CHBC services. Additional emphasis will be placed on strengthening two way referral linkages to ensure a functional continuum of care for PLWHAs, increasing efforts to reduce stigma and discrimination, and exploring the provision of food for ART clients. Based on the tremendous success of its community-based HIV/AIDS prevention, care, and support projects in Uganda and Kenya, Pathfinder initiated its CHBC program for PLWHA in Tanzania in December 2001. Beginning in September 2004, the USG assumed support of CHBC service provision to 6,832 PLWHA in 4 districts within the Arusha and Dar es Salaam regions. These are model districts for the expansion of CHBC services with recently awarded FY05 funds. By the end of FY05, the program will have expanded to 9 districts in four regions; and will have provided initial and refresher trainings to 775 Community Health Workers (CHWs). In FY06 and FY07, the program will expand to a total of 12 districts within five regions with a target of providing initial and refresher trainings to 969 CHWs. The trained CHWs will provide Home Based Care services to 10,650 PLWHA in the targeted district.

By building on the existing infrastructure, Pathfinder will rapidly expand its current CHBC efforts through reducing stigmatization of and discrimination against persons affected by AIDS by mobilizing and sensitizing community leaders, including religious leaders of all denominations. Through advocacy and lobbying in 48 wards, PLWHA will become "Ambassadors of Hope" and will be encouraged to share their experiences at community meetings, sensitization seminars for community leaders, and even during community cultural activities.

This activity will also link with other ongoing initiatives currently being undertaken by other organizations/donors in order to strengthen program activities, maximize resources, and increase program efficiency and effectiveness. Such linkages will include local agencies and facilities that provide care and treatment, voluntary counseling and testing, prevention of mother to child transmission, vocational education training centers, income-generation institutions/organizations; agencies working with orphans and vulnerable children (OVC); transport services; nutrition support projects; and community support groups.

Pathfinder will ensure collaboration with the Ministry of Health National AIDS Control Programme, and regional/district authorities. The proposed CHBC program will involve community stakeholders, particularly PLWHA, in the planning and implementation of its activities. The program approach to community mobilization will ensure community participation and involvement, while also encouraging community ownership of the project to enhance long-term sustainability. At the district and ward levels, Pathfinder will empower local community-based organizations and faith-based organizations to take on CHBC support.

Technical assistance will also be provided to 12 CHBC implementing partners to enhance their capacity in proposal development, management, governance, accounting and assume increasing levels of responsibility for continuous project monitoring and improvement. Each quarter, an implementing partners' meeting will be organized where project staff will orient implementing partners and community health workers on how to identify problem areas and operationalize improvements, report on activities undertaken during the quarter and submit plans for the subsequent period. Pathfinder's quarterly meetings will also provide a forum in which its partners can share best practices and lessons learned.

Beginning in FY05 and continuing in FY06, Pathfinder will further build capacity of community health workers by providing additional training in behavior change promotion. Appropriate BCC materials for CHBC and AIDS prevention will be adapted and disseminated for use in homes and at community mobilization meetings.

Lastly, Pathfinder, along with FHI and Tumaini, will support the Palliative Care Association of Tanzania to strengthen the association and promote their linkage between CHBC in Tanzania with the African Palliative Care Association (University of Cape Town, Sun Gardens Hospice in Pretoria, Hospice Uganda, and Zimbabwe and Zambia home-based care programs). Practices identified through this linkage can be integrated into the Pathfinder program plans.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	48	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	10,650	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Caregivers (of OVC and PLWHAs)
Widows/widowers
Religious leaders

Key Legislative Issues

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Arumeru

Monduli

Dar es Salaam

Kilimanjaro

Moshi Urban

Morogoro

Mvomero

Tanga

Muheza

Kinondoni

Temeke

Moshi Rural

Morogoro Urban

ILALA

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Peace Corps
USG Agency: Peace Corps
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5007
Planned Funds:
Activity Narrative: This activity also relates to activities in abstinence and be faithful (Peace Corps) and other prevention (Peace Corps).

B5

Peace Corps Tanzania (PC/T) directly implements Emergency Plan activities through its 110 Peace Corps Volunteers in 15 of 21 regions of the mainland. PC/T has designed an integrated HIV/AIDS program where all Volunteers in country are encouraged to implement HIV/AIDS activities. There are three projects that Volunteers are engaged with at present including: the Education project that brings in secondary school Volunteer teachers to teach mathematics and science; the Environment project that places Volunteers in communities to assist with better natural resources management and they contribute to the improvement of farming practices; and finally, PC/T houses the Health Education project that brings Volunteers in to communities to work as health educators. By working in communities, Volunteers witness a lot of suffering from people living with HIV/AIDS and orphans and vulnerable children (OVC).

In FY06, PC/T will expand the implementation of its HIV/AIDS program into the area of care. PC/T will work specifically with Palliative Care: Home-Based Care (HBC) and OVC activities with a 75% and 25% respective split in the care budget. PC/T will utilize the experiences gained in its Environment Project and experience with natural resources management to improve the nutritional status of OVCs, PLWHAs and their families/caretakers through the promotion of demonstration permaculture and home gardening activities in their communities. PC/T will not use Emergency Plan monies to purchase food directly for the beneficiaries of the project. The strategy will be to mobilize and train community groups including PLWHAs and their support groups, OVCs and their caretakers to engage in starting permaculture and home/community gardening activities and also to train them on care for PLWHAs especially in the area of nutrition.

Volunteers and their HCN counterparts will work with 200 PLWHAs to provide them with nutrition education and demonstrate on how to obtain supplementary food from permaculture and/or home/community gardening activities. The food that is produced from these permaculture and home/community gardening activities will be available for needy PLWHAs. Volunteers will also train 200 caretakers/family members on care for PLWHAs, specifically on how nutrition impacts the care continuum. The hope is that through these community mobilization activities, families and community members will be motivated to take action, i.e., starting community gardens and/or permaculture activities.

PC/T will conduct workshops on permaculture to Environment and Heath Education Volunteers and their HCN counterparts to give them the capacity needed to conduct these programs in their communities. PC/T will set aside monies to pay for a technical expert to conduct these trainings for Volunteers and their counterparts. Volunteers can also access Emergency Plan monies through small grants to fund community trainings and purchase some gardening tools for demonstration of home/community gardening and permaculture activities.

Training materials will be developed or/and bought: videos, manuals, posters and books for use in prevention and awareness activities organized by PCVs and HCN counterparts around Tanzania.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	200	☐

Target Populations:

Community leaders
People living with HIV/AIDS
Teachers (Parent: Host country government workers)
Volunteers
Children and youth (non-OVC)
Primary school students (Parent: Children and youth (non-OVC))
Secondary school students (Parent: Children and youth (non-OVC))
Caregivers (of OVC and PLWHAs)

Coverage Areas

Arusha
Dodoma
Iringa
Kagera
Kilimanjaro
Lindi
Manyara
Mara
Mbeya
Morogoro
Mtwara
Mwanza
Ruvuma
Singida
Tanga

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mnazi Mmoja Referral Hospital
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5102
Planned Funds:
Activity Narrative: A program announcement for building the capacity of the referral hospitals to provide a continuum of HIV/AIDS services was made in FY05. The recipients of these funds have just been determined and the notice of grant award has just been received. The Mnazi Mmoja Hospital (MMH), in Zanzibar has been awarded 500,000 for the combined scale-up of services in these program areas in FY05. The planned funding above is to continue this program into FY06.

Zanzibar is made up of the two sister Islands of Unguja and Pemba with a total population of 984,625. HIV/AIDS has been prioritised since the identification of the first three cases in 1986. MMH is linked to the College of Health Sciences as a teaching hospital as well as serving as a referral hospital for both Islands. A notable milestone in their history has been the provision of supportive care and management of opportunistic infections prior to the availability of HAART.

In 1988, the Zanzibar AIDS Control Program (ZACP) started home based care (HBC). These services were initially targeted to offer palliative and supportive services. These were stand alone services offering Saturday therapy sessions to the few clients who decided to disclose their status. Due to limited numbers of PLWHA who had decided to disclose, this assistance was then extended to offer HBC support to all chronically ill and debilitated patients, and not only those infected by HIV/AIDS. To date, these stand alone services have been introduced to eight out ten districts of Zanzibar. Recently, the services have been linked to health care facilities as part of the roll out of the HIV/AIDS care continuum.

The advent of HAART in Zanzibar has changed the perceptions and roles of HBC. It is now an integral part of comprehensive and care and treatment services for patients attending the Care and Treatment Clinic (CTC). HBC links HIV clinics to community based organizations and civil service organizations. It is an important entry point that synergizes counseling and testing efforts in mitigating stigma and discrimination of PLHWAs in the fight against HIV/AIDS. Effective institutionalization of HBC within the current CTC at MMH will strengthen the capacity and quality of care delivery and ensure the provision of comprehensive care to CTC clients.

Creating a continuum of care is a multi-faceted and multi-dimensional intervention that requires well orchestrated coordination and harmonization. Therefore in FY06, in partnership with the USG and other partners, particularly the Clinton Foundation, Columbia University (CU), ZANGOC, Médicos del Mundo, WHO, UNAIDS and UNICEF, MMH will introduce the continuum of care under the guidance of the Zanzibar AIDS Control Program (ZACP), the coordinator of all HIV health sector interventions.

Year one implementation will be focused not only on direct service delivery but also on infrastructure and capacity building. This includes the development of integrated CTC guidelines and HBC training manuals, defining a service delivery package and crystallization of the networking mechanism by strengthening the referral system. It will be critical to develop the terms of reference that will clearly define the roles and responsibilities of each of the expected actors, and define linkages with other related services. To increase program ownership, sensitization will be done for all hospital staff at MMH. Additional activities will include the placement of social workers, a psychologist and one PLHWA who will assist in the promotion of treatment adherence, discourage defaulting and promote service utilization and disclosure of individual serostatus to the family and community at large. Simple anti-stigma messages promoting HIV/AIDS related services and HBC in particular shall be developed and disseminated. Procurement of HBC kits and other related supportive/caring protective gear will also be done. Guidelines to support the

integration and monitor the effectiveness of implementation will be developed and institutionalized. MMH shall work closely with other clinics so as to have a good base for the cross fertilization of knowledge.

MMH plans to reach 1500 PLWHA with HBC services and double that number by September 30, 2007. There are 6 districts in Unguja and 4 in Pemba. Each district has approximately 25 "shehia", which can be likened to a ward. The plan is to cover 3 districts in Unguja (Urban, West and Central) and 2 in Pemba (Chake-Chake and Wete). For the scaling up of HBC services, MMH plans to train 5 health care workers (HCW) in each selected shehia. By September 30, 2006 they therefore expect to have trained 125 HCW. Each HCW will follow 12 PLWHA. By September 30, 2007, coverage will increase by an additional 25 shehia. Using the same strategy, this will add an additional 125 trained HCW, and will result in the service delivery to 3000 PLWHA, in 50 shehia through the efforts of 250 HCW.

To ensure quality and successful service integration, a technical multisectoral committee shall be institutionalized. The committee shall oversee the routine implementation process and shall report all of its findings to the national steering committee.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	50	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	3,000	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5328
Planned Funds:
Activity Narrative: During the next fiscal year, HHS/CDC will continue to collaborate closely with the Government of Tanzania, Ministry of Health (MOH), and other key partners to further strengthen technical and program capacity for implementing the Emergency Plan. This will include the establishment and expansion of quality-assured national systems in the areas of surveillance, prevention of mother to child transmission (PMTCT), laboratory services, blood safety and blood transfusion, antiretroviral treatment, care and TB/HIV programs.

B5

HHS/CDC provides direct technical support for all of its HIV/AIDS programs through US and Tanzania based organizations, which manage and implement in-country activities. These activities are funded through cooperative agreements and are performed at the field level in direct partnership and collaboration with Tanzanian governmental and non-governmental organizations. The non-governmental implementing partners have considerable experience in the field of HIV/AIDS and have established offices in Tanzania to carry out these activities. The technical assistance (TA) and support provided by the HHS/CDC through our cooperative agreements will ensure a long-term sustainable system for providing HIV/AIDS services to Tanzanians.

In FY06, this funding will support in-country ARV Services program staff and fund TA from CDC Headquarters. This staff will: assist with the preparation of plans for the scaling up and expansion of home based care (HBC) services in 12 new districts within 5 Regions of Tanzania; provide guidance for the harmonization of HBC activities using the results of a service mapping exercise; conduct field visits and supportive supervision to USG sites that are implementing HBC; review and compile quarterly and annual reports; and oversee the HBC program mid-term review.

Emphasis Areas	% Of Effort
Human Resources	51 - 100

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism: REDSO Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5492
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in counseling and testing, PMTCT and OVC, and specifically to the same activity that is funded under Other Prevention [redacted] This component will complement the prevention aspects of the program.

B5

Geographic Information Systems (GIS) mapping and regional prevalence statistics support the need to more effectively target most at risk populations (MARPS), especially along high-prevalence transport corridors in Tanzania. The overall goal of the multi-sectoral Transport Corridor Initiative (TCI) is specifically to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable people in communities along major East African transport corridors. There is a high HIV transmission rate among members of mobile populations – drivers and their assistants, prostitutes, and members of the uniformed services, all of whom tend to congregate at stop-over sites, where there are vulnerable populations of OVC and low income women.. Research demonstrates that truck drivers who travel these routes regularly will often have "steady" partners in the community; these women will often have regular partners in the host community thus serving as a "bridge" from the truck drivers to the larger community. Especially at cross-border stop-over sites where trucks can be held up for 2-3 days in customs clearance and where the poverty of the host communities is exceedingly high, the prevalence of transactional sexual behaviors involving not only community women but also orphaned children is also high. Services at these high risk sites such as C&T, PMTCT and STI diagnosis and treatment tend to be fragmented at best and/or unavailable or unwelcoming to those in greatest need. Furthermore, studies show that all key audiences in these communities are highly transient and most drivers are foreigners and are generally "lost" to prevention and other interventions as they cross borders. Interventions are also needed for the care of those affected by HIV/AIDS in the host communities. The TCI targets these high risk mobile populations through interventions based at stop-over site communities that focus on regionally coordinated messages and new or improved services tailored to meet their needs. It thereby adds value by maximizing the effectiveness of MARP country level interventions and thus the results of country programs. The TCI is presently working in Kenya, Uganda, Rwanda, Djibouti and the Southern Sudan and in 2006 will initiate activities in Burundi, and the DRC.

In Tanzania in 2006, the TCI will focus on program development activities and launch implementation activities through existing Emergency Plan partners. These activities will begin with rapid, participatory, community-driven assessments in select stop-over sites along the Dar-Mbeya road (a North/South corridor inclusive of the regions with the highest prevalence), as well as other sites along the Dar-Burundi road. These assessments will include working with the major trucking companies in Dar es Salaam, the transport union/association, relevant USAID/Tanzania Emergency Plan partners, the private sector and a broad array of community groups in. Based on the assessment, a subset of program sites will be selected for program implementation. Where necessary, TCI will assist local providers and community organizations to integrate interventions such as syndromic STI diagnosis/treatment, reduction of high-risk alcohol use; stigma reduction and CT, into ongoing care of those requiring service provision. Although they vary somewhat based on local context, TCI interventions include basic health services (risk reduction/prevention interventions including condom social marketing, C&T, syndromic STI diagnosis/treatment, home-based care, case-finding and referrals to other care and treatment services); alternative recreational activities (sports, faith services, fitness centers, men's discussion groups, adult education); PLHA and OVC interventions (education and health support, stigma reduction, income generation in small business and expanded agricultural production, linkages with FFP and WFP); and capacity building including

training for local institutions. These TCI program components will be supported with PEPFAR funding as appropriate as well as funding from the USAID/REDSO/ESA regional TCI program and private sector contributions. Targets for training of intervention implementers, numbers of participating sites, and people reached with prevention, care and mitigation support will be better established through the initial assessments and program design but it is anticipated that preliminary implementation activities will be introduced at the Port of Dar es Salaam and 5 select sites along the two identified transport corridors. The program will be implemented over five years and will be managed from TCI project headquarters in Nairobi with support from Tanzanian-based site coordinators. The program will be fully integrated with USG Emergency Plan programming in Tanzania to both maximize synergistic benefits and contribution to Tanzania's PEPFAR results.

All planned interventions are in full compliance with pertinent Government of Tanzania priorities and guidelines. Partners will include USAID/Tanzanian Emergency Plan partners, local NGOs, CBOs, FBOs, chambers of commerce and businesses; local multisectoral government front-line ministries; national and regional organizations (e.g., COMESA, TTCA); and the USG Mission.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	5	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	100	☐

Target Populations:

Business community/private sector
Commercial sex workers (Parent: Most at risk populations)
Community leaders
Community-based organizations
Faith-based organizations
Most at risk populations
Military personnel (Parent: Most at risk populations)
Mobile populations (Parent: Most at risk populations)
Refugees/internally displaced persons (Parent: Mobile populations)
Truck drivers (Parent: Mobile populations)
Orphans and vulnerable children
Men (including men of reproductive age) (Parent: Adults)
Women (including women of reproductive age) (Parent: Adults)
Migrants/migrant workers (Parent: Mobile populations)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Palliative Care Follow on
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: Basic health care and support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 5549
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in palliative care TB/HIV, OVC, and ARV treatment and training supported by PEPFAR. It will be a new activity to continue work underway in the existing Care/Tumaini and Africare/Zanzibar home-based care (HBC) programs. The Care/Tumaini activity, which will soon absorb the Africare/Zanzibar HBC program, will be re-competed during FY2006. It will continue the provision of comprehensive HIV/AIDS home-based care (HBC), using a holistic approach in order to meet the complex needs of HIV-positive individuals and their caregivers in a range of environments. The intention is to maintain support to the persons receiving HBC through the existing mechanism by transferring them and the most effective subgrantees to the new mechanism.

The critical components of HBC will continue: clinical management of HIV-related illness; nursing care for good health, hygiene, and nutrition; counseling and psycho-social/spiritual care; and material and social support. Basic services will be provided through frontline volunteers, followed by the involvement, as needed, of nursing or supervisory support.

An assessment was conducted with the assistance of OGAC staff based in South Africa to help inform the new activity. Using the results from the assessment, an updated program will be designed focusing on improving the quality of the interventions, as well as defining a more comprehensive program. It is expected that, in addition to taking on new subgrantees, the new program will continue to support existing high performing partners.

The new activity will be reoriented toward broad community mobilization and development with effective democratic structures and true gender-sensitive grassroots participation. The project will work with and empower vulnerable and marginalized individuals, groups, and communities to ensure maximum benefits from the program. Further, to support the increased number of beneficiaries, Tumaini will also be redesigned to encourage direct referrals by community members to the large number of mobilized volunteers.

To ensure a multi-disciplinary approach to the needs of PLWHAs, a minimum of four Alliance partners will be maintained. By the end of FY07, approximately 30 sub-grantees will be supported technically and financially to provide comprehensive HBC using a holistic approach. A total of 35,000 PLWHAs and affected families in five regions of Tanzania and all of Zanzibar will be supported.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	30	☐
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	35,000	☐

Target Populations:

Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Dodoma

Iringa

Mwanza

Pwani

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.07: Program Planning Overview

Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07

Total Planned Funding for Program Area:

B5

Program Area Context:

The Tanzania Health Sector Strategy on HIV/AIDS identifies TB as the leading cause of death among PLWHA. Despite the obvious close relationship between TB and HIV, the public health responses to TB and HIV have largely been separate. The National TB/Leprosy Program (NTLP) and the National AIDS Control Programme (NACP) operate as distinct vertical programs within the MOH. In 2001, Tanzania initiated collaborative TB/HIV activities through the support of WHO and the Global Fund, and adopted the UNAIDS/WHO policy statement and strategy to decrease the burden HIV-related TB.

With support from the USG, the WHO Strategy will be adopted as the national TB strategy in 2006. The WHO strategy calls for intensifying case identification, providing care and preventive treatment, rapidly introducing diagnostic counseling and testing (DCT) for TB patients, and bolstering referrals through existing systems in the public and private sectors. The strategy also focuses on building the capacity of existing TB and HIV structures and encouraging collaborative efforts between all partners that support these programs.

The USG has provided technical assistance to the NTLP/NACP to develop a training curriculum for HIV DCT in FY05. The main goal of this assistance was to train health care providers in DCT, ensuring that all patients who enter a TB clinic and are being evaluated for TB are also screened for HIV. Nine trainer-of-trainees (TOTs) were trained in DCT earlier this year. To date, these nine TOTs have trained over 100 TB clinic health care workers, supporting three MOH pilot sites' integration of TB/HIV care. In July 2005, 95 out of 122 new patients were counseled and tested for HIV at these sites. Out of the 95 tested patients, 49 patients were found to be HIV positive and were referred to the nearby HIV Care and Treatment Center (CTC). During the supportive supervision conducted by the USG/NTLP at the three pilot sites the following challenges were identified: lack of human resources at both the central and facility level, inadequate laboratory infrastructure for HIV diagnosis, poorly linked referral systems, and inadequate monitoring of treatment adherence for TB and ART.

In 2005, the Global Fund awarded $173,000 to the MOH-NTLP to expand the pilot program into additional regions for 1 year but will continue over 5 years. WHO and the KNCV Tuberculosis Foundation continue to provide technical assistance to the NTLP in the development of policy guidelines, and in January 2006, the WHO is planning to conduct an evaluation of the impact of early initiation of HAART on TB treatment outcomes for co-infected patients. The study will provide a scientific evidence base for scaling up the program nationally.

Although progress has been made, the above new bilateral program that was to be awarded to the NLTP in April 2005 for national roll out was delayed but will be in place by September 2005. One of the biggest challenges to this roll out continues to be human resource and capacity. Support to the NTLP in FY06 will include national level training of an additional 329 TB health care workers in DCT. USG partners involved in ART will provide site-specific strengthening of referrals between TB clinics and CTCs in which they are working and improving the treatment of TB/HIV co-infected patients at the CTCs through focused training in case management of these patients. In FY06, USG support will continue to support the development of policy guidelines and clinical management manuals for public and private sectors in identifying co-infected patients. Particular emphasis in FY06 will be placed on strengthening private networks and integrating them into the national intervention to complement the public sector response.

The NTLP in Tanzania already has a well established TB monitoring system. USG resources will be used to support modification of this system to capture TB/HIV data in 10 regions (9 in Mainland Tanzania and Pemba Island).

Program Area Target:

Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	102
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	57
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	20,602
Number of HIV-infected clients given TB preventive therapy	1,600

Table 3.3.07: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National Tuberculosis and Leprosy Control Program
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 3464
Planned Funds:
Activity Narrative: The National Leprosy and Tuberculosis Program (NTLP) is currently the only appropriate and qualified organization in Tanzania to conduct specific sets of activities supportive of the USG goals for TB/HIV services. Having implemented the DOTS (directly observed tuberculosis short course) strategy since the 1980s, the NTLP has provided national coverage and is a well-functioning program with high government and international commitment to TB control in the country. Consequently, the NTLP is poised to effectively coordinate the integration of HIV into TB services.

This activity involves integration of HIV/AIDS services at 43 TB clinics within 11 districts in nine regions and Pemba (Zanzibar). Through this initiative the USG will significantly and rapidly increase the number of patients on care and treatment in our program. To date, nine trainer-of-trainees (TOTs) have trained over 100 TB clinic health care workers, supporting three MOH pilot sites in the integration of TB/HIV care. Since the start of TB/HIV program in July 2005, 455 out of 513 new patients were counseled and tested for HIV at the three pilot districts sites. Out of those tested patients, 228 (72%) patients were found to be HIV positive and were referred to the nearby HIV Care and Treatment Center although very few were recorded to have accessed such care.

On a national level, USG funds will be used to support a TB/HIV coordinating body that will include members from the TB and HIV community. This group will be charged with guiding the strategic direction of TB and HIV integrated activities. They will also develop key TB/HIV policies, guidelines and training curriculum.

These funds will be used to expand TB/HIV roll-out to an additional 11 districts. Specific activities include training 215 TB clinic staff in DOT which will result in 13,194 TB patients receiving HIV counseling and testing by September 2007. It is estimated that 5,673 (43%) of these will be HIV-infected and 2184 (60%) will be eligible for ART. Patient referral and networking systems will be enhanced to ensure that all eligible TB/HIV patients access appropriate care and follow-up.

TB/HIV activities in TB clinics will be monitored by modifying the already established TB monitoring system to enable it to capture TB/HIV data including; number of TB patients accepting to test for HIV; HIV infection rates among TB patients; number of TB patients accessing HIV-related services including cotrimoxazole and ART. TB/HIV data from HIV care and treatment clinics will captured within the systems developed for these settings.

Human capacity and supervision gaps for TB/HIV integration will be addressed through staff training and the placement of one national and nine regional TB/HIV coordinators who will provide technical supervision and strategic guidance to TB/HIV integration.

To improve access and adherence to care, USG funds will be used to increase the involvement of community-based care providers, including faith-based organizations that will be trained in simple TB screening and referral techniques for HIV-infected patients receiving home-based care. This will result in an estimated additional 3,000 HIV-infected patients receiving treatment for TB disease.

USG funds will also be used to develop and implement a TB/HIV health communication strategy involving local media (print, radio and TV) that will inform TB patients of the relationship between TB and HIV, as well as available services

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	43	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	8,250	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of TB service outlets providing HIV counseling and testing.	43	☐
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.	13,194	☐

Target Populations:

Adults
Community leaders
People living with HIV/AIDS
Religious leaders
Public health care workers
Private health care workers

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Lindi

Mara

Rukwa

Singida

Iringa

Ludewa

Lindi Rural

Lindi Urban

Tarime

Morogoro

Mtwara

Mtwara Urban

Sumbawanga Urban

Mpanda

Manyoni

Tabora

Nzega

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Table 3.3.07: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: PharmAccess
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5093
Planned Funds: [redacted]
Activity Narrative: This activity also relates to activities in treatment (PharmAccess).

B5

The Tanzanian Peoples Defense Forces (TPDF) has a network of eight military hospitals through out the country, supporting a total of over 30,000 enlisted personnel and an estimated 90,000 dependents. The services at these hospitals are not limited to the military or their dependents with 80% of their patient load attributable to the civilian populations surrounding the facilities who otherwise might not have access to the services provided.

The TPDF and PharmAccess, a large not-for-profit organization based out of the Netherlands, have developed a strong working relationship over the past four years in the area of health service provision. PharmaAccess, along with direct technical assistance from the US Department of Defense, are the primary partners supporting Emergency Plan activities with the TPDF. PharmAccess is experienced in providing management services, products and technical assistance supporting HIV/AIDS care and treatment in resource poor settings in collaboration with governments, donor organizations, NGOs, and corporations through out Africa.

The TPDF initiated one of the first ART programs in Tanzania in March 2003 at Lugalo Hospital in Dar es Salaam expanding these services at Lugalo in FY04 under the Emergency Plan (supported by USAID). With Emergency Plan FY05 funds through the US Department of Defense supporting a comprehensive program with the military, an additional two hospitals (Mbeya and Mwanza) will be brought on line with plans for initiation of ART services in another four regional hospitals in FY06 (Morogoro, Arusha, Tabora and Ruvuma). Expansion of treatment includes the development of all services related to identification of and care for HIV positive individuals, including TB diagnosis and treatment.

The TPDF has started to test all TB positive patients at Lugalo Hospital for HIV and initiated an active two-way referral policy between the TB Unit and the HIV Care and Treatment Center (CTC). Approximately 40-50% of TB patients are HIV-infected and, conversely, it is estimated that roughly one-third of HIV-infected patients develop clinically-overt TB. Aggressive detection and treatment of TB is important in order to reduce morbidity and mortality associated with HIV infection. In addition, aggressive HIV counseling and testing of TB patients represents an important public health strategy which will be key in the further identification and treatment of other HIV-infected individuals.

Under this submission, PharmAccess will work with the TPDF to intensify the care and treatment of military, dependents and surrounding community civilians who are co-infected with TB/HIV. This will be accomplished by introducing HIV counseling and testing at the TB Units in the remaining seven military hospitals in Mbeya, Mwanza, Morogoro, Arusha, Ruvuma, Tabora and Zanzibar and establishment of referral systems between the clinic and CTCs mirroring the system at Lugalo. This will include the training of three personnel from each TB clinic (21 total) in providing quality HIV counseling and testing and provision of opt out HIV counseling and testing to all confirmed TB positive patients.

An active program of staff training will also be undertaken at the CTCs of these hospitals where health care providers will be trained in TB diagnostic methods to increase detection and referral of TB cases to the TB Unit among their HIV positive patients. Clinicians (four) and laboratory technologists (two) at each CTC and TB Unit of each of the regional seven military hospitals will undergo intensive (two to four week) training on ART and TB treatment options and complications. Training will be

organized in collaboration with the TB Unit of the NACP and the National TB and Leprosy Programme (NTLP). In addition, funding will support improvement in laboratory capacity for TB diagnosis. TB/HIV patients identified will receive cotrimoxazole prophylaxis administered in accordance with existing NTLP guidelines.

Funding will support the training of 21 personnel in HIV counseling and testing, training of four clinicians and/or medical officers and two laboratory technologists per site in TB/HIV care and treatment, purchase of TB-specific laboratory diagnostic equipment and reagents, consumables for HIV confirmatory diagnosis and cotrimoxazole for TB prophylaxis. It is expected that a total of 2,000, representing approximately 40% of the 5,000 HIV-infected patients who will be on care or treatment by September 2007, will be found to be co-infected with TB and will require TB services. Of these 2,000 TB/HIV co-infected patients, it is estimated that approximately 60% (1,200) will require treatment for clinically-overt TB illness with the remainder receiving cotrimoxazole prophylaxis. It is also anticipated that 1,500 of the TB positive individuals (at least 95% using opt out counseling) attending TB clinics at TPDF facilities will undergo counseling and testing for HIV. These patients will be referred to the associated CTC for evaluation for ART eligibility. As 80% of the population accessing services at military facilities is civilian, activities under this submission will support achievement of EP goals towards care and treatment for the *general public as well as among the high-risk, military population.*

Expansion of TB/HIV services in FY06 will ensure a close linkage of military implementation to national strategies and programs. Funding for the TPDF through *PharmAccess will provide much needed technical support,* management assistance and M&E for all TPDF activities in this COP. The military referral hospital in Dar es Salaam, Lugalo Hospital, will serve as the coordinating body for services and over see quality assurance following national standards. Additional support for military facilities in Mbeya and Ruvuma will be provided by the US Department of Defense field office overseeing civilian based activities in these regions.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	7	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	42	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	1,200	☐
Number of HIV-infected clients given TB preventive therapy	800	☐
Number of TB service outlets providing HIV counseling and testing.	7	☐
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.	1,500	☐

Target Populations:

Adults

Military personnel (Parent: Most at risk populations)

Children and youth (non-OVC)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Coverage Areas

Arusha

Mbeya

Morogoro

Mwanza

Songea Urban

Tabora

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.07: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5107
Planned Funds:
Activity Narrative: During the next fiscal year, HHS/CDC will continue to collaborate closely with the Government of Tanzania, Ministry of Health (MOH), and other key partners to further strengthen technical and program capacity for implementing the Emergency Plan. This will include the establishment and expansion of quality-assured national systems in the areas of surveillance, prevention of mother to child transmission (PMTCT), laboratory services, blood safety and blood transfusion, antiretroviral treatment, care and TB/HIV programs.

HHS/CDC provides direct technical support for all of its HIV/AIDS programs through US and Tanzania based organizations, which manage and implement in-country activities. These activities are funded through cooperative agreements and are performed at the field level in direct partnership and collaboration with Tanzanian governmental and non-governmental organizations. The non-governmental implementing partners have considerable experience in the field of HIV/AIDS and have established offices in Tanzania to carry out these activities. The technical assistance (TA) and support provided by HHS/CDC through our cooperative agreements will ensure a long-term sustainable system for providing HIV/AIDS services to Tanzanians.

In FY06, this funding will support the in-country TB/HIV program staff and fund TA from CDC Headquarters. These staff will: assist with the development of policy, training guidelines, curriculum and manuals for TB/HIV programs implemented by the National Tuberculosis and Leprosy Program (NTLP); support the development of a national TB/HIV register; conduct field visits and provide supportive supervision to the districts that are implementing TB/HIV programs; and support the NTLP in preparing scale-up and expansion plans of TB/HIV services on the mainland and Zanzibar.

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Emphasis Areas	% Of Effort
Human Resources	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease		☑
Number of HIV-infected clients given TB preventive therapy		☑
Number of TB service outlets providing HIV counseling and testing.		☑
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.		☑

Target Populations:

USG in-country staff

USG headquarters staff

Coverage Areas:

National

Table 3.3.07: Activities by Funding Mechanism

Mechanism: AIDSRelief Consortium
Prime Partner: Catholic Relief Services
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5114
Planned Funds:

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Activity Narrative: AIDSRelief, as a faith-based consortium, has the ability to harness not only the secular health system but also the extensive network of faith-based institutions in Tanzania for scaling up ART services. These faith-based institutions provide between 40-50% of all health services in the country. They are firmly embedded into communities, and evidenced by current activities, have the proven ability to develop strong outreach models to support patient adherence to ART. One of the reasons for AIDSRelief's success is it builds upon previous relationships with these communities by Interchurch Medical Assistance (IMA), and Catholic Relief Services (CRS).

Within their current sites, PASADA (Dar), Selian (Arusha), Haydom (Manyara), St. Elizabeth (Arusha), Muheza (Tanga), Bugando Medical Center (Mwanza) and Mvumi (Dodoma), AIDSRelief is currently supporting 2700 patients on treatment in seven points of service in six regions. The initial year one (February 2004 to March 2005) target was 3,000 patients and the revised year two (February 2005 to March 2006) target is 3800. By September 2006, these POS expect to reach 5772 patients, of which an estimated 13% will be children.

Recognizing the high burden of TB within PLWHA, and the need for integrated service delivery, AIDSRelief will provide institutional support and technical assistance to its network of institutions by developing linkages between counseling and testing and TB services, and improve the prevention, detection and treatment of TB/HIV co-infection within the ART client population. This is an activity that was begun with FY05 Rapid Expansion Funds and will continue into FY06 with funds from the in-country budget. At the end of FY06, Selian and PASADA, who will have been transitioned to direct USG funding, will no longer receive support from AIDSRelief for this activity, but will be replaced by two new sites.

In close collaboration with the National TB and Leprosy Control Program (NTLP), AIDSRelief will build on FY05 activities to ensure that within the POS catchment areas, voluntary counseling and testing (VCT) clients who are HIV-positive are screened for TB and referred to a TB clinic in a timely manner. This will build the capacity of VCT centers to detect more TB cases among PLWHA. In concert with the NLTP strategy of diagnostic counseling and testing (DCT), AIDSRelief will train health care workers (HCW) at surrounding TB clinics to provide counseling and testing services and to identify HIV positive TB patients who may require anti-retroviral treatment. Within their points of service, staff will be trained so that all patients visiting a health facility who receive a TB diagnosis are also counseled for HIV testing. This seizes on what is often a missed opportunity for early access to care and treatment. For the care of these co-infected patients, targeted training sessions will be provided to increase the ability of health providers to manage TB/HIV co-infected patients.

These core activities will provide for the improvement of clinical knowledge for health workers, establishment of efficient referral systems, community follow-up, supportive supervision and close monitoring and evaluation. This will be achieved through assistance for staffing, information, education and communication, as well as laboratory and pharmacy training. Strong referral linkages and monitoring between VCT and TB services are critical for the success of this activity in order to capture the maximum number of patients and identify those that do not complete the referral link, therefore building an efficient and effective referral system will be a critical activity within the program

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	6	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	3,252	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of TB service outlets providing HIV counseling and testing.		☑
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.		☑

Target Populations:

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Private health care workers

Key Legislative Issues

Wrap Arounds

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Mwanza

Tanga

Table 3.3.07: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Program for Appropriate Technology in Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5117
Planned Funds:
Activity Narrative: This activity links to activities under treatment.

The Program for Appropriate Technology in Health (PATH) proposes to support the launch of a coordinated response to TB/HIV through the public and private sectors in close collaboration with the Ministry of Health National TB and Leprosy Program (NTLP), the National AIDS Control Program (NACP) and the Association of Private Hospitals of Tanzania (APHTA). The project will supplement the budget of some Global Fund activities that were insufficiently funded but which are important with respect to the success of the program initiated under the Global Fund. Objectives guiding the project include; strengthening human resource capacity, introducing and scaling up integrated TB/HIV services, stimulating community awareness of TB and TB/HIV and mobilizing communities around reducing stigma, promoting HIV testing and seeking care.

Gaps in human resources will seriously impede the ability of the health system to provide TB and HIV care services. The project will capitalize on existing human resources in both public and private sectors, supplementing the existing core with a minimal number of critical staff at central, zonal and district levels. Similarly, the project will build on work already underway to develop TB/HIV training materials (including DVD-based remote training) for consistent and quality training at the district level. This funding will also support the provision of tools to guide regional and district TB coordinators on referral, case management and monitoring of systems for HIV testing among TB patients.

The project will have initiated activities in 10 districts late in the first year (2006) and (funding permitting) will expand facility coverage in the 30 additional districts where the Emergency Plan is expanding access to ART in 2007. By 2007 12,900 new TB/HIV co –infected individuals will be identified through the offering of HIV counseling and testing to confirmed TB positives at these site. These individuals will then be referred for HIV care and support at nearby HIV Care and Treatment Centers (CTC). It is also anticipated that by this same time, 7,500 HIV infected clients attending CTCs will receive treatment for TB.

By scaling-up TB/HIV integrated activities it is envisioned that by end of the project period (2009) the following practices will be routine in both TB clinics and CTCs at both public and private facilities in targeted districts: (1) diagnostic HIV testing of all TB patients and (2) TB screening of all confirmed HIV positives.

To most efficiently launch and expand TB/HIV integrated services, consideration must be given to the current health system capacity for TB and HIV testing and care while understanding the potential for growth of this capacity during the project period. To facilitate planning, PATH has considered health facilities in three categories. Tier 1 includes health facilities that currently have capacity to test for both TB and HIV, and to provide care and treatment for both (i.e. TB treatment or cotrimoxazole prophylaxis and ART and palliative care for HIV positives). Tier 2 includes health facilities that have capacity to test for and treat either TB or HIV, and are geographically located such that the services lacking in one facility can be delivered by another facility within an one-hour travel time. Tier 3 includes health facilities that could be expanded to include both TB and HIV testing and care services but which require investments in infrastructure, commodities, human resources and/or equipment to develop the needed capacity for TB/HIV management.

Immediate gains in the first year will be made by focusing on Tier 1 facilities,

introducing the capacity to test for both TB and HIV as well as provide associated services in treatment. In the second year, activities will expand to Tier 2 facilities, developing the capacity of these facilities to test and treat for either TB or HIV. To capitalize on the potential to reach patients through the private sector, the project will engage private sector providers, diagnostic and service delivery facilities in every aspect of the project. The private sector will play a crucial role in the referral network, ensuring a seamless flow of patients between the public and private sectors. District TB/HIV coordinators will support day-to-day implementation, including training and supervision of hospital, health center, clinic and peripheral laboratory staff totaling 288 by end of 2006 and another 96 by September 2007.

To stimulate community awareness of TB and TB/HIV and mobilize communities to reduce stigma, PATH will leverage its current social mobilization efforts based on the MOH NTLP Strategic Plan and the TB/HIV Collaborative IEC and Social Mobilization strategy. This plan will explore opportunities within schools and through public and private networks. It will also operate through media and health journalists to increase awareness and community knowledge and promote uptake of HIV testing and ARV treatment. PATH will develop weekly radio and TV spots focusing on TB/HIV factual information and locations of services. PATH will also develop and disseminate patient education materials covering HIV counseling and testing and treatment referrals.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Policy and Guidelines	10 - 50
Training	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	45	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	7,500	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of TB service outlets providing HIV counseling and testing.		☑
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.		☑

Target Populations:

Adults

Community leaders

Community-based organizations

Country coordinating mechanisms

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Policy makers (Parent: Host country government workers)

Teachers (Parent: Host country government workers)

Children and youth (non-OVC)

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

Secondary school students (Parent: Children and youth (non-OVC))

Men (including men of reproductive age) (Parent: Adults)

Religious leaders

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Doctors (Parent: Private health care workers)

Laboratory workers (Parent: Private health care workers)

Nurses (Parent: Private health care workers)

Pharmacists (Parent: Private health care workers)

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Arusha

Dar es Salaam

Mwanza

COAST

Table 3.3.07: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Harvard University School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 5120
Planned Funds:
Activity Narrative: The goal of this MDH (Muhimbili University College of Health Sciences (MUCHS)-Dar es Salaam City Council-Harvard School of Public Health (HSPH)) activity is to integrate HIV/AIDS services at 1 TB clinic within the City of Dar es Salaam. This initiative will help increase the number of patients on care and treatment in the program. Since the start of the program in November 2004, MDH has enrolled 4096 patients on care and treatment, including 200 TB patients. 2111 are on ART, and more than 50% of the remaining patients on care are eligible for ART and will be initiated as the more drugs become available. Over the last 2 years, MDH has greatly increased the capacity and quality of the program to cover all aspects of HIV care and treatment. MDH has a longstanding collaboration with the government TB program and has initiated discussions with them to coordinate their proposed contribution to their plans.

B5

Using the curriculum developed by the National Tuberculosis and Leprosy Program (NTLP), MDH will train TB clinic staff on diagnostic counseling and testing. They will strengthen lab diagnostics related to TB at their HIV clinics, and integrate monitoring and data requirements in close collaboration with the NLTP and NACP. Infrastructure will be strengthened at this 1 site, thereby increasing access to treatment and care for PLWHA. An estimated 2,000 TB patients will receive counseling and testing, 1000 of whom may be HIV-infected. Of the latter, 500 are estimated to be referred to MDH ART clinics and initiated on ART, while the other 500 will be provided with care services.

Although they propose to focus on one site given the allocated funds, additional funds in the future would allow MDH to scale up to more patients on treatment and care. MDH had already initiated discussions with the District Medical Officers (DMOs) and the TB coordinators, as well as facility directors of the following 7 sites: Mwananyamala, Temeke, Amana, Sinza, Tandale, Rangi Tatu and Buguruni. These health centers cater to urban and semi-urban populations of Dar es Salaam and form an important catchment area for patients co-infected with HIV and TB. Since some of these sites are already MDH sites, the addition of this activity builds on the infrastructure and experience already in place.

For this activity, MDH will train all staff currently based at the TB clinic. Minor renovations of the physical structures of the clinic to enhance privacy for confidentiality purposes will be done. Furthermore, a critical element for the success of this activity is the development of networks, linkages and referral systems among various stakeholders. The TB staff will be part of a network within the same facility/hospital that includes other care providers, and will also be linked upwards to the district hospital as well as downwards to community-based groups. Community follow-up within home-based care will be strengthened. All these measures are intended to strengthen the existing health systems and build a locally sustainable program in the long run. From these planned funds, 50,000 will be used to cover capital costs for development of infrastructure at the proposed clinic. This will allow for privacy and space for counseling and testing of TB patients.

Patients will be counseled, health care personnel trained, and the surrounding community sensitized to ensure proper adherence both to ART and to other elements of the care and treatment program (including visit schedules, OI prophylaxis) In order to reduce stigma and discrimination towards PLWHA, MDH will increase the number of community care and support groups for PLWHA and use the existing system to actively mobilize the community to seek VCT and services at all their sites

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	1	☐
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national or international standards	15	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	400	☐
Number of HIV-infected clients given TB preventive therapy	800	☐
Number of TB service outlets providing HIV counseling and testing.		☑
Number of TB postive individuals who received counseling and testing HIV and received their test results at TB service outlets.	2,000	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Dar es Salaam

Table 3.3.08: Program Planning Overview

Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08

Total Planned Funding for Program Area:

B5

Program Area Context:

The impact of HIV has compounded the vulnerability of children in Tanzania, leaving nearly 980,000 children orphaned by HIV. A far greater number of children are living in households weakened by illness and are on the verge of ophanhood. Without massive increases in prevention and treatment, the number of orphans is expected to climb to 2.8 million children by 2010.

Several trends have emerged that have impacted the way the GOT and USG plan OVC services. The majority of orphans are over 10 years old, indicating a need to focus more on adolescents. There are far more orphans in urban areas, where 14% of children under age 18 have lost one or both parents. Serious geographic inequities are apparent in regions that have the highest percentage of orphans and HIV prevalence. Finally, there is a high degree of variability in the services that are being provided to OVC and until recently, there has been little coordination between these efforts.

The response to OVC in Tanzania is moving ahead under the leadership of the Department of Social Welfare (DSW). It has established a National Plan of Action for Most Vulnerable Children and national level technical committees. It has secured alliances with other Ministries, launched a national monitoring system, and drafted care and support guidelines. Still, the DSW is not well resourced and it faces the difficult challenge of reaching into communities while operating under a highly centralized system. On top of this, the legal system that protects children in Tanzania is frail and social workers (primary GOT cadre to reach OVC) are not trained on OVC issues and are employed in only a third of the districts.

Despite all of these challenges, the GOT and the USG are riding on a wave of momentum created by the award of $58 million for OVC programs from the Global Fund. The National Plan of Action sets the course for the Global Fund and other donors' programs. This plan sets up a network, that links village-level Most Vulnerable Children Committees (MVCCs) to district and national coordinating mechanisms. Under this plan, services are provided to children by local NGOs and FBOs that receive support from one of many donors. The MVCCs coordinate and provide direction to OVC service programs and social workers in their area to ensure that the needs of these children in their communities are being met. With USG, Global Fund, World Bank, UNICEF, and Axios International funding, the DSW is on track to expand the MVCC network to 64 of the 126 districts in Tanzania this year.

In FY06, the USG will fund the implementation of this network in five districts, where approximately 163,770 OVC will be reached and will expand the network to at least 20 districts by 2008. In these districts, children's needs for shelter, food, education, health care, economic opportunity, psychosocial support, HIV education, and social and legal protection will be met. This will include supporting linkages of components of USG palliative programs to OVC services, involving OVC in the development of community agricultural plots for nutritional support. USG partners will also work to identify HIV+ OVC, linking them to ART facilities for care and treatment.

In addition to funding the network, the USG will also provide support to the DSW to enable it to address some of the challenges that it will face as it coordinates this massive network. The USG will strengthen the capacity of the DSW headquarters by providing a seconded staff member; training 200 social workers on OVC issues; and continue to support the DSW in using the national-level data management system. A twinning activity will facilitate the transfer of state-of-the-art curricula, case management, and supervision approaches to build a cadre of social workers to cover the 126 districts in Tanzania. The USG will also support the review of laws and policies that affect OVC and continue to sit on the National Stakeholder's Steering Committee for OVC.

Program Area Target:

Number of OVC served by OVC programs	163,770
Number of providers/caretakers trained in caring for OVC	13,315

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Kikundi Huduma Majumbani
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3376
Planned Funds: [redacted] B5
Activity Narrative: This activity also relates to activities in AB (KIHUMBE), palliative care (KIHUMBE), treatment (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices), and counseling and testing (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices),

Kikundi Hunduma Majumbani (KIHUMBE) is a large, local NGO that has been serving the needs of PLWHA in the Mbeya Municipality's 36 wards and surrounding rural wards since 1991. It has one of the more comprehensive care and support programs in the region, linking its clients to the continuum of care through direct associations with treatment facilities and by coordinating with a new Mbeya Network of regional NGOs/FBOs supported by the Henry M. Jackson Foundation, Medical Research International (HJFMRI) to maximize coverage. Under this submission, funding will assist KIHUMBE in the direct support of OVC living within the Mbeya Municipality. With this funding, they will expand their support to an additional 30 OVC to bring their total by September 2007 to 650.

Activities within this submission will include the provision of basic needs (clothing, bedding, school uniforms, nutritional support, and ensuring access to proper medical care), improvement of psychosocial support as part of services, education of OVC and care givers on their legal rights, and assisting in the identification of HIV positive OVC and ensuring their access to treatment. Support will also include assistance in financing appropriate fees for secondary school and access to vocational training for older OVCs.

In the Tanzania HIV/AIDS Indicator Survey 2003-2004, Mbeya was identified as one of the regions with the highest OVC population per capita (18%). In this same survey, it was also concluded that it ranked as one of the lowest regions as far as meeting the full needs of its OVC population. A concerted effort among three major organizations, Axios International, the Salvation Army and the U.S. Department of Defense (through local partners such as HJFMRI and KIHUMBE) will be required to address the this short fall, ensuring maximum, quality coverage. Coordination of coverage and sharing of expertise has begun through monthly meetings among USG partners.

In FY06, the well-developed training modules and resource manuals in OVC specific psychosocial counseling and support developed by the Salvation Army will be used to strengthen KIHUMBE services. By May 2007, the Salvation Army, through a coordinated training in the region, will train six individuals at KIHUMBE in psychosocial counseling for OVC and their caregivers. KIHUMBE will then support these six individuals in training at least 36 community members who live in one of each of the wards in the Municipality. By September 2007, these 36 individuals will in turn train and mentor 15 caregivers each to support the OVC of their ward. KIHUMBE will provide continuing oversight of the training and these individuals, offering them supportive supervision as part of ongoing direct services to the OVCs themselves.

Through informal training in the homes, KIHUMBE works on the development of caregiver's capacity to assist in long-term support. The expertise of KIHUMBE's palliative care service volunteers is called upon frequently to assist care givers in acquiring skills needed to manage OVC who are actually HIV positive themselves. In FY06, KIHUMBE will train at least 540 volunteers and care givers in various skills to address the collective needs of OCVs. As in previous years, KIHUMBE will assist the Mbeya Regional and Referral Hospitals in identifying OVC in the Municipality who are HIV infected. They will also continue to assist in patient care and adherence monitoring for those OVCs qualifying for ART and/or TB therapy. This year, KIHUMBE

identified and referred a total of 30 HIV positive OVC (11 male, 19 female) for care and treatment to these facilities.

National focus has added the need to address the legal and human rights and gender issues of OVC and their caregivers. KIHUMBE and a local Mbeya Network of NGOs and FBOs feel that legal rights education is a critical element to be added as part of their OVC support package. The Evangelical Lutheran Church of Tanzania (ELCT) through their Local Community Confidence Building (LCCB) program will conduct a training program for KIHUMBE and the other Network members. It will focus on improving the capacity of these organizations to sensitize OVC and caregivers on legal rights. The ELCT's LCCB has provided education in legal literacy as part of their platform for the past two years and use local legal organizations and firms in the training to provide up-to-date factual information and assistance in understanding the laws and issues that affect OVCs and PLWHA.

KIHUMBE and the Mbeya Network will also work together to bring regional and national focus on the plight of OVC and their caregivers as they struggle with the legal restriction regarding the disclosure of HIV status to youth under the age of 18. KIHUMBE will also participate with the Network and Mbeya Municipality to maintain a confidential list of OVC, their location, services being provided to each individual and the organizations offering them support.

The project will support the scale up of Tanzania's National Plan of Action for OVC/MVC (Most Vulnerable Children), involving key stakeholders through the recently established MVC Committees (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. KIHUMBE will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort.

Funding under this submission will cover the provision of all services and basic needs, including assistance with fees, transport for volunteers and supportive supervision, expansion of training in psychosocial support to the 36 wards, and peer support meetings and events for OVCs, which will include education on legal rights.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	650	☐
Number of providers/caretakers trained in caring for OVC	540	☐

Target Populations:

Orphans and vulnerable children

HIV positive children (6 - 14 years)

Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Wrap Arounds

Coverage Areas

Mbeya

Table 3.3.08: Activities by Funding Mechanism

Mechanism: Pact Associate Award
Prime Partner: Pact, Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3385
Planned Funds: [redacted]
Activity Narrative: This activity links to the following activities in the following program areas: Palliative Care: Basic Health Care & Support/FHI; OVC/Tumaini, SAWSO, CRS, Africare, Peace Corps, KIHUMBE, Jackson Foundation, and Deloitte; Other-Policy-System Strengthening/FHI, Pact

B5

Pact will play a major role in the USG OVC portfolio by facilitating a network of USG partners/cooperating agencies to implement the Government of Tanzania's (GoT) National Plan of Action for Most Vulnerable Children (MVC) through systems strengthening and establishing a manner to deliver comprehensive and quality services. Pact will reach 30,000 orphans and vulnerable children – locally known as most vulnerable children, OVC/MVC) by the end of FY06. Pact will use data from the Tanzanian Indicator Survey (THIS) and the GoT census to identify priority regions based on HIV/AIDS prevalence and orphanhood and low existing service levels (Mbeya, Mwanza, Iringa, Kilimanjaro, Mtwara, and Mara). The second component of the Pact agreement is to extend grants to indigenous NGOs/CBOs/FBOs and, where possible, to the newly established Most Vulnerable Children's Committees (MVCCs) to provide services for MVC and strengthen service systems and structures at the national, district, and community levels. For the grants component, priority will be given to complementing other USG-supported activities benefiting children and youth to maximize outcomes. A third core activity for Pact will be to maximize this network approach to increase linkages (wraparound programs) among MVC implementing partners and other USG activities focused on children and youth, as well as MVC activities supported by other donors. Pact is also implementing the MVC activities under the Global Fund Round 4 that will facilitate harmonization and coordinate support to the GoT's Plan of Action for MVC.

The Pact activity will play a key role in supporting the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through MVCCs (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare (DSW) at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System.

Pact will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort. One important step for coordinating efforts will be to map all of the services across sectors that relate to children and youth. Pact will do this in conjunction with other implementing organizations, using the DSW Data Management System. The multi-sector services include health (e.g., IMCI, reproductive health, malaria); education/girls scholarship fund; junior farmer program; child labor protection; economic growth opportunities; stigma reduction; HIV/AIDS prevention, care, and treatment services. Pact will convene network members to agree upon standards for defining the delivery and scope of each essential service (education, psycho-social support, health, protection, shelter, food, HIV prevention, economic opportunity).

Pact will also provide support, in collaboration with FHI/Tanzania (MVC network member with technical lead responsibilities), on the implementation of the standards. This project will involve working closely with the GoT and MVC network members to prioritize activities for strengthening systems and structures at the national, district, ward, and village levels relating to comprehensive and quality programming for MVC. This includes facilitating the training and ongoing support to CMACs and social workers by MVC network members as well as Pact. As part of coordination activities, Pact will facilitate MVC to participate and represent youth in programming decisions. MVC youth will also participate at the national stakeholder level, in collaboration with

UNICEF.

In addition to this, Pact will hire a technical person on MVC programming to be part of the GoT's DSW to manage implementation of the National Plan of Action, including engagement of government and civil society stakeholders.

Half of the funds to Pact will be dedicated to service delivery through its rapid sub-granting mechanism, which will issue and manage sub-grants to function as part of the MVC network and implement the DSW's Plan of Action for MVC service delivery model. Pact will support monitoring and evaluation of MVC activities through shared service tracking mechanism (i.e., the DSW Data Management System) and determining, with network members, shared outcomes indicators for each service area and for systems and structure strengthening at the community, district and national levels. Another key activity will be identifying opportunities for linking and leveraging activities of other USG-supported activities for children and youth (e.g., Peace Corps, Department of Defense) and the related activities of other donors, as well as to devise means for systematically and strategically engaging MVC network member activities with these other activities to maximize outcomes for beneficiaries. Result from mapping exercise will inform this activity. The project will also work to maximize activities in advocacy and policy reform to facilitate a supportive context for reducing stigma and discrimination and increasing child protection.

Pact has an established track record in Tanzania for building capacity among civil society organizations and forging linkages with government. Pact also supports a network of social advocacy organizations focused on human rights, especially women's rights.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	30,000	☐
Number of providers/caretakers trained in caring for OVC	350	☐

Target Populations:

Community leaders

Community-based organizations

Country coordinating mechanisms

Faith-based organizations

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

Program managers

USG in-country staff

Caregivers (of OVC and PLWHAs)

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Iringa

Kilimanjaro

Mara

Mbeya

Mtwara

Mwanza

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Henry M. Jackson Foundation Medical Research International, Inc.
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3404
Planned Funds:

B5

Activity Narrative: This activity also relates to activities in palliative care (KIHUMBE), AB (KIHUMBE), treatment (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices), and counseling and testing (Mbeya Regional Hospital, Mbeya and Rukwa Regional Medical Offices),

In the Tanzania HIV/AIDS Indicator Survey 2003-2004, Mbeya was identified as one of the regions with the highest OVC population per capita (18%). In this survey, it was also concluded that it ranked as one of the lowest regions as far as meeting the full needs of its OVC population. HJFMRI will also work with its three major partner organizations, Axios International, the Salvation Army and KIHUMBE.

The Henry M. Jackson Foundation Medical Research International (HJFMRI) was established in Tanzania to manage and provide technical assistance to HIV care initiatives in the Southern Highlands. As a locally based organization, HJFMRI has had two successful years in the Mbeya Municipality increasing the capacity of several other local organizations providing support to OVC and their caregivers. In FY05 it helped found a Mbeya Network of NGOs and FBOs which have been active in providing services to community members in the region and the Southern Highlands from anywhere between two to forty years. This year will also see the inclusion of several groups from the Rukwa Region, mirroring expansion of comprehensive care and treatment efforts.

HJFMRI has been working with local organizations caring for OVC to identify those best situated to benefit as sub-grantees in FY06. Five of the 14 organizations already identified are FBO's and have a longstanding presence in their communities and very good track records for providing quality services. The activities of these organizations are coordinated with programs implemented by other donors in the Mbeya and Rukwa Regions and will work to provide services in four of the six districts in Mbeya, the Mbeya Municipality itself and the large urban center of the Rukwa Region, Sumbawanga.

In FY05, network staff were trained to counsel orphans, especially those with HIV/AIDS. In FY06, HJFMRI will take advantage of the well-developed training and resource manuals in OVC specific psychosocial counseling and support developed by the Salvation Army. This will include supporting the attendance of 40 Network members at FY06 trainings in this skill by the Salvation Army in Mbeya who will in turn train another 160 providers within their organizations. Information from this training will also be shared with community home based care (CHBC) providers in these organizations to supplement their basic skills in OVC support as part of their palliative care services.

The Mbeya Network of NGOs and FBOs will address legal rights education as a critical element to be added to the OVC support package. The Evangelical Lutheran Church of Tanzania (ELCT) through their Local Community Confidence Building (LCCB) program will conduct a training program for KIHUMBE and the other Network members. It will focus on improving the capacity of these organizations to sensitize OVC and caregivers on legal rights. The ELCT's LCCB has provided education in legal literacy as part of their platform for the past two years and use local legal organizations and firms in the training to provide up-to-date factual information and assistance in understanding the laws and issues that affect OVCs and PLWHA.

Activities within this submission will include providing over 10,000 OVCs with basic needs (clothing, bedding, school uniforms, nutritional support, and ensuring access to proper medical care), improvement of psychosocial support as part of services,

education of OVC and care givers on their legal rights, and assisting in the identification of HIV positive OVC and ensuring their access to treatment. Support will also include assistance in financing appropriate fees for secondary school and access to vocational training for older OVCs. Capacity development of 200 OVC providers in improved psychosocial counseling skill and legal literacy education will strengthen OVC programming. In addition, through informal training using OVC providers, over 6,000 caregivers/heads of households (many of which are OVCs themselves) will learn skill in supporting of basic needs of OVCs. By virtue of linkages with each other through the Network, these organizations will support and strengthen each other through the sharing of lessons learned and identification of additional resources.

This Network and Mbeya Municipality have begun to establish a database list of OVC, their location, services being provided to each individual and the organizations offering them support. This will further improve the Networks coordination to maximize coverage. The activity will also support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established MVC Committees (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. HJFMRI will participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort.

Funding under this submission will cover the provision of all services and basic needs, including assistance with fees, transport for volunteers and supportive supervision, expansion of training in psychosocial support to the 36 wards, and peer support meetings and events for OVCs, which will include education on legal rights.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	10,000	☐
Number of providers/caretakers trained in caring for OVC	6,200	☐

Target Populations:

Orphans and vulnerable children

Children and youth (non-OVC)

Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Mbeya

Rukwa

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Africare
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3419
Planned Funds:
Activity Narrative: The Community-Based Orphan Care, Protection and Empowerment (COPE) Project is a regional project being implemented in four countries (Uganda, Tanzania, Rwanda, and Mozambique) to address the needs of orphans and vulnerable children (OVC). In Tanzania, the project is being implemented in the five districts of the Dodoma region: Dodoma Municipal, Dodoma Rural, Mpwapwa, Kongwa, and Kondoa. The program emphasizes a community approach to enhance community participation leading to sustainability of activities after Africare/Tanzania has completed its role in the project area. In order to avoid stigma and discrimination by only targeting orphans, the project will take a broader approach by targeting those considered "most vulnerable children" (MVC) who are likely to be orphaned, infected with HIV, suffer from extreme poverty and disease, or have dropped out of school. Africare's innovative peer education strategy and life skills program will enable the project to reach a great number of other community members (i.e., indirect targets) as they will be implemented in schools, churches, and other youth-serving organizations, providing greater community benefit and decreasing the potential of stigma and discrimination to the primary beneficiaries of the program.

The project will work with the local government and will emphasize community mobilization for participation; development of networks/linkages/referrals systems; information, education, and communication; capacity building of local organizations; quality assurance and supportive supervision; strategic information; training; and, to a lesser extent, infrastructure improvement. The project will support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established MVC Committees (part of the Council Multisectoral AIDS Committees—CMACS) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. Africare will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort.

Special attention will be paid to issues of gender (ensuring equal access to services such as education benefits), stigma and discrimination, and developing opportunities for "wrap-around" services including education, food and microfinance so that resources are optimized. COPE will work with communities to encourage a shared responsibility for orphans and vulnerable children and their caregivers. Over five years, the project will target 60,500 orphans and vulnerable children as well as 75,500 caregivers reaching a total of 136,000 with direct support and the surrounding community with indirect support. By the end of FY 2007, Africare's COPE activity will cover 45,000 OVC/MVC.

The project has five major components. The first, enhancing district and community capacity to coordinate care and support services to OVC and caregivers, will be accomplished to ensure greater community participation for sustainability. COPE will work with the Government of Tanzania's MVC Committees (part of the Community Multi-sectoral AIDS Committees—CMACs), ensuring effective identification and planning processes to provide quality services to MVC in the project area.

The second component is providing life skills training to youth in school and out-of-school, so that they can make responsible decisions. This will be accomplished through the training of youth and adults as peer educators. Psychosocial care and support services to OVC and caregivers will also be given priority. The project will train community volunteers as Africare HIV/AIDS Service Corps, who will oversee community-based activities and train OVC in Life Skills. Service Corps Volunteers will

also be prepared to provide psychosocial support to OVC and caregivers through community and school COPE Clubs. The COPE Clubs will be a platform for HIV/AIDS prevention education and youth activities such as games, songs, and drama.

The third component will be to increase access to health care and nutritional support, including nutrition education and food for OVC and caregivers. Established linkages with other donors and partners who provide nutrition education and food resources will be pursued to leverage HIV/AIDS resources. The project will also seek to increase food production at the household level through the development of backyard gardens and small animal husbandry. Africare will also link children and caregivers to national health care services such as child care clinics and immunization through its established community health workers and other partner organizations.

The fourth component seeks to increase educational opportunities for OVC. This will be accomplished through support to OVC and targeted funds to secondary schools to facilitate the enrollment and retention of OVC in schools. The project will provide support to the schools to write grant proposals and train key persons in grants management.

The last component, increased livelihood opportunities for OVC and caregivers, will be accomplished through partnership with Emerging Markets Group who will facilitate the enrollment of older OVCs into vocational training and will provide grants and micro-credit to caregivers for small business ventures. Partnerships will be formed at all levels to encourage collaboration and to learn from each other. Africare will also provide support to local organizations currently serving OVC/MVC so as to boost their capacity to work with more children and youth.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	45,000	☐
Number of providers/caretakers trained in caring for OVC	350	☐

Target Populations:

Adults
Community leaders
International counterpart organizations
Orphans and vulnerable children
People living with HIV/AIDS
Girls (Parent: Children and youth (non-OVC))
Boys (Parent: Children and youth (non-OVC))
Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Dodoma

Kondoa

Kongwa

Dodoma Rural

Dodoma Urban

Mpwapwa

...ties: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: CARE International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3426
Planned Funds:
Activity Narrative:

This activity also relates to activities in palliative care (non-ART); palliative care TB/HIV; and, ARV treatment and training supported by the Emergency Plan.
The Care/Tumaini Alliance will continue to implement five complementary strategies to protect, support, and care for orphans or most vulnerable children (OVC/MVC). First, the program will strengthen the capacity of families to protect and care for their children by providing for basic education, expanding social welfare and income generating activities. Second, community-based mechanisms will be mobilized and strengthened. Third, the capacity of children and young people will be strengthened to meet their basic needs and fulfill their rights by providing educational materials, life-skills education, and vocational training. Fourth, the rights of OVC will be protected and fulfilled by ensuring access to social services for children. Lastly, an enabling environment will be created to combat discrimination and stigma generated by HIV/AIDS. Institutionalized care is not appropriate and will not be supported.
The funding will go specifically to the: 1) procurement of educational and food-based Income Generating Activity materials and supplies; 2) community mobilization and participation to ensure the necessary expansion of OVC care and the regular/routine availability of support within each home; 3) support to human resources to build up the OVC protection, psycho-social support, and care services in a team approach; 4) development of network/linkages/referral systems to ensure a multidisciplinary approach (e.g., health services) for the complex needs of OVC; and 5) information, education, and communication to highlight the needs of OVC and reduce stigma and discrimination.
Funds will also be committed to reaching OVC and creating effective linkages with other sectors and initiatives to ensure coordination and support; this will also assist the program to better meet the increasing demands for improved and cost-effective care and support. A critical part of the support is for capacity building to those community-based organizations (CBOs) and faith-based organizations (FBOs) to ensure provision of the elements of OVC protection, care and support; to assure logistics systems for appropriate procurement, storage, distribution, and performance monitoring of the equipment and supplies; and to be certain that financial accountability and monitoring systems are in place.
The principles under which the Tumaini OVC program is set encourages actions that are based on the rights and needs of the child; specifically, child-centered and family/community-focused services. The program will promote, protect, and support the rights and freedoms of children with respect to inheritance, participation, confidentiality, and freedom from discrimination and exploitation, and need to work with communities to achieve a shared understanding of the principles of the children's rights. The program will involve OVC/MVC in decisions that affect their lives and will equip children with life skills to enable them face new challenges. The program will also focus on strengthening families and communities to provide them with skills/tools so they can plan and manage support that will enable OVCs to achieve their rights. The program will also support and enable the social and health systems to address concerns of OVC through integrated and comprehensive service provision, information, advocacy, and partnership. Activities will be geared towards reduction of stigmatization of OVCs by focusing on all the vulnerable children. The program will also adopt a gender-sensitive approach in recognition that the girl child is particularly vulnerable to HIV/AIDS, in terms of both infection and impact.

A total of 30,000 OVC will be targeted in the five regions of Tanzania. The most critical challenge currently facing Tumaini is to develop responses that measure up to the enormous scale of the crisis. Children, families, and communities alone cannot achieve the tremendous needs of OVC/MVC. Tumaini's response will pivot upon partnerships at all levels: the Government of Tanzania, religious bodies, the private sector, other international organizations. All levels and sectors of civil society will be

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...Country: Tanzania

Fiscal Year: 2006

urged and supported to commit time and resources. The program will strengthen the circle of partners who assume responsibilities for supporting OVC, i.e. "wraparound" programming such as accessing a highly successful micro-credit program.

The project will support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established Most Vulnerable Children's Committees (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. Tumaini will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort.

Targets of this program include: 23 local organizations provided with technical assistance for OVC-related policy development and institutional capacity building; 300 individuals trained in OVC-related policy; 100 CBO and FBO program managers trained in OVC-related institutional capacity building, 30,000 OVC served, and 5000 providers/caretakers trained to care for OVC.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Commodity Procurement	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	30,000	☐
Number of providers/caretakers trained in caring for OVC	5,000	☐

Target Populations:

Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Program managers
HIV positive children (6 - 14 years)
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Dodoma

Iringa

Mwanza

Pwani

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Deloitte Touche Tohmatsu
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3442
Planned Funds:
Activity Narrative: This activity links to other activities in orphans and vulnerable children.

B5

The Rapid Funding Envelope (RFE) has been evaluated as an effective mechanism to get funding to small community-based organizations (CBOs) for urgent and innovative projects. The RFE is supported by ten donors, and USG support is largely focused on the management of the RFE program and on special program needs, such an orphans and vulnerable children (OVC) focused grants. During FY05, over $3.6 million dollars was distributed to small organizations through the RFE. In FY06, Deloitte & Touche will receive additional grant funds from the Rapid Funding Envelope mechanism to manage OVC programs. Deloitte will make up to four special awards to NGOs and FBOs that will build community capacity to respond to OVC needs and train and prepare adolescent OVC for a profession.

Deloitte's CBO or FBO sub-grantees will help develop the local response to OVC needs by linking the sub-grantees with the newly formed Council Multisectoral AIDS Committee Most Vulnerable Children Committees (also known as MVCCs). This linkage will enhance the sustainability of the activities.

The sub-grantees will assist adolescent OVC to complete vocational training programs certified by the national Vocational Education Training Authority (VETA). This assistance will be aimed at enabling the adolescents to gain financial security and independence through suitable careers. This program will be of particular importance to OVC adolescents who are heads of households because it will provide training that will enable them to support their siblings with jobs that do not put them at risk.

Deloitte provides important technical assistance in proposal review and awards, technical assistance to grantees in implementation and reporting, and grants management in terms of financial management and monitoring. Deloitte's will be able to build on its experience with the current grantees, which were selected through a solicitation that targeted only well-established FBOs and NGOs that work with OVCs.

The technical assistance for small grantees provided by Deloitte & Touche under the RFE will complement the several OVC activities that were initiated in FY05. The RFE allows for the rapid "piloting" and evaluation of innovative interventions that then can be shared with and used by other OVC programs.

Present and future priority activities include a continued collaboration with civil society to find sustainable alternatives to institutional care and support for OVC; increasing the level of support and funding for impact mitigation projects, including life skills education and vocational training activities; and reaching a greater number of OVC affected by HIV/AIDS through the RFE mechanism.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	500	☐
Number of providers/caretakers trained in caring for OVC	100	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
Street youth (Parent: Most at risk populations)
International counterpart organizations
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Teachers (Parent: Host country government workers)
Volunteers
Girls (Parent: Children and youth (non-OVC))
Boys (Parent: Children and youth (non-OVC))
Primary school students (Parent: Children and youth (non-OVC))
Secondary school students (Parent: Children and youth (non-OVC))
HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Wrap Arounds

Coverage Areas:

National

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 3459
Planned Funds:
Activity Narrative: These activities also relate to the activity narrative under Other-Policy-System Strengthening program area, all the other activities in the OVC program area and more.

FHI will work with each of the partners that are implementing OVC programs in Tanzania to ensure that the vision for OVC care, which is articulated in the National Action Plan, translates into actual measurable services that are being delivered to OVC. This entails working closely with the USG OVC partners as a group to ensure that their approaches are coordinated, that they are using practices that are evidence-based, supported by the technical guidance provided by OGAC, and that they comply with national standards.

FHI will provide input on the technical components of each USG partner's approach. This input will be especially integral to two new USG programs. The new Tumaini activity will be a follow-on to the existing Care program, which will conclude in March 2006, and will need close technical oversight. The same can be said for the large new Pact program, which will begin in October, 2005, and is closely linked with the work that Pact is doing with the Global Fund Round 4 award.

FHI will also provide technical input on the training curricula that will be used to build the skills of social workers that need in-service training and to train new social workers. In addition to this, FHI will provide technical support on the implementation of the OVC Data Management System for tracking OVC/MVC needs and services at the local level. These linkages at the local level are expected to be arduous and labor intensive at first and organizations will likely need the expertise of partners that have a long history of working in Tanzania at the national and local level.

FHI will provide technical input and quality control for the activities of other USG partners with whom that FHI is linking, ranging from: creating linkages with the Council Multi-Sectoral AIDS Committees – Most Vulnerable Children (CMACS MVC) Committees; identifying OVC/MVC through HBC/OVC volunteers; registration; individual needs assessment; psycho-social support; legal aid; health care; vocational training; provision of educational support such as school uniforms and school fees; and the provision of short-term support to address long-term needs. FHI will also assist OVC implementing partners in linking with wraparound programs in their region (with a special emphasis on creating linkages with income generation, education, and food support programs).

FHI's linkages with other USG funded OVC programs will allow it to impact the quality of programs serving several thousand OVC. They will have a strong linkage to the Tumaini Alliance, which serves 40,000 OVC through its 27 CBOs/NGOs in 5 regions. FHI's partnership with Pact will support Pact's services to an additional 30,000 OVC.

B5

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs		☑
Number of providers/caretakers trained in caring for OVC		☑

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Volunteers
Caregivers (of OVC and PLWHAs)
Out-of-school youth (Parent: Most at risk populations)

Key Legislative Issues

Gender

Twinning

Volunteers

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Mwanza

COAST

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	Track 1 OVC Program
Prime Partner:	Catholic Relief Services
USG Agency:	U.S. Agency for International Development
Funding Source:	N/A
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	3471
Planned Funds:	
Activity Narrative:	This activity is linked to OVC/Pact, OVC Track 1 partners and HBC/Care Tumaini.

Under the goal of "Orphans and Vulnerable Children (OVC) having a higher quality of life," CRS works through three partner dioceses, one of which is nationally recognized as a center of excellence offering holistic comprehensive care services: PASADA in Dar es Salaam. PASADA is serving as model to be adapted and adopted by two other partners: the Archdiocese of Songea and the Diocese of Njombe. In FY06, CRS will continue to work through its partners at the community level and concentrate in the following intervention areas for orphans or most vulnerable children (MVC): education, nutrition, economic strengthening, life skills training, health care, human rights and child protection, psychosocial support, economic development, and housing, and shelter. The project will support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established MVC Committees (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children are included in the OVC/MVC Data Management System. CRS will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort. CRS will build on its past achievement supporting 3,771 OVC and increase that support to a total of 7,000 OVC by September 2006 and 8,500 by September 2007.

The program will develop more economic strengthening strategies to build the community's capacity to maintain and even increase its support for the OVC/MVC in their communities. Members of the Diocesan team will integrate fully with the CMACS, in their operational sites, ensuring that OVC/MVC and their needs are included in the national OVC/MVC Data Management System. In planning and implementation to reach its project targets, CRS will through the "Partnership Model" continue to collaborate with the following entities: CMACS, village/local government, small Christian communities, OVC care promoters, social workers, counselors, OVC guardians, teachers and OVC themselves.

The project has identified four opportunities for linking with other existing programs. Firstly, the project can be linked to an existing Seed for Survival-funded DAI PESA Agro-enterprise program to achieve higher economic strengthening objectives in Songea Rural and Nantumbo districts. Strengthened diocesan capacity will, in turn, allow them to expand existing IGA activities to OVC/MVC and their families. Secondly, in Njombe, the project has linked with the nutrition component of the Tumaini project involving Heifer International, a dairy goat program to provide goats to OVC guardians and CHH. Thirdly, the diocese has developed an informal working relationship with Peace Corps volunteers in the area of community mobilization as well as data collection and monitoring project progress. Lastly, Medecins San Frontiers (MSF) provides direct support to the Care and Treatment Centers (CTC) of the district hospitals in the same catchment areas of Njombe, and CRS partners will work with the teachers, guardians, and communities to sensitize them to the available services for those infected with AIDS, including the children. CRS partners will also assist in setting up referral mechanisms for the children to benefit from the services offered by these health facilities.

It is painstakingly obvious to the field workers that our project manages interventions for only a small portion of those affected. The challenge is to replace the "better than nothing" outlook, which can have a demoralizing impact, with a comprehensive community-based plan that manages expectations. This will be accomplished by

setting a long-term capacity-building strategy for income generation using available arable and productive land. In general, the key challenge this year is to respond effectively to lessons learned with activities that partners identified as most effective. CRS interventions are part of the continuum of care that has been adopted by all PEPFAR partners.

The overall approach of the project is focused on building community capacity to respond to OVC needs by networking an experienced and successful diocese (PASADA) with the more novice yet promising ones (Njombe and Songea). This project will create opportunities of learning between the different partners and Government councils, and will help strengthen each stakeholder's capacity to respond effectively to their specific environment, including joint best practices/lessons learned workshops, cross visits and cross training. At all operational sites, CRS will improve its coordination portfolio across sectors for OVC programming, monitoring and evaluation by addressing sound OVC registry systems, full participation of OVC Coordinators in the different levels of the CMACs, and training appropriate staff to increase capacity for management and monitoring of their programs. Through the institutional capacity-building initiative, FBOs, community groups and OVC families will be trained /retrained to access services and skills to effectively deliver services to OVC, families and communities. On one hand these interventions will develop the capacity to respond to children's needs On the other hand, through this strategy, the number of OVC in the households receiving/benefiting from assistance to become more economically self-supporting will increase.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	8,500	☐
Number of providers/caretakers trained in caring for OVC	255	☐

Target Populations:

Faith-based organizations

Street youth (Parent: Most at risk populations)

HIV/AIDS-affected families

Orphans and vulnerable children

Teachers (Parent: Host country government workers)

Volunteers

Caregivers (of OVC and PLWHAs)

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

District level staff

Key Legislative Issues

Stigma and discrimination

Wrap Arounds

Coverage Areas

Dar es Salaam

Iringa

Pwani

Ruvuma

Funding Mechanism: N/A
Mechanism:
Prime Partner: Salvation Army
USG Agency: U.S. Agency for International Development
Funding Source: N/A
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 4920
Planned Funds: [redacted]
Activity Narrative: This activity is linked to OVC/ Pact and OVC/ FHI activities.

The focus of the Salvation Army (SA) Track 1 Tanzania program are: strengthening communities to construct community-based responses to meet the needs of orphans and vulnerable children (OVC); providing psychosocial support for OVC; improving the economic security of OVC; and linking with complementary services that can address the multi-faceted needs of OVC. One model of community response that SA is already employing with success in Tanzania is the Mama Mkubwe Committees. These are local coordinating teams that are formed by identifying influential community members such as businessmen, church leaders, local government officials, and teachers who are interested in working on HIV/AIDS and issues of orphans and vulnerable children (OVC) and other children at risk, referred to as most vulnerable children (MVC). These teams then help coordinate and sustain the three integrated program activities of OVC care and support, psychosocial support for OVC, and economic strengthening for HIV-affected households and communities.

During FY06, the project will support the modification of this model so that it will support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established MVC Committees (part of the Council Multi-sectoral AIDS Committees--CMACs) at the local level, and working with the Department of Social Welfare (DSW) at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. SA will also participate in the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort. SA plans to be actively engaged in discussions about standards of performance and systems strengthening within the community of OVC service providers at all levels.

During FY2006, SA will also standardize its Psycho-social Support (PSS) curriculum. SA will rely upon SA's PSS experience both within Tanzania and across Africa. SA works closely with Masiye Camp, a well-known leader in PSS, that was started by SA in Zimbabwe. Approximately 140 volunteers will be trained in PSS for OVC. In the areas where it will work, SA will initiate the WORTH program, a unique income-generation training program that strengthens the ability of communities and female-headed households to care for the growing number of OVC/MVC. WORTH materials will be adapted for the Tanzanian context in terms of language, drawings and content, and Pact/Kenya will train staff to set up the WORTH program. At least 5,000 workbooks for WORTH will be distributed, and about 250 WORTH groups will be developed. SA will partner with Pact/Tanzania (and other organizations providing OVC services) for information and tool sharing, mutual learning opportunities through invitations to workshops on PSS and community counseling. About 50 Mama Mkubwa committees, working with the local MVC Committees, and 15,000 children and youth will be reached in 10 program districts.

In FY06, SA will call upon Pact/Tanzania to assist with capacity building training for its local programs in terms of financial management. The value added of this partnership is that Pact is implementing the OVC initiative funded by the Global Fund and has a significant USG-funded OVC activity that has just been initiated. SA will work with Pact/Tanzania on its annual work plan, and involve them in key activities. For example, SA intends to develop additional capacity-building curricula on topics such as the Memory Book Approach. SA will seek out the technical expertise of Pact/Tanzania and the Tanzanian DSW for the development of such curricula, as well as other entities with expertise on specific topics.

During FY06, SA will train 105 community volunteers in community counseling and PSS. It will also continue to help communities to establish community teams to coordinate and strengthen support for OVC, as well as set up Kids' Clubs. SA intends to work in coordination with the Tanzanian DSW MVC Committee framework. In the districts where the CMACs MVC Committees are operating, SA will ensure that the Mama Mkubwa individuals and/or committees are linked to this structure. In districts where CMACs are not yet operating, SA will work to build the capacity of the Mama Mkubwa Teams and prepare them for eventual linkage with the CMAC MVC Committees.

An important part of SA's work in FY06 will be to link SA's OVC program to the Tanzanian DSW's OVC/MVC Data Management System for service monitoring and OVC/MVC tracking. SA will work closely with DSW and other implementing partners (USG and others) to finalize the system and train appropriate users to use the system. Until that time, SA will work with its existing data collection system to track its progress towards reaching its targets in terms of OVC reached and services provided. SA also will work with its partner Pact for apply this Data Management System for program management and important basic data needs (e.g., identifying OVC and their particular needs; identifying where other service providers are present and how to establish essential links with these services). Wherever possible, SA will rely on existing baseline information available through national, district, ward, and village level government, TACAIDs, the Watoto Kwanza Network (the new USG-funded OVC activity run by Pact/Tanzania) and other NGOs.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Infrastructure	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	25,000	☐
Number of providers/caretakers trained in caring for OVC	300	☐

Target Populations:

Adults

Community leaders

Community-based organizations

Street youth (Parent: Most at risk populations)

HIV/AIDS-affected families

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

People living with HIV/AIDS

Program managers

Teachers (Parent: Host country government workers)

Volunteers

Girls (Parent: Children and youth (non-OVC))

Boys (Parent: Children and youth (non-OVC))

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Caregivers (of OVC and PLWHAs)

Out-of-school youth (Parent: Most at risk populations)

Religious leaders

Private Sector

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Dar es Salaam

Iringa

Kagera

Kilimanjaro

Lindi

Mara

Mbeya

Mwanza

Tabora

COAST

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	US Peace Corps
USG Agency:	Peace Corps
Funding Source:	GAC (GHAI account)
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	4981
Planned Funds:	
Activity Narrative:	This activity links to the Peace Corps activity in Palliative Care: Basic Health Care and Support.

B5

Peace Corps Tanzania (PC/T) directly implements Emergency Plan activities through the actions of its 110 Peace Corps Volunteers in 15 of 21 regions on mainland Tanzania. PC/T implements an integrated HIV/AIDS program where all Volunteers in country are encouraged to implement HIV/AIDs activities. There are three projects that Volunteers are engaged with at present including: the Education project that brings in secondary school Volunteer teachers to teach mathematics and science; the Environment project that places Volunteers in communities to assist with better natural resources management and they contribute to the improvement of farming practices; and finally, PC/T houses the Health Education project that brings Volunteers in to communities to work as health educators. By working in communities, Volunteers witness a lot of suffering from HIV/AIDS infected persons, patients and orphans and vulnerable children (OVC)s. This provides them with the need to take part in care provision to these infected and affected individuals.

In FY06, PC/T will expand the implementation of its HIV/AIDS program into the area of care. PC/T's care budget is 25% of the entire PC/T FY06 Emergency Plan budget. PC/T will work specifically with Palliative Care: Home-Based Care (HBC) and OVC activities with a 75% and 25% respective split in the care budget. PC/T will utilize the experiences gained in its Environment Project and experience with natural resources management to improve the nutritional status of OVCs, PLWHAs and their families/caretakers through the promotion of demonstration permaculture and home gardening activities in their communities. PC/T will not use Emergency Plan monies to purchase food directly for the beneficiaries of the project. The strategy will be to mobilize and train community groups including PLWHAs and their support groups, OVCs and their caretakers to engage in starting permaculture and home/community gardening activities and also to train them on care for PLWHAs especially in the area of nutrition.

Volunteers and their HCN counterparts will work with 120 OVCs to provide them with nutrition education and/or demonstrate on how to obtain supplementary food from permaculture and home/community gardening activities. The food that is produced from these permaculture and home/community gardening activities will be available for needy OVCs. Volunteers will also train 120 caretakers on how quality care for OVCs, specifically on how nutrition impacts the quality of care. The hope is that through these community mobilization activities caretakers and community members will be motivated to take action, i.e., starting community gardens and/or permaculture activities.

PC/T will conduct workshops on permaculture to Environment and Health Education Volunteers and their HCN counterparts to give them the capacity needed to conduct these programs in their communities. PC/T will set aside monies to pay for a technical expert to conduct these trainings for Volunteers and their counterparts. Volunteers can also access Emergency Plan monies through small grants to fund community trainings and purchase some gardening tools for demonstration of home/community gardening and permaculture activities.

Training materials will be developed or/and bought: videos, manuals, posters and books for use in prevention and awareness activities organized by Volunteers and HCN counterparts around Tanzania.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	120	☐
Number of providers/caretakers trained in caring for OVC	120	☐

Target Populations:

Community leaders
Orphans and vulnerable children
Teachers (Parent: *Host country government workers*)
Volunteers
Girls (Parent: Children and youth (non-OVC))
Boys (Parent: Children and youth (non-OVC))
Primary school students (Parent: Children and youth (non-OVC))
Secondary school students (Parent: Children and youth (non-OVC))

Coverage Areas

Arusha

Dodoma

Iringa

Kagera

Kilimanjaro

Lindi

Manyara

Mara

Mbeya

Morogoro

Mtwara

Mwanza

Ruvuma

Singida

Tanga

Table 3.3.08: Activities by Funding Mechanism

Mechanism: Track 1 OVC Additional Funding
Prime Partner: Africare
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 4986
Planned Funds: [redacted]
Activity Narrative: This activity is linked to other USG-funded sub-grants to Africare for prevention, VCT, and home-based care, as well as the mainland OVC activities underway funded centrally through Track 1 funding.

B5

While the number and needs of orphans and vulnerable children (OVCs) are visibly increasing in Zanzibar, little support is available. Africare, through local USG support in FY05, supported orphans and vulnerable children in three districts in Zanzibar. This cooperative agreement ends April 30, 2006. New activities for FY2006 will be funded through additional funding of [redacted] that will be put into the Track 1 agreement. Extending coverage to Pemba Island and improving the quality of services will be the primary objectives for this FY06 funding.

This program will reach 4,000 OVC in Zanzibar. The geographic coverage of Africare's program will increase from three to eight of Zanzibar's ten districts. Four local organizations (ZASO, ZAMWASO and ZAPHA+ and WAMATA) will be provided with grants to support OVC. Priority activities supported will include education, health, psycho-social support and training for caregivers. Communities, including religious leaders and organizations, will be mobilized to support OVC and to ensure that assistance is reaching the most needy children.

Specifically, educational support will involve supporting pupils and students in primary schools with exercise books, schools fees, and uniforms. They will also be supported with hygienic products, such as soaps to help them stay healthy and clean when going school. About 1,500 OVCs will be direct beneficiaries of educational support.

Caretakers or guardians will be supported with small seed grants to generate income. The four NGOs mentioned will be responsible for running income generation activities, while Plan International will provide technical assistance in micro financing for OVC caretakers. About 100 caretakers will benefit from income generation or micro financing.

Referral mechanisms will continue to be put in place to ensure that OVCs are linked to services that they need across the continuum of care. The OVCs infected with HIV/AIDS will be linked to both facility-based and community-based services. Links will also be established to institutions that work to protect rights of children.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	4,000	☐
Number of providers/caretakers trained in caring for OVC	100	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kaskazini Pemba (Pemba North)

Micheweni District

Wete District

Kusini Pemba (Pemba South)

The Regional District

Chake Chake District

Kaskazini Unguja (Zanzibar North)

North District A

North District B

Mjini Magharibi (Zanzibar West)

West District

Table 3.3.08: Activities by Funding Mechanism

Mechanism: Targeted Evaluation
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 5001
Planned Funds: [redacted]
Activity Narrative: *This activity relates to OVC – Pact, Tumaini, Africare, FHI, Peace Corps, and Jackson* Foundation activities.
This activity will be a part of a larger targeted evaluation effort being undertaken by USAID/Washington. The most vulnerable children's programming area lacks evidence on delivering comprehensive services to children to achieve outcomes in wellbeing. A targeted evaluation will be implemented to examine several models for designing, implementing, and tracking community-based approaches to strengthening family, community, and government structures and systems to deliver essential services. The targeted evaluation aims to determine which models make a measurable difference in wellbeing and to what extent. USG/Tanzania would like to invest [redacted] in the larger targeted evaluation to be done in several countries. The objective is to include the Government of Tanzania's Most Vulnerable Child Committee model among the other models to be evaluated. Results should also *inform standards of quality performance for each essential services (such as:* education, psycho-social support, shelter, food, protection, health care,economic opportunity, and HIV prevention and care.)

B5

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs		☑
Number of providers/caretakers trained in caring for OVC		☑

Target Populations:

Community leaders
Community-based organizations
International counterpart organizations
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Policy makers (Parent: Host country government workers)
Implementing organizations (not listed above)

Coverage Areas:

National

Table 3.3.08: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American International Health Alliance
USG Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 5002
Planned Funds:
Activity Narrative: This activity relates to activities in Palliative Care: .Basic Health Care and Support – FHI.

B5

Nearly two thirds of the districts in Tanzania are without social workers. Those charged with addressing the needs of orphans and vulnerable children (OVC), and Tanzania's broader definition of most vulnerable children (MVC) are usually individuals who have not been trained to handle the complex needs of MVC, including advocacy and legal support, psychosocial support, education, health services, food and nutritional support, housing, child rearing, life skills and vocational training, etc. To address these dramatic needs for the large number of children who are both vulnerable and orphaned, a trained cadre of social workers must be developed.

With FY06 funds, a twinning arrangement will be established between a U.S. school of social work (e.g, Catholic University) and the Institute of Social Welfare of Tanzania. The Department of Social Welfare and FHI will oversee a capacity assessment of the social service delivery environment (including pre- and in- service training, service modalities, beneficiary perception of services, etc.) to identify gaps, strengths, barriers, and opportunities for increasing quality services to most vulnerable children. The assessment will be supported by USAID/Washington in collaboration with FHI the UNICEF/Tanzania. Results will inform strategy and content for concurrently implementing at least three levels of effort: in-service training to re-tool district and national level social workers, updating of pre-service training for relevance to HIV/AIDS mitigation, and "para-professional" or vocational short-course training. Twinning will facilitate the transfer of state-of-the-art curriculums, case management, and supervision approaches within the African context. In addition to building a cadre of social workers to cover the 126 districts in Tanzania, immediate identification and training of lay persons to serve as "social referents" will provide a more immediate response in USG geographic priority areas for most vulnerable children. The social referent training will be a standardized certificate program guided by the Department of Social Welfare with advisory consultations with the Tanzanian Association of Social Workers. To complement this activity, Pact, another USG partner will provide a sub-grant to a Tanzanian civil service organization to partner with the Department of Social Welfare and the U.S. school of social work to enable on-going support/supervision of para-professionals. It is expected that by the end of FY06, 200 social workers will be trained.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	0	☐
Number of providers/caretakers trained in caring for OVC	200	☐

Indirect Targets

Nearly 300,000 OVC will be reached indirectly through this effort.

Target Populations:

Community leaders
Orphans and vulnerable children
Teachers (Parent: Host country government workers)
Volunteers
Girls (Parent: Children and youth (non-OVC))
Boys (Parent: Children and youth (non-OVC))
Primary school students (Parent: Children and youth (non-OVC))
Secondary school students (Parent: Children and youth (non-OVC))

Key Legislative Issues

Gender

Twinning

Coverage Areas

Arusha

Dodoma

Iringa

Kagera

Kilimanjaro

Lindi

Manyara

Mara

Mbeya

Morogoro

Mtwara

Mwanza

Ruvuma

Singida

Tanga

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	Orphans Follow On
Prime Partner:	To Be Determined
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	5548
Planned Funds:	
Activity Narrative:	This activity also relates to activities in palliative care TB/HIV, OVC, and ARV treatment and training supported by PEPFAR. It will be a new activity to continue the work underway through the existing Care/Tumaini OVC activity. The Care/Tumaini activity will be re-competed during FY2006. The intention is to maintain support to the OVC receiving services through the existing mechanism (Care/Tumaini) by transferring them and the most effective sub-grantees to the new mechanism.

B5

The follow-on award will continue to implement five complementary strategies to protect, support, and care for orphans or most vulnerable children (OVC/MVC). First, the program will strengthen the capacity of families to protect and care for their children by providing for basic education, expanding social welfare and income generating activities. Second, community-based mechanisms will be mobilized and strengthened. Third, the capacity of children and young people will be strengthened to meet their basic needs and fulfill their rights by providing educational materials, life-skills education and vocational training. Fourth, the rights of OVC will be protected and fulfilled by ensuring access to social services for children. Lastly, an enabling environment will be created to combat discrimination and stigma generated by HIV/AIDS. Institutionalized care is not appropriate and will not be supported.

The funding will go specifically to the: 1) procurement of educational and food-based Income Generating Activity materials and supplies; 2) community mobilization and participation to ensure the necessary expansion of OVC care and the regular/routine availability of support within each home; 3) support to human resources to build up the OVC protection, psycho-social support and care services in a team approach; 4) development of network/linkages/referral systems to ensure a multidisciplinary approach (e.g., health services) for the complex needs of OVC; and 5) information, education, and communication to highlight the needs of OVC and reduce stigma and discrimination.

Funds will also be committed to reaching OVC and creating effective linkages with other sectors and initiatives to ensure coordination and support; this will also assist the program to better meet the increasing demands for improved and cost-effective care and support. A critical part of the support is for capacity building to those community-based organizations (CBOs) and faith-based organizations (FBOs) to ensure provision of the elements of OVC protection, care and support; to assure logistics systems for appropriate procurement, storage, distribution, and performance monitoring of the equipments and supplies; and to be certain that financial accountability and monitoring systems are in place.

By the end of FY2007, a total of 40,000 OVC will be targeted in the five regions of Tanzania. The most critical challenge currently facing Tumaini is to develop responses that measure up to the enormous scale of the crisis. Tumaini's response will continue to be based upon partnerships at all levels: the Government of Tanzania, religious bodies, the private sector, other international organizations. All levels and sectors of civil society will be urged and supported to commit time and resources. The program will strengthen the circle of partners who assume responsibilities for supporting OVC, i.e. "wraparound" programming, such as accessing a highly successful micro-credit program.

The project will continue to support the scale up of Tanzania's National Plan of Action for OVC/MVC, involving key stakeholders through the recently established Most Vulnerable Children's Committees (part of the Council Multi-sectoral AIDS Committees—CMACs) at the local level, and working with the Department of Social Welfare at both the national and the local level to ensure that children served are included in the OVC/MVC Data Management System. Tumaini will also participate in

the coordination of activities with other implementing organizations, sharing tools, materials, effective practices, and lessons learned, as well as ensuring there is no duplication of effort.

Targets of this program include: 30 local organizations provided with technical assistance for OVC-related policy development and institutional capacity building; 40,000 OVC served, and 5000 providers/caretakers trained to care for OVC.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of OVC served by OVC programs	40,000	☐
Number of providers/caretakers trained in caring for OVC	5,000	☐

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Arusha

Dodoma

Iringa

Mwanza

Pwani

Table 3.3.09: Program Planning Overview

Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09

Total Planned Funding for Program Area:

B5

Program Area Context:

Counseling and Testing (C&T) continues to be a cornerstone of the national response to HIV/AIDS epidemic in Tanzania. According to the Government of Tanzania (GOT), the number of VCT sites has increased from 370 to 521 in the last 12 months now covering all districts. Over 100 of these sites are directly supported by the USG and have tested approximately 150,000 individuals in 2004 with a target of 300,000 in 2005. An additional 50,000 were tested at health facilities and 1,200 counselors were trained in the same time period. The GOT target is to have at least six public-sector VCT sites in each of Tanzania's 126 districts and 1,600 counselors trained by the end of 2006.

Through assistance to the MOH at the national level and direct support to point-of-service, the USG continues to work towards its goals of increased utilization and improved quality of C&T. In FY05, USG-supported NGO partners reached their goal of testing 117,000 people. Funding for the MOH is facilitating development of a national campaign to promote testing and national VCT guidelines have been finalized and are being distributed.

Other donors provide support for C&T. The Japanese International Cooperation Agency and Axios International procure HIV test kits. The German Technical Cooperation directly funds services in four regions. WHO provides technical assistance to the MOH while the Global Fund supports direct service delivery. Other donors indirectly contribute to testing through financial support of GOT treatment initiatives.

The GOT estimates that five million individuals will have to be tested to reach its goal of 100,000 on treatment by the end of 2006, recognizing that its current and almost exclusive reliance on VCT will be not be sufficient. They therefore wish to increase access points and focus on populations more likely to be eligible for treatment via provider initiated C&T services in inpatient wards and specialty clinics. At the same time, the GOT emphasizes that VCT should continue to be a significant component of the national response.

In FY06 the USG will continue to support national consensus building towards provider initiated, opt-out C&T complemented by VCT. USG will assist in the development and roll out of national guidelines for provider initiated C&T and referral as well as harmonization of MOH testing guidelines across clinical interventions (such as PMTCT and VCT); address gaps in monitoring; support the development and implementation of quality assurance strategies such as certification; and assist with coordination. USG support will include technical assistance and funding for service expansion, training, and advocacy and social marketing.

An important new element for identification of treatment eligible patients will be the use of C&T as part of the USG prevention platform for high-risk groups. This will include focused development of services along transportation corridors and the use of mobile VCT centers for hard to reach high-risk groups. Where USG partners are conducting VCT, both through mobile interventions and at static centers, linkages to treatment and care will be established. Numbers of individuals receiving USG supported C&T will be augmented through activities and partners described in the TB and treatment sections. Support nationally will be on quality improvement of C&T services through the assistance of government efforts to strengthen supervision and improve coordination by the MOH.

The USG will support the testing of 590,000 individuals through a combination of VCT and provider initiated C&T between March 2006 and September 2007. Movement towards provider initiated testing by USG partners and targeting higher risk populations will significantly increase the number of treatment-eligible individuals identified. This comprehensive, multi-pronged approach will ensure that the maximum number of individuals are not only made aware of their sero-status but are also linked to services.

Program Area Target:

Number of service outlets providing counseling and testing according to national or international standards	149
Number of individuals who received counseling and testing for HIV and received their test results	571,200
Number of individuals trained in counseling and testing according to national or international standards	1,037

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mbeya Referral Hospital
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 3372
Planned Funds:
Activity Narrative: This activity also relates to activities in treatment (MRH).

The National AIDS Control Programme (NACP) will establish zonal training centers or centers of excellence that will be part of a sustainable HIV/AIDS program. Each "center" will support zonal training and quality control/quality assurance covering PMTCT, CT, HIV care and treatment and supporting laboratory services. The center for the Southern Highlands will be located in the Mbeya Referral Hospital which will serve the Mbeya, Rukwa, Ruvuma and Iringa Regions.

At the Mbeya Referral Hospital, the integration of counseling and testing services into basic health care services will continue in FY06. It is estimated that 40-50% of inpatients as well as 50% of patients who are TB infected are HIV positive. These patients, as well as those attending out patient clinics, offer the best opportunity to identify HIV positive individuals for treatment.

Currently, 35% of the health care staff at the referral hospital is trained in counseling and testing but services are not provided on a regular basis outside of the VCT clinic. Activities in FY06 will expand upon progress in FY05 and will provide 140 individuals continuing education in providing quality counseling and testing, introduction of counselor support group and assistance for staff that works long hours.

The integration of services to in patient wards for rapid identification of patients qualifying for ART in FY05 has been slow. Barriers remain regarding the use of provider initiated counseling and testing and guidelines for VCT (currently being followed for all counseling and testing services) restrict the number of clients any counselor can service in one day. Though the MOH and the National AIDS Control Programme (NACP) has begun policy discussions on integrated counseling and testing services in clinical settings, the staff at the Mbeya Referral Hospital will work to ensure identification of as many HIV positives attending the facility within current guidelines. This will be accomplished by sensitizing current staff to the need for integrated counseling and testing and such an approach still includes patient consent. Activities under FY06 funding will focus on this integration of counseling and testing in inpatient wards and as a regular part of all out patient services, including the TB clinic, will be reinforced through a rotation of staff from the HIV Care and Treatment Center (CTC) to assist regular staff in patient identification and provision of this service.

In order to provide the estimated care and treatment population at the Mbeya Referral Hospital for FY06, this facility will counsel and test at least 4,000 individuals attending outpatient clinics (including TB) and admitted to in patient wards in addition to those attending the VCT clinic by September 2007. Referrals between these clinics and wards have been established as part of FY04 and FY05 activities and will continue to be improved upon to maximize patient access to treatment.

Funds will support an annual refresher training for 140 qualified staff, procurement of reagents for confirmatory diagnostics, strengthening of referral mechanisms within the hospital and from external VCT services, and conducting workshops to educate personnel working in the various wards in identification of patients who may be HIV positive. The latter will include education of hospital staff on the range of services available at the CTC for HIV positive patients. It will also support the referral hospital's role in the Southern Highlands in leading this effort in integrating provider initiated counseling and testing, undertaking sensitization at facilities through out the zone. As part of a coordinated regional program, establishment of referral mechanisms and education of hospital staff will be done in coordination with the Mbeya, Rukwa and

Ruvuma Regional Medical Offices with each partner supporting the training held in their facility/region. The Mbeya Referral Hospital will provide supportive supervision as such services are initiated and work with the regional medical offices to address this challenge together, sharing successful models and lessons learned.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	4,000	☐
Number of individuals trained in counseling and testing according to national or international standards	140	☐

Target Populations:

Adults

Orphans and vulnerable children

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Coverage Areas

Mbeya

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Mbeya Regional Medical Office
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	3388
Planned Funds:	
Activity Narrative:	This activity also relates to MRMO's activities in treatment.

The Mbeya Regional Medical Office (MRMO) and its Regional AIDS Control Programme (MRACP) have implemented very successful VCT interventions since 1991, testing over 39,000 individuals (with an overall prevalence of 18% among those tested) in 2004 alone. Currently, these services are provided mainly at secondary and tertiary treatment facilities and several stand alone centers servicing the Mbeya Municipality and its surrounding peri-urban communities. Even with the success in VCT uptake, services have not been integrated as part of routine care or at centers serving individuals with a higher possibility of being infected and qualifying for treatment such as TB clinics.

FY05 Emergency Plan funding will assist the MRMO to provide these services to smaller, more remote communities and villages through expansion to an additional 10 health centers and dispensaries and the training of an additional 40 counselors to provide these services. This implementation has just begun due to the late arrival of funds in FY05. The expansion of VCT in FY06 will also be supported by other organizations such as Axios International and AMREF, and will ensure adequate coverage in the region.

The activities in this submission will focus on the integration of provider initiated counseling and testing within the clinic setting. It will also strengthen referrals within hospitals and from stand-alone services to the HIV Care and Treatment Centers (CTC) where ART as been initiated. In FY06, funding will support the MRMO in further integrating counseling and testing for HIV as a necessary component of in patient services and out patient clinics at the five hospitals in the region in which ART has started or will soon be initiated. This includes the Mbeya Regional Hospital and three district hospitals (Kyela, Rungwe, and Mbozi) and one Catholic mission hospital (Igogwe). It will also support the continued strengthening of counseling and testing in regional TB clinics started in FY05 and the referral systems being established.

In order for Mbeya Regional Hospital and the district/mission hospitals to reach the estimated FY06 targets for care and treatment in the region, a total of 12,000 individuals will need to be counseled and tested by September 2007. This is based on a prediction that an estimated 85% of these individuals will be reached by provider initiated services in the facilities (and associated TB clinics), while around 15% will be accessed through VCT services and referred to the CTC.

To reach this goal, funds will support the training of 20 additional staff (four at each of the five treatment facilities) serving in inpatient wards and out patient clinics in counseling and testing; provision of annual refresher training for the current 180 qualified staff in the region; and procurement of reagents for confirmatory diagnostics for the five hospitals in the region. Also supported in FY06 will be minor renovations in out patient clinics and in patient wards, which will provide space for confidential counseling and support of referral mechanisms both within the facilities and from external VCT services. Workshops will be conducted to educate personnel in the various wards at these facilities in the identification of patients who may be HIV positive and what services are available at the CTC for those who are confirmed as HIV positive. As part of a coordinated regional program, the establishment of referral mechanisms and education of hospital staff will be done in coordination with the Mbeya Referral Hospital and partners supporting VCT outside of hospital facilities in the region.

As availability of ART is expanded in Tanzania, the growth of counseling and testing services will be critical in identifying patients that are ready for treatment and providing a means for patients to accessing both the treatment and care through effective referral mechanisms.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	5	☐
Number of individuals who received counseling and testing for HIV and received their test results	12,000	☐
Number of individuals trained in counseling and testing according to national or international standards	160	☐

Target Populations:

Adults
HIV/AIDS-affected families
Infants
People living with HIV/AIDS
Pregnant women
Children and youth (non-OVC)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Widows/widowers

Coverage Areas

Mbeya

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: PharmAccess
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 3394
Planned Funds:
Activity Narrative: This activity also relates to activities in other prevention (PharmAccess) and treatment (PharmAccess).

The Tanzanian Peoples Defense Forces (TPDF) has a network of eight military hospitals throughout the country, supporting a total of over 30,000 enlisted personnel and an estimated 90,000 dependents. The services at these hospitals are not limited to the military or their dependents with 80% of their patient load attributable to the civilian populations surrounding the facilities who otherwise might not have access to the services provided.

The TPDF and PharmAccess, a large not-for-profit organization based out of the Netherlands, have developed a strong working relationship over the past four years in the area of health service provision. PharmAccess is experienced in providing management services, products and technical assistance supporting HIV/AIDS care and treatment in resource poor settings in collaboration with governments, donor organizations, NGOs, and corporations through out Africa. The US Department of Defense has offered direct technical assistance and has acted as the primary partner in supporting TPDF and PharmAccess.

Seven military hospitals (Mbeya, Mwanza, Morogoro, Arusha, Tabora, Ruvuma and Zanzibar) geographically spread throughout Tanzania, already provide counseling and testing (C&T) services initiated with FY05 support. Under FY06 EP funding, PharmAccess and the Tanzanian Peoples Defense Forces (TPDF) will improve upon existing C&T services while moving towards provider initiated C&T. Provider initiated C&T is already being implemented as part of PMTCT and TB services at the military referral hospital in Dar es Salaam, Lugalo Hospital, and has resulted in a 95% uptake of C&T. Facilities that have been selected will also receive support in FY06 for TB/HIV and/or ART services and a direct link between Emergency Plan supported prevention programs will be formed.

In addition to the services at the seven established regional military hospitals, VCT will be introduced to reach high risk groups outside clinical settings. This includes the 14 training camps of the National Services. This service is under the TPDF and includes individuals ranging from 18 to 22 years of age who enlist for a two-year, pre-service training. These young adults are removed from family and other support mechanisms, putting them at greater risk of infection. In addition, not all military camps have access to hospital facilities where C&T will be offered. Given the widespread scattering of military personnel countrywide, an additional two mobile VCT centers will pilot VCT services at 16 border and special detachment camps. The prevalence rate in these camps is estimated at no less than 10-12%; based on military data from the area. HIV-infected patients from the camps and from the surrounding civilian communities accessing these services will be referred to the nearest military, district or regional hospital as necessary for follow-up. The higher cost of services in FY06 is due to the need to procure the mobile testing vehicles and establish 14 new VCT sites that will operate within the National Service camps, while also expanding the number of trained counselors. It is anticipated the overall cost per client will decrease dramatically in out years.

Funding for FY06 will support training of a total of 69 nurse-counselors, three from each hospital, training camp and mobile centers. Additionally, funding will allow for procurement of the mobile centers, HIV and renovation of counseling rooms and storage facilities at the dispensaries in the training camps. The C&T centers at the eight military hospitals have already been renovated with FY04 and FY05 funding. Provision of condoms at TPDF C&T centers through linkages with other USG funded

partners under prevention will complement these C&T services.

HIV/AIDS prevention and awareness campaigns and the options of testing will not only be available for service members but also at civilians in the communities surrounding camp sites who, otherwise, would have no access to these services. Through these efforts, it is expected that approximately 15,000 individuals will be tested by September 2007.

The TPDF and PharmAccess, have developed a strong working relationship over the past four years in the area of health service provision. Expansion of VCT activities in FY06 will ensure a close linkage of military implementation to national strategies and programs. Funding for the TPDF through PharmAccess will provide much needed technical support, management assistance and M&E for all TPDF activities in this COP. The military referral hospital in Dar es Salaam, Lugalo Hospital, will serve as the coordinating body for services and over see quality assurance following national standards. Additional support for military facilities in Mbeya and Ruvuma will be provided by the US Department of Defense field office overseeing civilian based activities in these regions.

Most CT will be facility based (about 1,500 per site with 7 sites). The VCT being put in place out side of hospitals/facilities will be a new service and it will take time to develop demand for such services. It is estimated that they will be able to test approximately 5,000 individuals through the stand alone and mobile VCT units in the first year but it is anticipated that this will increase significantly in the out years. Mandatory testing for entry into the Tanzania Peoples Defense Forces (TPDF) is not included in this entry as TPDF funds this activity through its own annual budget. Discussions are ongoing regarding the development of more solid referral mechanisms for HIV positives identified through the mandatory testing to nearby public health facilities but these discussions have just begun and elements of such an activity are not included in this entry.

There will not be any duplication of activities associated with Crown Agents as the test kits will actually be procured through other mechanisms and supported through part of their Global Fund award.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	51 - 100
Logistics	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing counseling and testing according to national or international standards	23	☐
Number of individuals who received counseling and testing for HIV and received their test results	15,000	☐
Number of individuals trained in counseling and testing according to national or international standards	69	☐

Target Populations:

Adults

Military personnel (Parent: Most at risk populations)

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Rukwa Regional Medical Office
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	3397
Planned Funds:	
Activity Narrative:	This activity also relates to activities in treatment (Rukwa).

The Rukwa Regional Medical Office (MRMO) and its Regional AIDS Control Programme will be scaling up existing counseling and testing (C&T) services in FY06. Currently, C&T is provided mainly through VCT centers in the region and are supported by the African Medical and Research Foundation (AMREF). AMREF sites have provided much needed interventions in Rukwa but additional C&T services are needed, especially services located in public health facilities. The limited number of health facilities providing C&T has serious implications in the number of HIV positive and treatment ready patients that can be identified and linked with care and treatment services as they are expanded in the region.

The Rukwa Regional Medical Office will introduce counseling and testing services at the regional hospital, one health center and two nearby TB clinics beginning at the regional hospital in accordance with the network model with the other facilities brought on through out the course of the year. It is anticipated that these services will reach at least 3,000 individuals, but due to the delayed receipt of FY05 funds, the implementation is just now being initiated. Even as they begin introduction of VCT at these facilities, there is a concern that without integration of C&T as part of routine care, potential treatment ready populations will not be reached.

As in the Mbeya Region, in FY06 the Rukwa Regional Medical Office will focus on integrating provider initiated C&T through out clinical services and strengthening referrals within hospitals and from standalone services such as the AMREF sites to the HIV Care and Treatment Centers (CTC). The Rukwa Regional Medical Office will work towards this goal as a necessary component for identifying HIV infected individuals in the in patient wards and out patient clinics at the regional hospital in which ART has initiated and at the Nkasi District Hospital which will begin offering ART with support from FY06 funding. Over the course of the year, a successful model of this integration will be introduced to the other four district, mission and designated district hospitals in the region slated to begin ART in FY06 and FY07. Activities will also support continued strengthening of C&T in regional TB clinics started in FY05 and the referral systems being established.

In order to reach the estimated FY06 targets for care and treatment in the region, at least 9,000 individuals will need to be counseled and tested by September 2007 as part of provider initiated services in the hospitals and associated TB clinics (85% contribution) as well as VCT services established in FY05 (15% contribution). To reach this goal, funds will support the training of 20 additional staff (four at each facility) in counseling and testing; conducting annual refresher training for the current 15 qualified staff in the region; procurement of reagents for confirmatory diagnostics; undertaking minor renovations in out patient clinics and in patient wards to provide space for confidential counseling; and strengthening of referral mechanisms both within the facilities and from external VCT services. Workshops to educate personnel in the various wards at these facilities in identification of patients who may be HIV positive and the services available at the CTC will be undertaken with technical support from the Mbeya Referral Hospital. Community mobilization will be undertaken as part of the hospital outreach program promoting integrated C&T and will be linked to ART education programs initiated as part of treatment in FY05.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	5	☐
Number of individuals who received counseling and testing for HIV and received their test results	9,000	☐
Number of individuals trained in counseling and testing according to national or international standards	35	☐

Target Populations:

Adults

Orphans and vulnerable children

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Coverage Areas

Rukwa

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ruvuma Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 3401
Planned Funds:
Activity Narrative: This activity also relates to activities in treatment (Ruvuma).

In FY05, Emergency Plan funds will support the Ruvuma Regional Medical Office in scaling up VCT services through out the region. In Ruvuma, though there are some mission based and free standing VCT clinics, counseling and testing (C&T) services are lacking at the regional hospital and most public health facilities. National expansion of such activities to the public health sector has not reached this region. This not only has implications in supporting the development of personal prevention programs through knowledge of one's serostatus but more importantly, indicates a gap in treatment provision for identifying HIV positive individuals at these facilities.

Activities in FY05 in Ruvuma will be used in the introduction of VCT services at the regional hospital, a nearby health center and five TB clinics, one per district, targeting 3,000 individuals. Through the Ruvuma Regional Medical Office and its Regional AIDS Control Programme, modifications to clinic structures at the regional hospital and the health center will be undertaken. A total of 20 counselors will be trained to provide services at the seven facilities. Ten peer counselors will be trained to assist in community mobilization campaigns in surrounding communities using existing community networks at the ward level to ensure up take of services. This program is just being implemented, due to the late arrival of FY05 funds. As in Rukwa, there is concern that without the integration of counseling and testing as part of routine care, potential treatment ready populations will be overlooked.

As part of a concerted effort in the Southern Highlands, FY06 activities by the Ruvuma Regional Medical Office will focus on strengthening integration of provider initiated C&T and referrals within two hospitals being supported under the treatment section (the Ruvuma Regional and Tunduru District Hospitals). The Regional Medical Office will also strengthen referrals from standalone services to the HIV Care and Treatment Centers (CTC) at the two treatment sites. Achieving this goal is a necessary component for identifying HIV infected individuals in the in patient wards and out patient clinics at the regional hospital, which was initiated ART in June 2005. As the regions in the Southern Highlands work together to address this challenge, successful models and the sharing of lessons learned will called upon to introduced this type of C&T to the other seven district, mission and designated district hospitals in Ruvuma, slated to begin ART in FY06 and FY07. Activities will also support the continued strengthening of counseling and testing in regional TB clinics started in FY05 and the referral systems being established.

In order to reach the estimated FY06 targets for care and treatment in the region, at least 9,000 individuals will need to be counseled and tested by September 2007. It is anticipated that with the rapid expansion plan developed by the Ruvuma Regional Medical Office and commencing under FH05 funding, they should be able to reach 10,000 by September 2007. To reach this ambitious goal, funds will support the training of 32 additional staff (four at each facility) in counseling and testing; conducting annual refresher training for the current 20 qualified staff in the region; procurement of reagents for diagnostic testing; undertaking minor renovations in out patient clinics and in patient wards to provide space for confidential counseling; and strengthening of referral mechanisms both within the facilities and from external VCT services.

Workshops to educate personnel in the various wards at these facilities in identification of patients who may be HIV positive and the services available at the CTC will be undertaken with technical support from the Mbeya Referral Hospital. Community mobilization will be undertaken as part of the hospital outreach program

promoting integrated counseling and testing and will be linked to ART education programs initiated as part of treatment in FY05. These community campaigns will include the participation of HBC providers, drama group artists, church and mosque leaders, representatives for NGO's dealing with HIV/AIDS, traditional birthing attendants/Herbalists and PLWHA open with their status, all of whom will be taking part in education on community sensitization on counseling and testing in FY05.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	8	☐
Number of individuals who received counseling and testing for HIV and received their test results	10,000	☐
Number of individuals trained in counseling and testing according to national or international standards	52	☐

Target Populations:

Adults

Orphans and vulnerable children

People living with HIV/AIDS

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Coverage Areas

Ruvuma

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	USAID
Prime Partner:	African Medical and Research Foundation
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	3431
Planned Funds:	
Activity Narrative:	*This activity links to activities under counseling and testing (MOH) and USG palliative* care and treatment programs.

The African Medical and Research Foundation (AMREF) VCT program (also called ANGAZA) will continue to provide services through its existing static and mobile sites as well as expand to additional locations in FY06. The AMREF program compliments the Ministry Of Health's (MOH) VCT strategy and the location of MOH sites. The AMREF program has been instrumental in moving closer to the MOH's target of having "at least 2 stand alone VCT sites for every district, covering a population of about 200,000 people in each district". Meeting this goal will be critical if the MOH is to meet the national target of putting 100,000 people on ART by the year 2006.

The existing 41 static and 5 mobile VCT services will continue to be supported in the provision of traditional VCT services. Sites will receive grants for service provision, the procurement of test kits, equipment, supplies, as well support through refresher training and community mobilization. The target is to have 211,600 individuals who will voluntarily receive counseling, testing and results through the existing sites.

In FY06 AMREF plans to scale up and increase access to C&T using several strategies:
(1) AMREF will identify and provide grants to 20 new sites integrated within health facilities to provide quality counseling, and testing services to reach approximately new 61,500 individuals. The regions that will have the new sites include Dar es Salaam, Mbeya, Mtwara, Lindi, Dodoma, Songea, Rukwa, Dodoma, Singida, Manyara, Kigoma, Musoma. AMREF will pick-up the support of four VCT sites in Zanzibar as the AFRICARE agreement comes to an end in March 2006.
(2) AMREF will scale up C&T through ensuring that in its current 22 integrated sites, and the new 20 sites. The new sites will implement patient initiated C&T, should it be approved in the national guidelines. AMREF will work with the MOH and other partners to push for making C&T a routine service in all clinical settings. AMREF has estimated that it could reach an additional 48,000 clients accessing counseling if provider initiated testing were made possible.
(3) AMREF will increase access to rural, underserved or high risk populations such as fishermen, miners, people frequenting border post areas, taxi and bus stands, and plantation workers through mobile C&T services. AMREF will procure and refurbish three fully equipped mobile clinics in order to reach these underserved populations. These mobile clinics will operate and be linked to static health facilities and counseling centers within the locality so that supportive back-up services are available. The vehicles will also be equipped with audiovisual equipment that will be used to draw attention and create a greater demand for services. Existing VCT and C&T materials that have already been develop by AMREF and other partners will be used. Using its mobile clinics, AMREF estimates that it will reach another 21,100 clients.
(4) AMREF will introduce and pilot home based C&T. Households for home based tests may be identified through an index of positive, client identified (at stationary or mobile clinics or post-test clubs).
(5) AMREF will also focus on couples C&T. The program plans to promote and advocate couples counseling in churches, mosques and other religious settings and will advocate for premarital and in-marriage C&T. AMREF will explore the introduction of special clinic day/hours for couples counseling.
(6) AMREF will develop and pilot a "lay counselors" program that will allow PLWHA and other non-clinicians to counsel individuals under the supervision of professional counselors. The lay counselors will provide general HIV/AIDS information, will discuss treatment adherence and will be versed in behavior change communication.

Through all these six approaches, AMREF estimates that it will be able to serve a

total of 342,200 individuals (i.e. counseled, tested and received results) in FY06.

AMREF will continue to promote same day testing using simple and rapid HIV testing kits that are relatively easy to administer. AMREF will also continue to bolster the quality assurance mechanisms that are built into its C&T sites. AMREF will also work with the MOH and partners to strengthen, document and monitor linkages in services for clients found to be HIV positive in AMREF and other sites. AMREF will assist in the development and modification of the tool for such documentation, and ensure that the tool is used by facilities. These forms will assist in tracking clients who avail (or fail to avail) services and will be instrumental in ensuring patient follow up. It is estimated that an estimated 23,000 PLWHAs will benefit from this monitored referral. These PLWHA will be enrolled in AMREF's Posttest Club (PTC). Currently, AMREF has 16 PTCs that are providing psychosocial support, legal support, peer counseling, and family planning options for positives and referrals to clinical services.

In the 20 new sites and the 3 new mobile teams AMREF will build the capacity of 210 selected service providers through training. Additionally, all the existing counselors will receive refresher training and AMREF will build the supportive supervision skills of its supervisors. Finally, AMREF will work with the new sub-grantees to ensure that their sites are improved through renovations, their equipment is procured in a timely way, that equipment orders are based on needs, and that quality services are delivered.

In FY 05 AMREF participated in harmonization of MOH/NACP data collection tools. AMREF is looking forward to work with MOH and roll-out these tool through the sites it supports. Monitoring the quality of the counseling service will be done through supportive supervision as well as periodic mystery and client exit surveys. AMREF will work with other partners to carry-out evaluation of the C&T program in FY06.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	84	☐
Number of individuals who received counseling and testing for HIV and received their test results	342,200	☐
Number of individuals trained in counseling and testing according to national or international standards	350	☐

Target Populations:

Adults
Community leaders
Community-based organizations
Disabled populations
Faith-based organizations
Discordant couples (Parent: Most at risk populations)
HIV/AIDS-affected families
International counterpart organizations
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Policy makers (Parent: Host country government workers)
Journalists
Children and youth (non-OVC)
Widows/widowers
Partners/clients of CSW (Parent: Most at risk populations)
Religious leaders
Host country government workers
Public health care workers
Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Kagera

Kigoma

Kilimanjaro

Lindi

Mara

Mbeya

Morogoro

Mwanza

Rukwa

Ruvuma

Shinyanga

Singida

Tabora

Tanga

COAST

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.09: Activities by Funding Mechanism

Mechanism: USAID TBD (former BBC)
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4931
Planned Funds: [redacted]
Activity Narrative: This new TBD will implement a mass media radio campaign that aims to deliver demonstrable improvements in knowledge, attitudes and behaviors relating to HIV/AIDS. Guided by the National Multi-Sectoral Strategic Framework on HIV/AIDS (NMSF) and the National Care and Treatment Plan, activities look to increase the number of Tanzanians seeking treatment, address stigma and discrimination and reduce the number of new HIV infections using entertainment formats to promote acceptance and recall of messages on sexual and reproductive health. The project is designed to run for 3.5 years and consists of a variety of radio formats to broaden its appeal to a large number of Tanzanians, while allowing flexibility to address issues and concerns of specific population groups. The advantage of this type of program is that it can rapidly adapt messages to incorporate issues that emerge in the area of C&T that will have a greater benefit.

Following lessons-learned in Nigeria, Angola, India, and Cambodia, this new TBD will use an approach to large-scale health campaigns that is based on a 'production partnership' model that forges alliances between government ministries and public and private broadcasters to create highly synergistic campaigns that benefit both public health and broadcasting objectives. In exchange for training and capacity building, local broadcasters donate airtime for all of the campaign's outputs. In Tanzania, outputs are delivered in Kiswahili under the guidance of the NACP and TACAIDS.

Radio listening is the most popular media outlet in Tanzania. In a 2002 survey, 81% of respondents claimed to have listened to radio within the past day. It is anticipated that the project will reach at least 10,000,000 Tanzanians (one third of the national population), with important messages regarding comprehensive services across the prevention-to-care continuum. Radio broadcasters that will play an important role in disseminating messages about C&T include: Radio Tanzania Dar es Salaam, Radio Free Africa and Radio One, and RFA. Additional partnerships with radio broadcasters and community radio stations will be forged if research indicates that specific messages are needed in additional catchment areas.

Under FY06 Emergency Plan funding, this new TBD will improve linkages within the prevention to care continuum through the promotion of CT. In the ongoing effort to increase numbers of Tanzanians on treatment, increasing testing numbers is paramount, particularly among MARPS and others who are most likely to be HIV positive and/or treatment eligible. Thus, the goal will be to develop messages specifically oriented at dispelling myths, misconceptions and stigma around CT, as well as increasing the demand for treatment and care services (commensurate with the increase in the availability of these services). Messages will focus on fostering an improved understanding of what CT services are, where they are located, promoting CT as part of routine clinical services, promoting the acceptability and advisability of testing oneself in order to create a direct link between prevention programs, CT and advanced care and treatment. In addition to information on CT, the new TBD will be able to expand upon existing VCT messages as access to mobile VCT services increases.

The USG's support for this TBD in FY06 will be focused on several media formats, targeting different population groups within Tanzania and will include: 1) A variety of radio spots and mini-dramas for segmented audiences will be produced and broadcasted frequently on partner radio stations through donated time. Radio spots of 30-60 seconds and mini-dramas of 60-120 seconds constitute a key component of the campaign as they can be carefully and rapidly targeted to address specific audiences and messages using drama, testimonies, comedy, music and celebrities to

address the pertinent subject.
2) A weekly radio drama will deepen the linkages of all messages, enabling modeling of relevant life skills and positive behavior change. The serial drama formula is an excellent vehicle through which to explore the complex issues surrounding human relationships, life skills, societal norms and social environments that all have an impact on HIV epidemics. Through its characters such a drama can show the benefits of adopting certain behaviors and demonstrate that change is possible, increasing the sense of self-efficacy necessary for the adoption and sustaining of new behaviors. A key component to the drama is a follow-up interactive discussion program to be broadcast after each episode; Based on listener letters and input from a studio audience the intent is to explore the issues raised by the drama and to drive home the messaging of each episode.
3) Training of radio broadcasters to increase quality programming.

The flexibility of community-based radio communications will allows this activity to weave in multi-pronged messages into programming. Working together with NACP, TACAIDS, and other Emergency Plan partners to assure messages are appropriate, support policies, and are linked to services, the new TBD will work to strengthen links between local radio broadcasters and GOT thus enabling more effective health campaigning both during a project lifetime and in the future by increasing media skills in the Government sector and by working closely with local broadcasters to enhance their commitment and capacity to produce health programming.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Adults
Business community/private sector
Commercial sex workers (Parent: Most at risk populations)
Community leaders
Community-based organizations
Faith-based organizations
Military personnel (Parent: Most at risk populations)
Mobile populations (Parent: Most at risk populations)
Orphans and vulnerable children
Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Crown Agents
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4933
Planned Funds:
Activity Narrative: This activity links to Counseling and Testing (NACP), Laboratory Infrastructure (MOH-NACP, CDC).

Crown Agents will help contribute to the USG testing goals by purchasing 392 units of HIV tests. Each Capillus and Determine unit contains 100 tests, and there are 192 tests per unit of ELISA tests. Therefore, the amount purchased includes 150,000 Capillaus tests, 74,900 Determine confirmatory tests, and 38,208 ELISA "tie-breakers"

The procurement of test kits through Crown Agents will complement the GOT's procurement efforts. The quantities and specifications for these test kits are detailed in the National Laboratory Operational Plan for HIV/AIDS. Crown Agents will be responsible, in coordination with the NACP and other partners, for following these specifications. Procurement activities will also include ordering, purchase, freight and delivery to Medical Stores Department (MSD). MSD will be responsible for distribution of test kits to the facilities. Crown Agents will be the primary purchaser of test kits until the Supply Chain Management Contract for Emergency Plan is functional.

Other donors that will procure test kits in Tanzania are Japanese International Cooperation Agency (JICA) and AXIOS International.

The availability of test kits has improved, as supplies were previously sporadic. This activity will complement the GOT's purchasing to ensure that test kits are available and availability does not become a bottleneck for reaching HIV positive people.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Logistics	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Adults

Faith-based organizations

Discordant couples (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Children and youth (non-OVC)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

Caregivers (of OVC and PLWHAs)

Public health care workers

Private health care workers

Private Sector

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: International Rescue Committee
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4934
Planned Funds:
Activity Narrative: This activity is related to a PMTCT activity.

Refugees in Tanzania are among the most restricted groups in the African Great Lakes region. They are not allowed to travel beyond 4km from their refugee camp and they rely entirely upon services provided by implementing partners of the United Nations High Commission for Refugees (UNHCR) for their livelihoods. In 2006, the International Rescue Committee (IRC) will provide VCT services to a population of more than 75,000 Burundian refugees and approximately 4,000 local Tanzanians in the Kibondo district. IRC started voluntary counseling and testing (VCT) services more than two years ago with USG funding; however, funding has been insufficient to meet the increased demand for services generated by this successful program.

In 2004, the VCT clinics provided services to 9,533 beneficiaries. Of those tested, 153 were found positive, giving a general HIV prevalence rate of 1.6%. In the first 6 months of 2005, 4,650 beneficiaries accessed VCT services and 75 (1.6%) were found positive for HIV. The numbers of clients accessing VCT services appears to be stabilizing to about 9,500 per year. Regular awareness campaigns and VCT training for community-based health workers and community groups are conducted in the camp blocks. The VCT services are hospital based and at each of the four health facilities there is one VCT clinic on a daily basis being run by an HIV Counselor. There is an HIV counselor who offers VCT to youth daily at all four youth centers and the centers are closely linked to the adjacent health facility. The HIV counselors at the VCT clinics in the health facility and at the youth center provide continued counseling to their clients and offer referral to specified clinics depending on what their needs are.

With additional funds for FY06, IRC will also provide test kits, train additional HIV counselors, and promote community mobilization through a network of post-test clubs. Although VCT services were available at the hospitals as well as at youth centers in all the camps, the access to VCT rapid tests has been a constant challenge to IRC since the inception of the VCT services in the camps. Additional HIV counselors are needed to address the staff turnover, due to the difficult work in remote parts of Tanzania, and to improve their counseling capacity. Vigorous IEC campaigns will be supported to mobilize the beneficiary communities to utilize the available VCT services. IRC will continue using its network of post-test clubs to promote community mobilization and hence utilization of the VCT services. Post-test clubs are actively involved in sensitization/awareness raising campaigns about HIV-related issues and they provide counseling and psychological support to fellow HIV-positive members of their communities. Eight VCT sites will be maintained by IRC along with four PMTCT sites.

IRC has provided services to refugees in Tanzania since 1996 and the USG has partnered with UNHCR to fund IRC to provide clinical services in Kibondo for more than three years. IRC is UNHCR's main implementing partner for health and sexual and gender-based violence (SGBV) programs in Kibondo. Currently IRC is operating three hospitals and four health outposts offering a complete spectrum of curative, reproductive, and preventative health services. An average of 500 outpatient clients are served on a daily basis. The USG will continue funding IRC's activities, which also provide several wrap-around programs that enhance the effectiveness of the VCT program. These include behavior change communication through mass media and increasing access to condoms.

Burundi is the country of origin for the majority of the refugee population in Kibondo. With the completion of the recent successful elections and government transition,

refugees have started to return. There are presently more than 220,000 Burundian refugees in Tanzania. Since there is a complete lack of infrastructure in Burundi, refugees will likely continue to be hosted in Tanzania for at least the next two years. There are almost no HIV/AIDS services currently being provided in Burundi, so providing these services in Tanzania will have a positive multiplier effect as refugees return to their country of origin with knowledge of prevention practices and HIV status.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	8	☐
Number of individuals who received counseling and testing for HIV and received their test results	10,000	☐
Number of individuals trained in counseling and testing according to national or international standards	12	☐

Target Populations:

Refugees/Internally displaced persons (Parent: Mobile populations)

Children and youth (non-OVC)

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Kibondo

Kigoma

Funding Mechanism

Mechanism: N/A
Prime Partner: Kilombero Community Trust
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4936
Planned Funds:
Activity Narrative: This activity is linked to Palliative Care, HIV Treatment, and Other Prevention.

The Mobile Health Clinic program to be run by the Kilombero Community Trust (KCT) seeks to bring HIV/AIDS education, testing, counseling, and referral services to rural populations throughout the Kilombero Valley of Tanzania. Infection rates in the area are particularly high, in part due to a lack of education on HIV, and are exacerbated by the yearly influx of thousands of migratory workers to the Valley's now vibrant sugar cane industry. The Mobile Health Clinic program will provide VCT services free of charge and strives toward sustainable provision of these services. The Kilombero plan recognizes that the only way it will be possible to provide a reliable long-term program for HIV/ AIDS in the region is to offer complementary primary health-care services on a user-pays system, which would provide the necessary income for a complementary rural HIV/AIDS program.

Many families at Kilombero have experienced growing incomes in recent years. Since privatization of the sugarcane industry in 1998, it is estimated that incomes have more than tripled in the region, attracting larger numbers of farmers who seek secure markets for cash crop production. During 2003/4, the KCT and Outgrower leadership identified that the growing rate of HIV infection was not being adequately addressed by existing capacity in regional facilities. Further research demonstrated that health service and education facilities had not developed to meet the growing demands of this recently expanded population that remained geographically out of reach. With increasingly secure livelihoods, the outlying communities and their leaders have indicated that they are able to pay for accessible and reliable health services. Due to the remote location of these fairly dispersed agricultural communities, mobile health units were determined to be the most efficient platform for providing care. To address local demands, two traveling clinics, operated on a user-pays system will serve these communities. By charging fees for select, non-HIV services, (as well as by generating advertising and other sponsorship revenue), the clinics will be able to overcome existing health service infrastructural deficiencies, bringing desperately needed HIV/AIDS counseling and testing, education, care and treatment to villagers throughout the year.

This project is a public-private enterprise between the Kilombero Community Trust (KCT), Managed Mobile Health Clinics (MMHC), and a national HIV/AIDS NGO, SHDEPHA+. KCT has supported the development of the communities in Kilombero since 2002 and receives significant in-kind support from agricultural companies and its Kilombero Community Trust Farm – a 1,200 hectare farm where all profits are designated for the Trust's community development projects. MMHC provides managerial expertise and also shares the expertise that they have developed through other mobile health clinic programs throughout Sub-Saharan Africa. SHDEPHA+ Network is an acronym for Service Health & Development for People Living Positively with HIV/AIDS (PLHAs) and is has been operating since 1994 and is one of the oldest HIV/AIDS organizations in Tanzania.

Thirty-one villages in the Morogoro region in Tanzania's Kilombero valley will benefit from the two mobile health clinics. Initially, the mobile healthcare units will provide the following HIVservices in conjunction with fee-for-service primary care: HIV/AIDS education and information services; rapid testing and counseling, and primary level treatment of HIV/AIDS opportunistic diseases. Nearly 100 patients will be reached with health services per day by each mobile clinic with an additional 200 community members exposed to informational media. An estimated 10,0000 people will be counseled and tested by the units.

In terms of referrals, the mobile clinics will be operated on a "Hub and Spoke System," where "Hubs" are existing permanent public or private clinics. The program will refer patients from the mobile units to the facility situated at the mobile program's hub, and onwards to the District/Regional hospital when necessary, thereby linking additional HIV positive people to the continuum of care.

In addition to USG support and user fees further support will be provided through in-kind corporate donations including medicines, supplies, fuel and logistical assistance.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	2	☐
Number of individuals who received counseling and testing for HIV and received their test results	10,000	☐
Number of individuals trained in counseling and testing according to national or international standards	100	☐

Target Populations:

Adults

Family planning clients

Infants

Pregnant women

Children and youth (non-OVC)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kilombero

Kilosa

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Macro International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4938
Planned Funds:
Activity Narrative: *This activity is a targeted evaluation linked to Strategic Information, Palliative Care* and HIV Treatment activities.

According to the 2005 HIV/AIDS Indicator Survey (THIS), 8% of couples tested for HIV were found to be discordant. The THIS states that "the vast majority of these cohabitating couples do not mutually know their HIV status", confirming anecdotal experiences on the ground. The goal of this targeted evaluation is to assist in the development of interventions that will increase the likelihood of self-disclosure of HIV status and reduce the negative impacts, perceived or real, related to disclosure. To meet this goal the evaluation will ask the question "what are the social and personal factors that either promote or hinder an individual's decision to disclose their HIV status to their partner(s)"?

The evaluation will employ qualitative methods with clients who have been tested in clinical (i.e. those that are providing CT as part of other services such as ANC and TB) as well as VCT sites. In the VCT setting, clients will be asked, pre-test, if they had considered implications of a positive test result vis-à-vis partner notification and strategies they think they might employ to disclose their status. Interviewees identified through clinical settings will not be interviewed pre-test as they will not have entered the service for the purpose of getting tested for HIV and have, presumably, not considered this issue. Both types of clients will then be followed-up to document actual disclosure decisions and behaviors as well as barriers and facilitators related to disclosure. It is anticipated that barriers might include fear of stigma and discrimination as manifested through property dispossession, familial separation, and social isolation; fear of being blamed for bringing HIV into a relationship and possible violence and retribution; being faced with difficult decisions regarding childbearing; and perceptions that telling a partner that they might be HIV infected could hasten illness or death. All of the barriers to disclosure mentioned above have been documented in other settings but have not been validated in the Tanzanian context. Validation and/or identification of other possible concerns is critical for the development of effective counseling and community support interventions. Understanding factors that facilitate disclosure is also critical for the development of action oriented interventions. Findings will be validated through focus groups and individual interviews with members of PLHA organizations.

Outputs of the evaluation, which will be completed within FY 06, will include documentation of: barriers and facilitators of disclosure for adult men and women; manifestations of stigma and discrimination in the Tanzanian context; societal, communal, and familial contexts that support the seeking of voluntary testing services; and the role that counselors and providers can play in preparing a client to self-disclose. Findings will be disseminated through national stakeholder events as well as during USG program review meetings.

The timing for this evaluation is ideal because the Ministry of Health, through intensive support from the USG, will be considering the development and implementation of integrated CT across clinical services. The findings of the study will inform the content of new protocols and guidelines and play a key role in developing effective counselor training materials. The result will be counseling techniques targeted towards Tanzania specific barriers to disclosure and overall improvement of provider-patient communication. Counselors and providers will be more effective in preparing and assisting clients to voluntarily disclosure and will also be able to introduce clients to the concept of shared confidentiality.

Evaluation findings will be utilized by all USG partners that are developing mass media,

and print materials and by partners that are working within communities to address stigma and discrimination. Community engagement efforts will help identify specific actions that can be undertaken by leaders or key community members to create an environment where people feel free to disclose their status. The findings will also feed into activities that are designed to create dispel myths about C&T and ART.

Emphasis Areas	% Of Effort
Information, Education and Communication	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Strategic Information (M&E, IT, Reporting)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

Adults
Business community/private sector
Brothel owners
Community leaders
Most at risk populations
Program managers
Volunteers
Religious leaders
Host country government workers
Public health care workers
Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National AIDS Control Program Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4941
Planned Funds:
Activity Narrative: This activity also relates to activities in Counseling and Testing (NACP, MHIC), TB/HIV (MOH), PMTCT (MOH), CDC TDY/TA, AMREF – ANGAZA, and CT activities at MRH, MRMO, Rukwa) and palliative care (Pathfinder International, Care Tumaini, Kihumbe, HJFMRI)

The National AIDS Control Program (NACP) has the responsibility of coordinating the national health sector response to HIV/AIDS. The national VCT program was initiated in 1989. Currently there are over 521 VCT sites in the country, of which 113 operate with direct support from USG. During 2004 more than 365,000 clients were reported by NACP to have attended VCT services in the existing sites. NACP through its Counseling and Social Support Unit (CSSU) coordinates the national CT program through development of policies and guidelines, national training protocols and manuals; standard operating procedures and job aides; provides supervision and technical guidance to the implementing partners; strengthen the training of counselors to secure the required quantity and quality of services; monitors the progress of implementation of CT activities through reports from district councils, NGOs, and other stakeholders.

USG FY06 plans include continuing to support the national coordination function and national expansion plan to increase access to quality CT services in public health facilities. The funds will strengthen the Counseling and Social Support Unit (CSSU) at NACP to carry out their coordinating roles and support the training of at least 80 health workers to ensure a minimum quality standard for the services, promote the availability of routinely offered CT services, printing and disseminating revised CT guidelines and information, education and communication materials on CT services. The activities will focus on two broad areas; provision of quality Voluntary Counseling and Testing (VCT) services while promoting other Counseling and Testing (CT) approaches. This funding will support 25 new sites within ten new regions and maintain the existing activities in 16 regions.

To harmonize and standardize CT training USG will support the MOH/NACP in its efforts to institutionalize CT training in four zonal training centers including Muhimbili Health Information Centre (MHIC). In FY06 USG will assist the NACP to develop national CT quality assurance systems including accreditation of CT facilities, strengthening of Regional and Council Health Management Teams to manage and supervise the implementation of quality CT services at regional and council level. NACP will strengthen the referrals and linkages to care; treatment and prevention activities in USG supported sites. In addition, USG will assist the NACP and its key partners to strengthen and improve logistics systems for the rollout of CT services. In order to ensure continued supplies and commodities for services

The second component of this activity aims at promoting Diagnostic Counseling and Testing (DCT) in health facilities. In the USG 5-year strategy for the Emergency plan in Tanzania, CT is identified as a key entry point in the continuum of care for HIV/AIDS. To date, the CT strategy involves the VCT model that is more suitable for HIV prevention but may not be the most effective approach for Care and Treatment. The USG strategy is to introduce the provider-initiated diagnostic counseling and testing model to respond to the increased demands of the national care and treatment program. It is envisaged that by increasing the coverage of CT services in clinics providing TB, STI and PMTCT services, people living with HIV/AIDS (PLWHA) requiring care and treatment will be identified and be referred to ART services. Increased availability of services and stigma reduction will create an increased demand for CT services.

Currently, the Ministry of Health (MOH)/National AIDS Control Program (NACP) is reviewing the counseling and testing guidelines to put greater emphasis on provider initiated counseling including DCT, couples counseling, and community - based counseling. The development and finalization of the CT policies, technical guidelines, protocols and manuals will enable health care providers (HCPs), and community lay counselors enhance their ability to provide quality CT services. These new proposed approaches to CT would provide support to enhance disclosure of HIV status and promote other preventive interventions. Discussions on the roll out of there CT models are currently ongoing between the MOH and key CT stakeholders. The USG is supporting the MOH process in making rapid CT roll out in public health facilities in the country and introduce provider-initiated CT starting with DCT in IPD, OPD, TB, and STI clinics. This will be coupled with training programs for counselors. In an effort to operationalize CT, a pilot project in 3 sites will assist the CSSU at NACP to assess and review its structure and functions in order to provide adequate capacity for managing and coordination of the CT activities in the country. NACP will collaborate with partners to conduct needs assessment, site selection, personal training, and setting up of the CT services in the health facilities and assessment of the performance of the pilot. Currently, DCT is piloted in the three districts of Temeke, Iringa and Korogwe. A total of 34 TB health care providers have been trained and they are providing DCT in these piloted districts.

With technical assistance from the USG, the NACP will conduct Monitoring and Evaluation of the CT activities, through conducting supportive supervision, strengthening of monitoring and reporting. Through these efforts, it is expected that approximately 100,000 individuals at these Emergency Plan (EP) supported sites will be counseled and tested by September 2007.

Emphasis Areas	% Of Effort
Training	10 - 50
Community Mobilization/Participation	10 - 50
Infrastructure	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	25	☐
Number of individuals who received counseling and testing for HIV and received their test results	100,000	☐
Number of individuals trained in counseling and testing according to national or international standards	80	☐

Target Populations:

Adults

Faith-based organizations

Discordant couples (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Children and youth (non-OVC)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

Caregivers (of OVC and PLWHAs)

Public health care workers

Private health care workers

Private Sector

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Mwanza

Kagera

Kigoma

Mara

Mbeya

Rukwa

Ruvuma

Shinyanga

Singida

Tanga

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 4944
Planned Funds:
Activity Narrative: This activity also relates to the roll out of the care and treatment activities (MNH/MHIC, MOH/ NACP, AMREF – ANGAZA, MRH, MRMO, Rukwa, KIHUMBE, HJFMRI)

In the roll out of the care and treatment program in the country due to the fact that as access to antiretroviral treatment is scaled up in the regions there is a critical opportunity to simultaneously expand access to HIV testing. In rapidly scaling up other CT approaches the Ministry of Health (MoH) through the National AIDS Control Program (NACP) will require technical assistance in the program area of CT. The TA will be provided on quarterly basis to the MoH. As the primary model for HIV testing has been and still is the provision of client initiated voluntary counseling and testing services for the past 10 years. Provider initiated approaches are being initiated without validation in different parts of the country. Health workers routinely initiate an offer of HIV testing in a context in which provision of, or referral to, effective prevention, care and treatment services is not assured.

Activities that will be proposed for the TA include: meeting with partners dealing with CT activities (MOH/NACP, TACAIDS, Muhimbili, AMREF, PASADA and CCBRT) and discussing areas that can be supported by the technical assistance team. Discussions on the strategies to implement the WHO/UNAIDS HIV testing and counseling policy will be conducted in this meeting. Another working group meeting will be organized with USG agencies supporting MoH and other partners in the area of CT.

In assessing the different implications of adopting other CT models the team will visit a variety of CT sites that are being managed by different partners (AXIOS – Morogoro, GTZ – Mbeya, AMREF – Dar es salaam). The team will also visit sites operated by other NGOs and FBOs. More time will be spent in clarifying issues of quality assurance and other logistical issues of test kits supplies with NACP management and other key partners. Laboratory strengthening component will be included in quality assurance issues. At the end of the site visits the team will provide relevant feed back to stakeholders and discuss the recommendations set forward.

The team will review the National VCT guidelines and training manuals. HIV testing protocols/ algorithms will be reviewed in collaboration with the MoH diagnostic sections and Muhimbili HIV/AIDS Reference Laboratory.

This TA will assess and determine the strategies for scaling up other CT approaches in health facilities (stand alone, diagnostic counseling and testing, routine offer). This activity will involve the technical working group of the NACP and USG CT team. The TA team will consider the following key factors from WHO/UNAIDS guidelines which are mutually reinforcing and should be addressed simultaneously: clinical and prevention benefits of testing; the right to refuse; follow up services that will offered and assurance of linkages to other care and support services; ensuring an ethical process for conducting testing; reducing HIV/AIDS related stigma at all levels – notably within the health care settings; ensuring a supportive legal and policy framework is in place prior to scaling up CT services.

Through the proposed activities the TA team will consist of three experts in CT from CDC who will conduct 4 visits to Tanzania. The team will conduct site visits to six regions being supported by the USG, conduct a needs assessment and review the care and treatment program. The final component of this activity is a link to activity xx in this program area.

Emphasis Areas	% Of Effort
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results		☑
Number of individuals trained in counseling and testing according to national or international standards		☑

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Volunteers

Stigma and discrimination

Coverage Areas

Dar es Salaam

Iringa

Kilimanjaro

Mbeya

Morogoro

Mwanza

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Counseling and Testing Pilot
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 5557
Planned Funds:
Activity Narrative: This activity also relates to activities in treatment (MoH/NACP), TB/HIV (MoH/NTLP) and CT (MoH/ NACP, MRH, MRMO, Rukwa) and MNH/MHIC) and palliative care (KIHUMBE, HJFMRI, Pathfinder, Care Tumaini).

The TBD partner in collaboration with NACP will conduct a pilot project that will be designed to increase the capacity of the public health facilities to provide other Counseling and testing approaches, including diagnostic counseling and testing in specialized clinics (TB, STIs, IPD, OPD). Since, the start of the National Care and Treatment Program (NCTP) in 2004, the demand for CT services has increased dramatically in all public health facilities that are providing CT services. In order to reach treatment targets that have been set by the NCTP and Emergency plan approximately 85% of those tested in FY 06 will need to be identified in high prevalence environments like medical facilities.

Based on the above factors the partner working with NACP will design a pilot program for CT that will help inform policy and decision makers in the scale up of CT services in the country. The partner will work with the 3 sites staff to design, implement, manage and evaluate effective, appropriate and locally sustainable ways of scaling up CT services. The pilot project will be implemented in 3 district hospitals whereby the diagnostic model will be used for the provision of CT for diagnostic purposes to provide more patients to be enrolled in the treatment program. Activities proposed in these pilot regions include: training of 30 health workers on the DCT approach (each hospital will have 10 participants), provide CT services to an estimated 3000 clients attending OPD, IPD, STIs and TB services in the health facilities. The USG will work with the partner and NACP in the selected district hospitals to address the sustainability of CT services and the need for provider initiated CT services. The result will be a NACP expansion strategy that includes integration of CT into existing TB, STI, IPD, and OPD services at health facilities level and technical assistance and training for district personnel. Funding will go specifically to develop a pilot protocol for DCT with same day results, as well as procurement and distribution of test kits, support supervision, monitoring and evaluation.

The second component of the activity will be to increase the uptake of provider initiated CT services and this will be achieved through IEC activities involving community leaders, policy makers, and educators. The activity will design, develop and pretest IEC messages for the public health facilities. This will be done in collaboration with the IEC/BCC unit at NACP will address uptake of CT services.

The final outcome of this activity will be to inform the policy development process at all levels. The NACP will continue the process and develop a policy framework in place to guide the CT activities in the country.

Emphasis Areas	% Of Effort
Needs Assessment	51 - 100
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	3	☐
Number of individuals who received counseling and testing for HIV and received their test results	3,000	☐
Number of individuals trained in counseling and testing according to national or international standards	30	☐

Target Populations:

Adults

Faith-based organizations

Discordant couples (Parent: Most at risk populations)

Non-governmental organizations/private voluntary organizations

Children and youth (non-OVC)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

Caregivers (of OVC and PLWHAs)

Public health care workers

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Morogoro

Mwanza

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Ministry of Health, Tanzania
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	5568
Planned Funds:	
Activity Narrative:	Health care statistics suggests 50% of patients admitted to medical wards have HIV infection while 70% of patients who have TB are co-infected with HIV. Currently, less than 10% of the health care staff at the national referral hospital and city health care delivery system is trained in counseling and testing. Routine offer of HIV counseling and testing is not provided in inpatients wards or outpatient settings. The only freely available service is in freestanding VCT sites. The integration of counseling and testing services in patient wards, outpatient, TB, STIs clinics and Reproductive Health clinics will greatly expand the number of patients who are ready to start Anti Retroviral Treatment (ART). In order to meet the FY06 EP targets for care and treatment, Muhimbili Health Information Centre (MHIC) will support scaling up of HIV prevention, care and treatment continuum through the training of large number of health care providers in Counseling and Testing (CT) approaches. The focus will be on the provider initiated counseling and testing, diagnostic counseling and testing to respond to the increased demands of national care and treatment program. These models will increase the coverage CT services in clinics providing TB, STIs, and reproductive health clinics, inpatient and outpatient departments, where PLWAs requiring care and treatment will be identified and captured by ART services. MHIC in collaboration with other stakeholders within Muhimbili National Hospital (MNH) will facilitate the integration of counseling and testing services into basic health care delivery in FY05 and FY06 through training in counseling and testing. Activities in FY06 will include training of 50 health workers, 25 from MNH and 25 from City health care facilities, using the expanded training infrastructure that was developed with FY04 funds and development of training program for counselors, trainers of counselors and supervisors of counselors. Also MHIC will provide counseling supervision and support through continuing education and introduction of health care provider-counselor support group activities to avoid burnout. Counseling and testing for 12,000 individuals attending MHIC and 9,000 individuals attending both outpatient departments and admitted to in patient wards will be done over the course of one year. In addition, MHIC will collaborate with NACP and Zonal Training Centres (ZTC) in ensuring the provision of quality CT trainings. In FY 06, taking into account lessons learnt from FY05, MHIC aims to offer training and supervisory support to trainers and supervisors from zonal training centers located at referral hospitals in Tanzania. It is anticipated that these trainees will offer training to other health care providers in their catchment areas. The new set of skills gained will enable health care workers to impart HIV related knowledge that is required to get a large number of people who are HIV infected on treatment.

Emphasis Areas	**% Of Effort**
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results	21,000	☐
Number of individuals trained in counseling and testing according to national or international standards	50	☐

Target Populations:

Adults

Children and youth (non-OVC)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

Caregivers (of OVC and PLWHAs)

Public health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Dar es Salaam

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Bugando Medical Centre
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 5570
Planned Funds:
Activity Narrative: This activity links to Bugando Medical Center activities in PMTCT, ARV services and Laboratory Services.

A program announcement for building the capacity of the referral hospitals to provide a continuum of HIV/AIDS services in the areas of PMTCT, ARV services, counseling and testing and Laboratory was posted in FY05. The notice of grant award has been received for FY05 funding and the recipients of the funds have just been determined. Bugando Medical Center (BMC), located in the Mwanza region, in the Lake Zone, has been awarded 700,000 for scale-up of these services. This activity will begin implementation with FY05 funds in calendar year 2006.

The Lake Zone is comprised of six regions, and is larger than the state of Minnesota. These are Mwanza, Shinyanga, Tabora, Kagera, Kigoma, and Mara. The Lake Zone is the catchment area for BMC, a zonal referral and University teaching hospital with a bed capacity of 850. The mandate of BMC is to provide training, technical support, supportive supervision, preceptorship and outreach to the six regions in the Lake Zone. BMC also oversees MOH programs in the zone and provides technical support for their implementation.

The Lake Zone is a very high HIV-burden area in Tanzania. It has an aggregate population of 13 million which is about a third of the country's population. It borders with Uganda to the north, on the north east is Kenya, northwest is Burundi, and on the west is the Democratic Republic of Congo, all high-burden countries. It has refugees from Burundi, Rwanda and Congo. The first AIDS case was reported in Kagera region in 1983. The HIV prevalence in the Lake Zone ranges from 5% to 19.4%. Extrapolating from national figures, the estimated number of PLWHA in the Lake Zone is over 700,000, and of these, 100,000 require antiretroviral treatment. The grim HIV/AIDS statistics in the Lake Zone justify the need for a zone-wide program to scale-up the continuum of HIV/AIDS prevention, care and treatment through the network model.

The leadership at BMC has determined that current counseling and testing strategies of using voluntary counseling and testing (VCT) methods are not conducive to the rapid roll-out of ART/PMTCT services. BMC has already adopted an opt-out counseling and testing strategy for all patients in the medical, TB and pediatric inpatient wards, delivery rooms, and all medical, TB/STI, pediatric and ANC outpatient clinics, using same-day results rapid tests. These recently awarded FY05 funds will enable BMC to strengthen and expand these services to all hospital wards and clinics. In collaboration with surrounding community organizations, they will introduce family and community-based HIV testing and counseling, making every household with a PLWHA an entry point to HIV/AIDS/TB prevention, care, treatment and support.

Workshops will be conducted for heath care workers to promote opt out counseling and testing in reproductive and child health (RCH) clinics , sickle cell anemia clinics and all inpatient wards. Funding will support the training of more counselors in the use of rapid tests for testing with same day results, and as the demand for testing increases within the hospital, BMC will recruit more counselors.

BMC has determined that universal voluntary knowledge of HIV status should be a prevention goal in a high burden country like Tanzania. Furthermore, counselors are gatekeepers to the entry to HIV prevention, care, treatment and support. Only 5% of the population in Tanzania knows their HIV status. This proactive new strategy of routine counseling and testing should reach more PLWHA who are asymptomatic. These steps are crucial to improve survival and response to antiretroviral treatment.

In addition, high mortality rates associated with ART in late presenters may send negative signals to the community about ARVs and may negatively impact adherence and treatment seeking behavior.

In order for BMC and the surrounding district/mission hospitals to reach the estimated targets for treatment in the region, it will need to reach the 25,000 individuals that will need to be counseled and tested. An estimated 85% of these individuals will be reached by provider initiated services in the facilities (and associated TB clinics), while around 15% of these individuals will be accessed through VCT services.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	25,000	☐
Number of individuals trained in counseling and testing according to national or international standards	75	☐

Target Populations:

Adults

Most at risk populations

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Kagera

Mara

Mwanza

Table 3.3.09: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mnazi Mmoja Referral Hospital
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 5571
Planned Funds: [redacted]
Activity Narrative: This activity links to Mnazi Mmoja entry in PMTCT, ART, Laboratory and Palliative Care

A program announcement for building the capacity of the referral hospitals to provide a continuum of HIV/AIDS services was posted in FY05. The recipients of these funds have been determined, and the notice of grant award has just been received. The Mnazi Mmoja Hospital (MMH) in Zanzibar has been awarded [redacted] for the combined scale-up of services in laboratory, counseling and testing, PMTCT, ART and home-based care in FY05. The funding from FY05 will be used for implementation into FY06.

Zanzibar is made up of the two sister islands of Unguja and Pemba, with a total population of 984,625. HIV/AIDS has been prioritised by the government in Zanzibar since the identification of the first three cases in 1986. MMH is linked to the College of Health Sciences as a teaching hospital as well as serving as a referral hospital for both islands. A notable milestone in their history has been the provision of supportive care and management of opportunistic infections prior to the availability of HAART.

Creating a continuum of care is a multi-faceted and multi-dimensional intervention that requires well orchestrated coordination and harmonization. Therefore in FY06, with FY05 funding, and in partnership with the USG and other partners, particularly the Clinton Foundation, MMH will introduce a continuum of care. MMH will work under the guidance of the Zanzibar AIDS Control Program (ZACP), the coordinator of all HIV health sector interventions as it implements this continuum of care.

The availability of ART and provision of laboratory equipment, through the ongoing support from the USG and other partners, has increased the potential for MMH to be a model for comprehensive ARV service provision. The Ministry of Health and Social Welfare (MOHSW) has identified the MMH as focal point for the expansion of ART services scale-up. To achieve this, the establishment of a strong counseling and testing program is critical.

In its first implementation year, given the country context, the overall goals for this award will be to reduce stigma and create demand for care and treatment services. The specific activities will focus on four areas: 1)establishing a comprehensive counseling and testing (CT) service at MMH, 2)strengthening community home based care interventions, 3)establishing linkages with faith based institutions, civil service organizations and community based organizations and 4) offering ART/PMTCT training and guidance to lower level ART sites.

Currently, there are 21 voluntary counseling centers (VCT) in both Unguja and Pemba. Fourteen of these services are located in Unguja while seven are in Pemba. About 67% (14 out of 21) of these services are governmentally operated. These government operated services are currently being supported by Medicos del Mundo (MDM) through European Union support. In 2004, more than 14000 people accessed VCT services through these centers. MDM support will end in March 2006. Therefore, MOHSW, through ZACP and other partners, shall assist MMH to set up a strong, reliable and integrated counseling and testing service and work with stand alone VCT centers to help expand the availability of these services.
MMH will establish a counseling and testing center within MMH. Their approach will include both routine and voluntary counseling and testing (VCT) services, and be accessible to both in-patients and outpatients. Counselors within this center shall also provide training and direct services within the in-patient wards and outpatient clinics. Family counseling will be a growing part of their strategy. Given the success of

routine counseling in MMH PMTCT clinics, this methodology will be a core element of the program. In PMTCT, nearly 100% uptake of HIV testing was achieved in the first six months of the program. Health care workers in all MMH departments will be trained with an emphasis on post-test counseling. This will ensure appropriate follow up after the test results have been received. It will also strengthen referrals within hospitals and from stand alone services to the HIV Care and Treatment Centers (CTC) where ART has been initiated. MMH will introduce a client satisfaction and quality of service assessment tool, and perform periodic community sensitization to promote the center and encourage service utilization. Youth and other vulnerable and high risk populations will be specifically targeted. To successfully meet the demand for services, infrastructural capacity such as systems for good client flow, patient records, referrals and hiring of qualified personnel will be built. In MMH's role as a referral center, it will serve as an information center, and operate in a mentoring capacity for smaller facilities. To do this, MMH will offer a 24 hour hotline, network with other CT service providers and help build the counseling capacity of both the public and private sector. Guidelines for the provision and management of CT services will be modified or developed, and MMH will serve as a training hub for counselors and other services providers in the region. Funds will also support the recruitment, training and placement of 10 additional staff serving in inpatient wards and out patient clinics in counseling and testing. Also supported will be minor renovations in out patient clinics and in patient wards, which will provide space for confidential counseling and support of referral mechanisms both within the facilities and from external VCT services.

In order for MMH to reach the estimated targets for treatment in the region, it will need to reach the10,000 individuals that will need to be counseled and tested. An estimated 85% of these individuals will be reached by provider initiated services in the facilities (and associated TB clinics), while around 15% of these individuals will be accessed through VCT services. This calculation assumes a prevalence of 1% and a 4% prevalence of HIV within in-patient wards.

For effective implementation of this project, MMH will collaborate with the ZACP VCT unit and other partners who are leading service provision. These include Zanzibar AIDS Commission, WHO, Medicos del Mundo, UNICEF and civil society organisations, particularly the Zanzibar Nursing Association (ZANA) and the Zanzibar ZANGOC. Technical assistance will be sought in the areas of human resource capacity development, establishment of confidential and reliable monitoring systems.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	***Target Value***	***Not Applicable***
Number of service outlets providing counseling and testing according to national or international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results	10,000	☐
Number of individuals trained in counseling and testing according to national or international standards	20	☐

Target Populations:

People living with HIV/AIDS

Public health care workers

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Table 3.3.10: Program Planning Overview

Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10

Total Planned Funding for Program Area: [redacted]

B5

Percent of Total Funding Planned for Drug Procurement: 15

Amount of Funding Planned for Pediatric AIDS: [redacted]

Program Area Context:

Drug procurement has been one of the greatest obstacles facing the USG supported roll out of ART in Tanzania. Additional challenges have included coordination of the four USG centrally funded ART programs and the limitation encountered as a result of the Government of Tanzania's (GOT) policy regarding the use of generic, fixed-dose combinations for first line treatment.

Significant progress was made in FY05 following the signing of a Memorandum of Understanding (MOU) between the USG and the GOT for drug procurement and through a determination that there would be only one procurement mechanism for ARV with USG resources. This decision obviated the need for other USG ART partners to procure drugs, and will allow for a more consolidated response while at the same time freeing up resources for USG partners to expand ART services.

The MOU established the parameters for the procurement by the GOT and USG, including resources which will come to the GOT through the Global Fund through Rounds 3 and 4. Given the increased number of companies and their respective products which have been granted provisional FDA approval, the USG may need to revisit the terms of the MOU in FY06 in order to determine how best to access these newly approved drugs and respect the parameters of the memorandum.

Activities in this program area have been twofold, enhancing the National AIDS Control Programme (NACP) in accurately quantifying their ARV needs and supporting these needs through the procurement of drugs, valued at over [redacted] in FY05, to complete the first and second line treatment regimens. For FY06, activities will continue to support the NACP's efforts to procure and distribute ARV to a rapidly growing number of sites. The NACP plans to expand from 96 initial facilities to an additional 104 sites, for a total of 200 facilities in the next year with an aim to treat 100,000 people by December 2006. *While these goals are certainly ambitious, the USG plans to undertake* procurements to support movement towards this target.

The greatest potential liability to the USG program is the miss-allocation of ARV. Logistical activities supported by the USG in FY06 will be expanded to ensure that drugs procured by all parties arrive at *their final destination, the patient. This will be accomplished through a two-pronged approach* providing both central level and zonal/regional support. Centrally we will continue direct logistics support to the Medical Stores Department with a dedicated advisor and provide technical assistance to the NACP in the quantification of future orders. In the zones and regions, we will institute "SWAT" teams with the dual purpose of: supporting facilities to quantify and order drugs; and to ensure that once procured, these drugs arrive safely at the site where they are properly recorded and stocks are *monitored until prescribed for patients. In addition to these teams, the roll-out of the Integrated* Logistics System beyond its current pilot status will continue. This system, piloted in FY05, will provide a valuable tool for sites to use in quantifying and ordering necessary drugs. We will also continue to build capacity within the faith-based consortia in the Northern regions of the country to complement public efforts. Lastly, the USG will assist the MOH and Tanzania Drug Authority in fast tracking new FDA approved, non-branded drugs onto the national formulary.

In FY06 approximately [redacted] are expected through the Global Fund (Rounds 3 and 4) for the procurement of ARV. The USG has been able to establish a cohesive coordinating mechanism with all its ART funded partners to define needs and determine available resources at sites. We anticipate continued strong collaboration in this regard to assure adequate quantification for all drugs and to directly procure second line, alternative first line and pediatric formulations, with pediatrics making up at least 10% of USG procurements, to complement GOT orders.

Table 3.3.10: Activities by Funding Mechanism

Mechanism: Deliver
Prime Partner: John Snow, Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 3433
Planned Funds:
Activity Narrative: This activity links to all activities under antiretroviral treatment.

Activities in 2005 represented a turning point in the implementation of the Emergency Plan in Tanzania. With the first purchase and receipt of anti-retrovirals (ARVs) purchased with USG funds, the Tanzania program turned the corner into full-scale implementation of the ART strategy.

In 2006 support for logistics will continue through funding of JSI's DELIVER project. Building on the successes in the previous years, the logistics activities will be expanded. Support to the National AIDS Control Program (NACP) will continue for the quantification of all ARVs purchased under the National Care and Treatment Plan (not just those purchased by the USG, but all first and second line drugs).

With the increasing influx of drugs to support the ART program comes a concomitant concern over the safety and security of these commodities from the time they enter the country until they are received by the patient. In order to provide a greater level of security, in 2006, zonal "SWAT" teams will be established, which will create a linkage between the 8 Zonal Medical Stores Departments (MSD) and the clinics. These teams, comprising of two people each (an individual with clinical expertise and an individual with pharmacy expertise) will move within the MSD zone to support facilities to quantify their drug requirements, and ensure that MSD is able to fill these requests. The team will also serve as a way of following the drugs from the zone to the facility. An additional supervisor, based in Dar es Salaam, will serve to link the central MSD warehouse with the 8 zonal stores and thus complete the system from drug entry into the logistics system to exit at the service delivery point. The clinical staffer of the two person team will support staff in the sites to understand the prescription and ordering process for the drugs. The two person team will serve as an end use checker; it will ensure that ARVs are available at the facility and are prescribed properly.

These teams will also serve as an opportunity to link into the activities of the Twinning Center (see ART AIHA activity narrative for more information). The Twinning Center will provide preceptors for ART facilities which do not have a direct USG partner. The preceptor may join the team to provide expert input at the facility level and as on-going supervision for sites which may "graduate" from preceptorship.

In FY 2005, DELIVER piloted an Integrated Logistics System for commodities for PMTCT, ART and home-based care in the Iringa region. Following on from FY 2005 activities, the roll-out of the Integrated Logistics System (ILS) will continue. In 2006, the ILS will expand to two regions which will require training an additional 1,200 people. Following the evaluation of the pilot program, DELIVER will focus on developing the MSD's computerized database to capture facility-level data on usage of drugs and related medical supplies this year in order to ensure a more smooth roll out and utilization of the ILS. As in the pilot, the MOH Zonal Training Centers will be used to implement the roll out. The progressive roll out of the ILS will have profound implications on MSD's data entry requirements, and DELIVER will support MSD through locally-procured IT services, including piloting electronic ordering between districts and MSD zonal stores.

DELIVER will also continue to provide technical assistance to a wide range of development partners including all PEPFAR partners, Global Fund partners, the Development Partners Group, as well as the various divisions of the MOH involved in commodity distribution; NACP, Reproductive Child Health Services, Pharmaceutical

Supply Unit, etc. In addition to support in the development, training and implementation of logistics systems for the various commodity groups and programs (ART, PMTCT, STI drugs, HIV test kits, essential drugs, etc.), DELIVER will attempt to expand their annual quantification and ongoing monitoring to other product groups as well, particularly ARVs and PMTCT-related commodities including HIV test kits.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Infrastructure	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Target Populations:

HIV/AIDS-affected families

People living with HIV/AIDS

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Medical Stores Department
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 3449
Planned Funds:
Activity Narrative: This activity links to all activities under PMTCT, counseling and testing, care and treatment.

Medical Stores Department (MSD) was established by an Act of Parliament in 1993 as a semi-autonomous department within the Ministry of Health (MOH). MSD has been operating upon strict guiding principles laid down in the Act. One principle is that MSD be a "non-profit seeking institution that is financially self-sustaining. However, in order to be financially self-sustaining, the same act requires MSD to run on commercial principles. In compliance, MSD has been financially breaking even since its inception, generating very little profit that is insufficient to meet the rapidly increasing demands of the health sector.

MSD's existing operation capacity has to adjust in response to the new demands of the National AIDS Control Program (NACP). In support of the program, MSD is expected to procure all HIV/AIDS related pharmaceuticals and medical commodities on behalf of the MOH and its donors, store them in its eight stores located in all eight zones of Tanzania, and distribute the drugs through a "pull" system to all MOH health facilities. The efforts involved in supporting the supply chain management of HIV/AIDS related pharmaceuticals and medical commodities are substantial, requiring financial resources that MSD currently does not have. Another USG supported partner, John Snow International (JSI)/ DELIVER, will procure pediatric, second-line and alternative ARV drug formulations. MSD will be responsible for procuring all other HIV/AIDS commodities with stock quantification and maintenance, storage and distribution. JSI/DELIVER has been providing MSD with technical assistance.

New programs for HIV/AIDS drugs and medical supplies will need storage space, which simply does not exist at MSD. Vertical programs, such as the National TB and Leprosy Program (NTLP), Expanded Program on Immunizations (EPI), and NACP, currently represent approximately 35% of MSD's operation volume and are expected to reach 50% in the near future. Existing human resources have been stretched by these expanding programs and MSD does not have sufficient technical capacity to manage this added burden. The current staff in warehouses and sales cannot cope with the operational complexity of HIV/AIDS supply chain management. In this regard, MSD needs external funding support for recruitment, training and further technical assistance, not only in warehouse management and but also in procurement logistics. In addition, MSD does not have sufficient storage facilities to deal with the further roll out of HIV/AIDS programs. The supply of HIV/AIDS related drugs and commodities has to be robust and uninterrupted, with a constant and reliable flow of drugs to PLWHA. Therefore, highly secure logistic arrangements should be in place before expanding distribution efforts.

With USG support, MSD will begin to address some of these challenges. With FY05 funds and continuing into FY06, support to MSD will be directed to three areas: 1) building capacity of existing human resources in procurement and logistics 2) enhancing storage capacity, and 3) augmenting MSD's capacity to distribute HIV/AIDS commodities.

Some specific activities that will be funded include purchasing well-secured modes of transport for drugs; purchasing a GPS radio communication system for safe distribution; building more safety cages, purchasing chiller machines, creating cold rooms, renting a new complex warehouse and acquiring necessary warehouse equipment, allowing for separate, secure and temperature controlled storage facilities for HIV/AIDS commodities. Over the long term, MSD intends to install an internet based HIV/AIDS order processing system. Hospital and health facilities would be able

to order and track their *own orders online*.

USG will work very closely with MSD in FY06 as the success of the ART program relies heavily on the capacity of MSD.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Logistics	51 - 100
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Target Populations:

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas:

National

Table 3.3.10: Activities by Funding Mechanism

Mechanism: RPM+
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 3469
Planned Funds:
Activity Narrative: This activity links to activities in ARV drugs (JSI and MSD) and care and treatment undertaken by mission hospitals and FBOs.

There are two distinct activities that are related to drug procurement: (1) Support to Faith-Based Facilities; and (2) Support for the accreditation of drug dispensing outlets.

Support to Faith-Based Facilities:

Initially, Mission for Essential Medical Supplies (MEMS) was expected to be similar to the Tanzania Medical Stores Department (MSD), in that it would procure, store and distribute pharmaceuticals and other health commodities. It now appears as though this model is not yet ready for full-scale rollout. An assessment of the strengths and weaknesses of the current MEMS model, coupled with technical assistance (TA), will strengthen and build the capacity of MEMS. At the same time, MSH will work with the Christian Social Services Commission (CSSC), the national umbrella for several large churches. MSH will provide TA to a number of hospitals that are operated by CSSC member organizations to strengthen pharmaceutical management.

MSH will work with CSSC, MEMS and other FBOs to coordinate and provide TA in the following areas: Quantification and forecasting training for staff working in referral hospitals; implementing MSH electronic tools for managing the availability and use of drugs; and training staff on the use of other supply management tools. Based on the work initiated with FY05 funding, MSH will support the faith-based hospitals in site preparedness for ART and will improve technical skills of staff (based on the site-specific needs already identified in an assessment).

MSH has developed and designed pharmaceutical training modules in other countries in the region and will use these materials to adapt in service training programs to Tanzania. MSH will work to support adaptation of the pharmaceutical management for ART training materials for the faith-based hospital sector as well as monitor inventory management of ARVs and other health related medicines and supplies. Activities will also establish Standard Operating Procedures (SOPs) and assessing the use of E-tools for dispensing; and promote rational use and adherence strategies.

FY06 support will continue to strengthen the logistics systems. MSH will intensify its activities in the Northern region while expanding elsewhere. At the same time, MSH will continue to monitor the gestation of the MEMS prime vendor model and should it reach a point where greater implementation is possible, additional TA will be provided so that the MEMS model or similar model could be used by additional FBO and public health facilities.

Support to the Tanzanian Drug Authority (TFDA) and drug dispensing outlets:

To improve access to critical medications for OIs in rural and peri-urban areas, MSH will assist the MOH and the TFDA to expand a pilot network of accredited drug dispensing outlets (ADDOs) for providing selected essential medicines and other health supplies. Although the duka la dawa baridis (DLDBs) drug dispensing outlets provide an essential services in nearly every region, evidence has mounted that DLDBs are not operating as had been intended. Prescription drugs that are prohibited for sale by the TFDA are invariably for sale, quality cannot be assured, and the majority of dispensing staff lack basic qualifications, training, and skills. The ADDO program will work with the DLDB's to improve operations and prescribing practices. Major ADDO program elements include accreditation based upon

MOH/TFDA-instituted standards and regulations governing ADDOs; business skills training, pharmaceutical training, education, and supervision; commercial assistance; marketing and public education; and regulation and inspection.

Based upon the experience from Ruvuma, the MSH will continue the expansion of the ADDO model into the Morogoro region and support the TFDA in two additional regions. The idea is to have ADDOs become centers for providing basic HIV/AIDS information on prevention, voluntary counseling and testing, STI treatment, and other ART services. Promotion of the ADDOs as a local source for HBC kit drugs for volunteers caring for patients living with HIV/AIDS will also be expanded. In addition, the possibility for ADDOs to serve as antiretroviral (ARV) prescription drop-off or refill services will be explored.

Public education on HIV/AIDS campaigns related to availability of VCT for HIV/AIDS, the availability of ARV treatment facilities, and information on prevention using available IEC materials, and social marketing techniques in collaboration with other partners (e.g. T-MARC), will reach groups and areas that might not otherwise be reached. ADDOs, in collaboration with community-based organizations and NGOs, may provide HBC services to remote and rural areas through the provision of HBC kits and services. In addition, ADDOs may serve as a source for replacement of kit supplies. Selected ADDO shops will be assigned a catchment area where they can provide HBC services to volunteers and possibly HIV patients identified by local NGOs and/or hospitals.

In the long term, and with appropriate regulatory approval, training, and supervision from the TFDA, and as the network of ADDOs spread, ADDOs could conceivably have the capability of providing an ARV and other HIV/AIDS medicines prescription refill service. This may include storage of prescribed ARVs from public facility in ADDO shops at locations close to the patient. This would help ensure an uninterrupted flow of ARVs to stable, chronically ill patients in rural areas where travel to a care and treatment facility to obtain prescription renewals would be a hardship for the patient and family. Under this scenario, ADDOs would ensure ARVs are properly stored, maintain records of dispensation, provide patient education and adherence counseling, and possibly deliver the ARVs directly to patients during HBC visits. The rollout of the ADDOs will take place in coordination with the expansion of the Integrated Logistics System (ILS) by JSI/Deliver.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Target Populations:

Adults

Pharmacists (Parent: Public health care workers)

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Coverage Areas

Arusha

Kilimanjaro

Manyara

Morogoro

Mwanza

Ruvuma

Table 3.3.11: Program Planning Overview

Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11

Total Planned Funding for Program Area:

Amount of Funding Planned for Pediatric AIDS:

Program Area Context:

In the first Emergency Plan annual report, the USG was supporting 1,518 PLWHA on ART. Less than 10 months later, this has increased to over 14,000 individuals, of which approximately 11% are children and over 50% are women. Tanzania continues to face human capacity shortages, limited laboratory capacity and fragile procurement systems; all of which have been compounded by substantial technical and policy challenges.

Although the GOT makes a significant financial investment towards the purchase of ARV (approximately [redacted] in FY05), contributions from external donors, including the Global Fund, are required to meet treatment targets. In an effort to support GOT policy and work together to address future ARV needs, an MOU was signed by the GOT and USG in March of 2005 to ensure ongoing drug availability. Early on, the limited drug allocation to sites was identified as a major impediment to scale-up. However, the GOT has now transitioned from a "push" to a "pull" system, where sites may now initiate requests for ARV based on need.

The USG is working hard to help the GOT realize its goals, and currently directly supports 75% of all patients on treatment though only working in 25% of the sites. However, the USG remains disappointed by the rate of expansion. To proceed more strategically into FY06, the GOT and USG have organized a series of interagency meetings with the goal of assessing ways to produce a more aggressive and integrated effort to maximize the coverage of treatment services.

Though the USG is the major donor directly supporting treatment at sites, several bilateral donors such as the German Technical Cooperation and Medicine Sans Frontier also participate in direct service provision. The Netherlands provides technical support to the MOH in assessing site readiness. The Clinton Foundation has been a strong policy advocate for human capacity development and pediatric treatment while money from Global Fund Rounds 3 and 4 will be used for the purchase of ARV.

In FY06, the three pillars of the USG ART strategy are: (1) geographic alignment of partners (in order to provide greater coverage by one partner in a given region, supporting services across the network); (2) ART service strengthening using mentors or preceptors through the Twinning Center; and (3) improving integration and quality of ART, TB/HIV, C&T, and PMTCT services. Using the established network model, the USG will focus partners in specific regions and require them to "graduate" out of some current sites, develop services at lower level facilities within their region(s) and expand in strategically identified areas. Another critical element of the FY06 USG approach includes utilizing the mentor/preceptors model as a key driver of site implementation, using local and international experts through a twinning mechanism. The USG will send preceptors to non-USG funded sites to rapidly launch services at these facilities and build sustainable local capacity.

Pediatric ART services are presently fragmented. Support through the Emergency Plan will expand a specialized pediatric AIDS center in the Kilimanjaro Region which will function not only as a model center for direct care but also assist the NACP to develop policies and training to be disseminated nationally. All USG ART partners are taking steps to increase pediatric caseload over the current average of 11% in FY05. Establishment of formalized referral networks to PMTCT services will enhance the identification and follow up of infants born to HIV+ women. Lastly, the USG will minimize the fragmentation of HIV services by strengthening linkages between treatment and other services through coordinated development of community programs (especially OVC and palliative care services) serving populations near treatment facilities. These activities have been designed to maximize USG contributions to reach 90,000 individuals with ART by September 2007.

Program Area Target:

Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	151
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	29,775
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	60,700
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	50,000
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	3,820

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National AIDS Control Program Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3378
Planned Funds:
Activity Narrative: The Government of Tanzania (GOT) adopted care and treatment for PLWHA as one of its key strategies in the Health Sector Response to HIV/AIDS. The Ministry of Health (MOH) Care and Treatment Plan was approved by the cabinet in October 2003. To implement the plan, the MOH established the Care and Treatment Unit (CTU) within the National AIDS Control Program (NACP) as the focal point for management and coordination. In January 2004, NACP developed the operational plan for GOT financial year 2004/05. Under this plan, in May 2004, the MOH/NACP created an initial list of 91 sites that would initiate the provision of ART to cover 44,000 patients by the end of calendar year 2005.

Given that human capacity is a key limiting factor to ART scale-up, one of the main themes of the operational plan is the training of health workers in the management of HIV/AIDS. This is to ensure that all sites have the technical capacity to roll out services.

In support of the national strategy, USG began funding the NACP in 2003, and has continued to do so under the Emergency Plan. In FY04, with funds from USG and WHO, NACP conducted HIV/AIDS management trainings for 492 health care workers. The trainings were conducted at four referral hospitals around the country: Muhimbili National Hospital, Kilimanjaro Christian Medical Center, Bugando Medical Center and Mbeya Referral Hospital. The duration of training was six days, and each facility brought four to six participants. Each site team included clinicians, pharmacists, laboratory technologists, nurses, counselors and home based care providers. For these trainings, facilitators were drawn from within these referral hospitals, the NACP and several non-governmental organizations. Preparations for these trainings were lengthy, and involved the complex process of selecting and training trainers, designing the curriculum and appropriate training modalities for adult learning.

With the recent arrival of FY05 funds, the NACP has begun implementation of a work plan for the continuation of the same activities but on a much broader scale. The MOH/NACP has recently selected an additional 104 sites for ARV service provision, and their goal is to enroll and maintain a cumulative total of 100,000 individuals on ART by December 2006 in over 200 sites. The implementation of this ambitious expansion plan will require the training of several additional clinical teams. In addition, going forward into FY06, planned activities will also focus on addressing evolving challenges and applying lessons learned from the first year of implementation.

FY06 funds will be used to expand the range of training activities beyond the standard six day training, especially as the number of sites increase. Several issues have been considered and incorporated into the FY06 work plan. For example, since the supply of ARV's was delayed at some sites by several months, refresher trainings will be performed. Training back-up teams is critical planned activity, as service provision is interrupted if any member of the original team is absent. One-time trainings have been shown to be insufficient given the complexity of HIV/AIDS clinical management, so a continuing education program will be institutionalized by the NACP.

In addition, the model used in the first implementation year was centralized. As such, the trainings were held only at the referral hospitals, and mostly in Muhimbili National Hospital in Dar es Salaam. The training duration for this HIV/AIDS management course is 6 days, and therefore clinic staff were frequently absent from their clinics either as teachers or students. It was agreed that the eight Zonal Training Centers (ZTC) should also be used for these HIV/AIDS management courses. This would

allow more cost-efficient and localized trainings. This transition plan is being developed and involves among others things, building the capacity of these ZTC to run the trainings and the logistics of sending funds directly to these ZTC from NACP. As indicated in the National Institute of Medical Research (NIMR) OPSS activity entry, the USG is providing financial and technical assistance for this effort.

For all of these activities, the USG will continue to support the NACP. USG care and treatment officers will work in close collaboration with the NACP in the planning, implementation and monitoring of these plans in FY06.

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	800	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
National AIDS control program staff (Parent: Host country government workers)
Host country government workers
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Other health care workders (Parent: Private health care workers)
District level staff

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mbeya Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3386
Planned Funds:
Activity Narrative: This activity also relates to activities in C&T (Mbeya Regional Medical Office), palliative care (KIHUMBE and HJFMRI), treatment (Mbeya Referral Hospital, DoD TA), Lab (Mbeya Referral Hospital, AMREF, ASCP, CDC TA), and SI (DOD).

Mbeya is one of four regions including Iringa, Rukwa and Ruvuam which make up the Southern Highlands in Tanzania. Zonal health services for these four regions are provided by the Mbeya Referral Hospital which works in concert with but not over the regional medical offices. Based on a network model, the Mbeya Regional Medical Office (MRMO) supports the implementation of prevention, care and treatment programs throughout the region, providing funding and supervision to the regional hospital and district level facilities. This office supports not only the needs of hospitals, health centers and dispensaries in providing primary care but also works to strengthen the continuum through providing quality counseling and testing (C&T) and PMTCT services, strengthening of referrals between facilities and services, conducting the training in palliative care to HBC providers, and supporting community education on health service initiatives. All three regions (Mbeya, Rukwa and Ruvuma) supported through the US Department of Defense (DoD) are implemented in a coordinated and almost parallel fashion, directly supporting the MOH's desire for donor agencies to undertake a more regional focus in developing networks of care.

Though the MRMO was originally slated to begin receiving Emergency Plan support with FY05 funding for ART, due to initiation of treatment at the regional, two district (Kayela and Rungwe) and one mission (Igogwe) hospital, as part of the MOH rapid roll out plan, work with this partner in the area of treatment began in January 2005. Through the Mbeya Referral Hospital (another DoD partner), required training under the National AIDS Control Programme (NACP) was provided. The Referral Hospital also supported reagents for monitoring, drugs for prophylaxis (including cotrimoxazole) and treatment of OI, and supportive supervision as treatment was initiated at these four hospitals leveraging FY04 funds. Under this support, these four facilities have over 350 individuals on treatment and another 900 patients on care. This rate of enrollment will have them exceeding their September 2006 treatment target of 500 patients under FY05 funding by approximately 200 patients.

Funding in FY06 will support expansion of treatment services at these four facilities plus the addition of a fifth, Mbozi District Hospital, with a combined September 2007 target for the MRMO of 1,000 patients on ART and over 2,000 patients on care. FY06 support will ensure four out of the six districts in Mbeya are supported with ART services. This expansion will include increasing the number of individuals trained through NACP efforts to an additional 26 personnel (at least six individuals per facility) under the Mbeya Referral Hospital submission in this section.

A referral mechanism, using existing structures, is being strengthened in FY05 to link services to centers providing counseling and testing at TB clinics, stand alone sites and lower level health facilities. Efforts in FY06 under the MRMO in CT will look to strengthen the integration of provider initiated counseling and testing in the five facilities' out patient clinics and in patient wards to identify the maximum number of treatment ready patients. Women, children and family members identified as HIV positive through PMTCT programs will also be referred to the CTC at the five hospitals for evaluation for treatment.

HIV-positive children are identified through PMTCT programs supported at four rural health centers near the Mbeya Municipality and services being introduced at the ANC at each of the five treatment sites in FY05. Through these sites, the pediatric ward at the hospitals, and linkages with local NGOs and FBOs providing support to OVCs in

the communities surrounding the facilities, pediatric cases are identified and evaluated for treatment. Currently over 11% of the ART and care population is between the ages of zero to 14 years. Experience from other USG partners focusing on the family care model will be used to inform program elements in improving the percent pediatric caseload and treatment in the Southern Highlands.

In FY06, an electronic medical record system being piloted at the Mbeya Referral Hospital (SI DoD submission) will be introduced at each of these sites. Currently these facilities use the paper versions of the patient report forms for this database with the Mbeya Referral Hospital keeping the electronic version and providing the hospitals with weekly patient reports. This record system has been not only helpful in improving patient management but also tracking of patients as they are referred back to their district hospitals for primary care from the regional or referral facility. It also provides advanced tracking of drug use, assisting in projecting need and accurately quantifying orders.
By extending this capacity directly to the districts, physicians and hospital administrators can make better real time decisions that will improve services at their facilities and develop a network of information on care and treatment in the region.

Under this submission, the MRMO will continue to develop capacity of local NGOs and FBOs in provision of HBC, focusing on the introduction of ARV education into HBC training and treatment adherence as part of service delivery. In FY06, the MRMO will work with the medical staff of a large NGO in the region, Kikundi Hunduma Majumbani (KIHUMBE), to devise a six-day course for HBC providers to cover topics in adherence and basic patient monitoring for individuals on ART. The MRMO will train 80 HBC providers in basic palliative skills with KIHUMBE training current providers in the region in the "advanced" care package. At all five treatment facilities, linkage of ART and care patients to HBC providers, under the HJFMRI umbrella submission under palliative care, will be built upon in FY06 to provide this at home follow up. The MRMO will continue to evaluate and monitor HBC programs in the region supporting a continuum of care approach and ensuring quality services are provided.

Direct FY06 funding to the MRMO will provide for modest renovations for the Mbozi HIV Care and Treatment Center (CTC), consumables for monitoring and medications for OI prophylaxis and treatment and ART (exclusive of ARVs to be purchased and supplied by MOH and USAID) at all five hospitals, strengthening of regional referral mechanisms and patient tracking (linked to SI section), and training of HBC provider in palliative care services. Laboratory equipment for the four district/one mission hospitals procured either by the MOH or CDC.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	5	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	400	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,100	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	1,000	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults

Faith-based organizations

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Children and youth (non-OVC)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive children (6 - 14 years)

Coverage Areas

Mbeya

Mbozi

Mbeya Rural

Mbeya Urban

Kyela

Rungwe

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: PharmAccess
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3390
Planned Funds:
Activity Narrative: This activity also relates to activities in PMTCT (PharmAccess), counseling and testing (PharmAccess), treatment (DoD TA), Lab (RPSO) and TB/HIV (PharmAccess).

The Tanzanian Peoples Defense Forces (TPDF) initiated one of the first ART programs in Tanzania in March 2003, at Lugalo Hospital in Dar es Salaam. As part of FY04's Emergency Plan funding from USAID through FHI, Lugalo Hospital has been able to expand care and treatment services at this facility to reach a total of 600 HIV-infected military personnel and dependents. In FY05, the TPDF will be initiating counseling and testing (C&T) services in the seven remaining military hospitals throughout the country (Mbeya, Mwanza Morogoro, Arusha, Tabora, Ruvuma and Zanzibar) with PMTCT services to be introduced at three of these same hospitals (Mbeya, Mwanza and Morogoro) all in preparation for ART roll out to these facilities. FY05 funding will see ART services begin at two facilities, Mbeya and Mwanza, closest to large USG supported programs at nearby public referral hospitals, the Mbeya Referral Hospital and the Bugando Medical Center. These activities are just now being initiated due to late arrival of FY05 funds.

Under this submission, PharmAccess will work with the military to expand ART services in two FY05 supported hospitals (Mbeya and Mwanza) and start ART services in four new facilities (Morogoro, Arusha, Tabora, and Ruvuma) using ART-experienced clinicians, nurse-counselors, laboratory and pharmacy specialists from Lugalo, Mbeya and Mwanza as preceptors. This exemplifies expansion using the network model. All hospitals will be included in the FY06 plans for C&T, PMTCT and TB services. Expansion of ART services will be made into the surrounding civilian communities and all HIV-infected men and women will be referred for further evaluation and qualification for TB treatment and ART within the facility.

Funding will support initial and refresher training of 35 medical personnel from the two experienced and the four new ART sites; community education/mobilization on ART; much needed infrastructure improvement to the labs; equipment and consumables for basic laboratory monitoring of patients (to include hematology and chemistry testing); treatment of OI's; and, ARVs (to be supplied by Emergency Plan funds through USAID and the MOH). Capacity for CD4 monitoring will not be developed at these additional four medical treatment facilities as it will be supported through nearby regional and zonal facilities under the National Care and Treatment Plan.

It is expected that a total of 1,800 patients (20% pediatric) will be on ART and an additional 1,800 – 2,000 on non-ART care and treatment by September 2007. As 80% of the population accessing services at military facilities is civilian, activities under this submission will support achievement of EP goals towards care and treatment for the general public as well as among the high-risk, military population.

HIV-positive children are identified through PMTCT programs supported at Mwenge Maternal Child Health Center, the large ANC serving Lugalo Hospital in Dar es Salaam. Through Mwenge, the ANCs at the associated military hospitals, and the pediatric wards, pediatric cases will be identified and referred to the HIV Care and Treatment Centers at these hospitals for staging and ART eligibility. Currently over 20% of the ART and care population at Lugalo Hospital is between the ages of zero to 14 years and experience at this facility will be mirrored at new military hospitals being brought on line for ART. Experience from other USG partners focusing on the family care model will be used to inform program elements in improving the percent pediatric caseload and treatment in the Southern Highlands.

The TPDF and PharmAccess, a large not-for-profit organization based out of the Netherlands, have developed a strong working relationship over the past four years in the area of health service provision. Expansion of ART services in FY06 will ensure a close linkage of military implementation to national strategies and programs. Funding for the TPDF through PharmAccess will provide much needed technical support, management assistance and M&E for all TPDF activities in this COP. The military referral hospital in Dar es Salaam, Lugalo Hospital, will serve as the coordinating body for services and over see quality assurance following national standards. Additional support for military facilities in Mbeya and Ruvuma will be provided by the US Department of Defense field office, overseeing civilian based activities in these regions.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	6	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,500	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	2,000	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	1,800	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	35	☐

Target Populations:

Adults

Military personnel (Parent: Most at risk populations)

People living with HIV/AIDS

Children and youth (non-OVC)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

Coverage Areas

Mbeya

Morogoro

Arusha

Mwanza

Tabora

Ruvuma

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Rukwa Regional Medical Office
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3395
Planned Funds:	
Activity Narrative:	This activity also relates to activities in PMTCT (Rukwa Regional Medical Office), counseling and testing (Rukwa Regional Medical Office), palliative care (HJFMRI), treatment (Mbeya Referral Hospital, DoD TA), Lab (Mbeya Referral Hospital, AMREF, ASCP, CDC TA), and SI (DOD).

Rukwa is one of four regions in the Southern Highlands which includes Iringa, Mbeya and Ruvuma and is served by the Mbeya Referral Hospital for all its advanced care and supervisory needs. This referral hospital works in concert with but not over the regional medical offices. As with the Mbeya Regional Medical Office (MRMO), the Rukwa Regional Medical Office (Rukwa RMO) supports the implementation of prevention, care and treatment programs through out its region, providing funding and supervision to the regional hospital and district level facilities. This includes supporting direct care services, providing quality counseling and testing (C&T) and PMTCT services, strengthening of referrals between facilities and services, conducting training in palliative care to HBC providers, and supporting community education on health service initiatives.

Identified as one of the MOH sites for initiation of ART in FY04, the Rukwa Regional Hospital in Sumbawanga is poorly equipped, its infrastructure inadequate, it has few trained staff, and critical commodities are limited to support such efforts. Laboratory equipment to support CD4 monitoring and safety labs purchased by the MOH recently arrived to meet one of their most critical needs. FY05 Emergency Plan funding, which is just arriving in country, will support the development of additional infrastructure and capacity through clinic and lab renovations and the training of additional staff. The Mbeya Referral Hospital (a USG partner) will provide ongoing technical assistance through supportive supervision in both lab and clinical services to guide all aspects of care and treatment. Targets for ART and care for FY05 are 500 and 600 respectively.

Funding in FY06 to the Rukwa RMO will support expansion of treatment services at the regional hospital plus extension of support to a second site, Nkasi District Hospital. This includes increasing the number of individuals trained through NACP efforts in the region to an additional 12 personnel (at least six individuals per facility) under the Mbeya Referral Hospital submission in this section. Direct FY06 funding to the Rukwa RMO will provide for renovations for the Nkasi HIV Care and Treatment Center (CTC), consumables for monitoring and medications for OI prophylaxis (including cotrimoxazole) and treatment (exclusive of ARVs to be purchased and supplied by MOH and USAID) for both hospitals. Laboratory services will continue to receive technical support from the Mbeya Referral Hospital with required equipment for the Ngazi District Hospital procured either by the MOH or CDC. It is anticipated that these two hospitals will support a combined 900 patients on treatment and another 1,350 patients with care by September 2007.

Similar to the model currently used at the Mbeya Referral Hospital, HIV-positive children will be identified through follow up of HIV+ women accessing PMTCT services at the two facilities. Through these ANC, the pediatric wards at the hospitals, and linkages with local NGOs and FBOs providing support to OVCs, pediatric cases will be identified and evaluated for treatment. Based on experience at the Mbeya Referral Hospital, it is anticipated that between 10-12% of the ART and care population in FY06 at these two hospitals will be between the ages of zero to 14 years. Experience from other USG partners focusing on the family care model will be used to inform program elements in improving the percent pediatric caseload and treatment in Rukwa.

In support of the expansion of treatment to other facilities in the region, the Mbeya Referral Hospital will assist the Rukwa RMO in developing a treatment supervisory team to support Nkasi and other CTC in the region as they come on line. Experienced clinicians will be placed with this team for two to three weeks in the early stages to maximize effective monitoring. This capacity building in supportive supervision for the region is critical to ensure quality services are provided and is a major part of the MOH's HIV/AIDS care and treatment roll-out plans.

A referral mechanism between newly established VCT and PMTCT services in the region is being introduced in FY05. Building upon existing structures, this referral system aims to link services at centers providing counseling and testing at TB clinics, lower level health facilities and PMTCT interventions at antenatal clinics to the CTC. As with all USG partners in the Southern Highlands, efforts in FY06 under the Rukwa RMO in C&T will look to strengthen the integration of provider initiated counseling and testing in these two facilities' out patient clinics and in patient wards to identify the maximum number of treatment ready patients.

In FY06, an electronic medical record system being piloted at the Mbeya Referral Hospital (funding is under the SI DOD submission) will be introduced at each of these sites. In FY05, use of the paper versions of the patient report forms for this database will be introduced at the regional hospital to familiarize medical staff with the use and benefit of the system. The Mbeya Referral Hospital will maintain the electronic medical record system and provide the hospital with weekly patient reports. This record system has been extremely helpful in the Mbeya Region in 2005, improving patient management and tracking of patients as they are referred back to their district hospitals for primary care from the regional of referral facilities. It also provides advanced tracking of drug use, assisting in projecting need and accurately quantifying orders. By extending this capacity directly to the region in FY06, physicians and hospital administrators can make better real time decisions that will improve services at their facilities.

Lastly, based on the model of the continuum of care developed by the regional medical offices in the Southern Highlands, the Rukwa RMO will continue to develop the capacity of local organizations and dispensaries in extending support for HIV care and treatment into the community. Training of these providers in basic palliative services will include the addition of ARV education and counseling in treatment adherence as part of service delivery. Using the module on ART support in HBC which will be developed by the Mbeya Regional Medical Office and a large NGO in the Mbeya Municipality, FY06 funds will also support the Rukwa RMO in training 40 HBC providers/dispensary personnel. Linkage of hospital patients to these dispensaries and organizations for support and follow up will be undertaken and evaluation and monitoring of HBC programs in the region conducted ensuring quality care.

Funding under this submission will support direct patient services including reagents for continued monitoring of patients, drugs for treatment of OI, required improvement of infrastructure, supportive supervision to the region, strengthening of regional referral mechanisms and patient tracking (linked to SI section), and expansion of the community referral system and technical support to participating NGOs and FBOs. ARVs will be supplied by the MOH and funding under the USAID submission.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	2	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	400	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,000	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	900	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults

Faith-based organizations

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Children and youth (non-OVC)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive children (6 - 14 years)

Coverage Areas

Rukwa

Sumbawanga Urban

Nkasi

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ruvuma Regional Medical Office
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3399
Planned Funds:
Activity Narrative: This activity also relates to activities in PMTCT, (Ruvuma Regional Medical Office), counseling and testing (Ruvuma Regional Medical Office), treatment (Mbeya Referral Hospital, DoD TA), Lab (Mbeya Referral Hospital, AMREF, ASCP, CDC TA), and SI (DOD).

Ruvuma is the third of the four regions in the Southern Highlands, which includes Iringa, Mbeya and Ruvuma, to be included as a prime partner for treatment under the US Department of Defense. The Mbeya Referral Hospital supports Ruvuma for all its advanced care and supervisory needs, working in concert with but not over the regional medical office with the later supporting direct implementation of prevention, care and treatment programs through out its region.

Situations surrounding care and treatment in Ruvuma are very similar to Rukwa and development of treatment capabilities will mirror plans for Rukwa. Both are geographically isolated areas of the Southern Highlands and lacking support for basic services. Identified as one of the MOH sites for initiation of ART in FY04, the Ruvuma Regional Hospital in Songea is only now receiving MOH purchased laboratory equipment to support CD4 monitoring and safety labs. Currently, only one treatment team (one medical officer, clinical officer, nurse, pharmacist and laboratory technologist) have received the National AIDS Control Programme's (NACP) six day ART training course. FY05 Emergency Plan funding, which is just arriving in country, will support the development of additional infrastructure and capacity through clinic and lab renovations and the training of additional staff. Targets for ART and care for FY05 are identical to those for Rukwa, with the expectation of reaching 500 (ART) and 600 (care) individuals respectively.

Funding in FY06 to the Ruvuma RMO will support expansion of treatment services at the regional hospital plus extension of support to a second site, Tunduru District Hospital. This second hospital is in the far east of the region while the Regional Hospital in Songea serves the western/central populations. This selection will ensure maximum geographic coverage in the region until other hospitals are brought on line. If required, the DoD is prepared to maximize upon funding to the Ruvuma RMO and Mbeya Referral Hospital to extend support to other facilities in the region in support of MOH expansion plans and exceed estimated targets.

Current expansion plans will include increasing the number of individuals trained through NACP efforts in the region to an additional 12 personnel (at least six individuals per facility) under the Mbeya Referral Hospital submission in this section. Direct FY06 funding to the Ruvuma RMO will provide for renovations for the Tunduru HIV Care and Treatment Center (CTC), consumables for monitoring and medications for OI prophylaxis (including cotrimoxazole) and treatment (exclusive of ARVs to be purchased and supplied by MOH and USAID) at both facilities. Laboratory services will continue to receive technical support from the Mbeya Referral Hospital with required equipment for the Tunduru Hospital procured either by the MOH or CDC. With similar capacities being developed in Ruvuma as in Rukwa, it is anticipated that the two hospitals in Ruvuma will support a combined 900 on treatment and another 1,350 with care by September 2007.

Similar to the model currently used at the Mbeya Referral Hospital, HIV-positive children will be identified through follow up of HIV+ women accessing PMTCT services at the two facilities. Through these ANC, the pediatric wards at the hospitals, and linkages with local NGOs and FBOs providing support to OVCs, pediatric cases will be identified and evaluated for treatment. Based on experience at the Mbeya Referral Hospital, it is anticipated that between 10-12% of the ART and care

population in FY06 at these two hospitals will be between the ages of zero to 14 years. Experience from other USG partners focusing on the family care model will be used to inform program elements in improving the percent pediatric caseload and treatment in Ruvuma.

As in Rukwa, the Mbeya Referral Hospital will assist the Ruvuma RMO in developing a treatment supervisory team to support CTC in the region as they come on line. FY06 being requested in this submission in support of these teams will include costs for transport, lodging and meals incurred during supervisory visits. A referral mechanism between newly established VCT and PMTCT services in the region being introduced in FY05 will be built upon to link services at centers providing counseling and testing at TB clinics, lower-level health facilities and PMTCT interventions at antenatal clinics to the CTC. FY06 submissions under CT will look to strengthen the integration of provider-initiated counseling and testing in these two facilities' outpatient clinics and in patient wards in support of treatment efforts. And lastly, the electronic medical record system being piloted at the Mbeya Referral Hospital (funding under the DoD submission in SI) will be introduced at each of these sites to aid in patient management, reporting to the MOH and tracking patients as they are referred back to smaller facilities to receive their primary care. It also provides advanced tracking of drug use, assisting in projecting need and accurately quantifying orders. All of these efforts combined, strengthen the overall program in the region with a focus on developing sustainable systems.

Strategic planning meetings with the Director General of the Mbeya Referral Hospital and the Regional Medical Officers of Rukwa, Ruvuma and Mbeya continue the development of similar program plans to be implemented in the Southern Highlands in support of HIV prevention and care. Follow-up site visits by US DoD personnel to Songea and Tunduru have honed these plans for Ruvuma. As in Rukwa, the Ruvuma Regional Medical Office has expressed a desire to develop the capacity of communities to take part and support care and treatment as it is introduced into the region. This will include the training of local NGOs, FBOs, and several of its own dispensaries in provision of palliative care and ART adherence counseling to assist in patient follow-up. In FY06, the Ruvuma RMO will train and additional 40 HBC providers/dispensary personnel with the ART module being developed by the Mbeya Regional Medical Office and a large NGO in the Mbeya Municipality. The Ruvuma RMO will work with the Regional Hospital and Tunduru District Hospital in strengthening referrals of hospital patients to these dispensaries and organizations for support and follow up. Key organizations providing this service will be mentored by linking them with a counselor or nurse working in the CTC. Funding will support the training of providers/dispensary personnel, commodities for patient follow up, and continued supportive supervision by the hospitals and Regional Medical Office.

Funding under this submission will support direct patient services including reagents for continued monitoring of patients, drugs for treatment of OI, ART, required improvement of infrastructure, supportive supervision to the region, strengthening of regional referral mechanisms and patient tracking (linked to SI section), and expansion of the community referral system and technical support to participating NGOs and FBOs. ARVs will be supplied by the MOH and funding under the USAID submission.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Human Resources	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	2	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	400	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,000	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	900	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults

Faith-based organizations

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Children and youth (non-OVC)

Men (including men of reproductive age) (Parent: Adults)

Women (including women of reproductive age) (Parent: Adults)

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive children (6 - 14 years)

Coverage Areas

Ruvuma

Songea Rural

Tunduru

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Muhimbili National Hospital
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3412
Planned Funds:	

Activity Narrative:

With a population of about 3 million, the City of Dar es Salaam has an estimated 300,000 HIV infected persons, of whom 60,000 require anti-retroviral treatment (ART). A number of surveys have shown that about 50% of all admissions to Muhimbili National Hospital (MNH) are due to HIV or HIV-related opportunistic conditions. In 1999, an HIV/AIDS clinic was started mainly to provide care to people living with HIV and AIDS (PLWHA) by treating opportunistic infections (OI) and providing prophylactic treatment against tuberculosis (TB), and other bacterial infections, using isoniazid (INH) and cotrimoxazole. For the very few patients that could afford ART, the clinic provided advice and support. With assistance from a number of organizations, MNH has been able to train its workers on the management of HIV/AIDS using ART. Experience has been gained in monitoring patient adherence. MNH as a training center is now taking the lead in providing care and treatment of PLWHA in Tanzania.

In FY04, "track 1.5" funds were used to strengthen the existing HIV/AIDS clinic, providing it with needed space, staff and infrastructure that laid the foundation for an HIV care and treatment center. With those funds, MNH was able to support the Government of Tanzania's 3-month pilot with technical and additional financial assistance from Columbia University (CU) and Elizabeth Glaser Pediatric Foundation (EGPAF). At the end of the pilot, in September 2004, 733 patients were on treatment. As of today, the clinic is supporting over 1200 patients on ART and an estimated 3000 in care.

The leadership at MNH would like to further develop the role of the hospital as a referral rather than a primary care center. As such, the MNH HIV/AIDS clinic plans to slowly decrease the enrollment of new patients and begin the process of "down referral" of their current patients. In this model, lower level health centers will perform routine follow-up of MNH's stable ART patients. This will enable the MNH clinic, which is operating at near full capacity, to use its specialized technical expertise to manage only complicated treatment cases such as pregnant women and treatment failures. In theory, this concept is rational, but its implementation is fraught with many challenges.

The most notable challenge is the absence of effective referral mechanisms between the district hospitals and health centers and MNH. In Dar es Salaam, the district hospitals, health centers and dispensaries are under the authority of the municipalities of Dar es Salaam. On the other hand, MNH is an autonomous institution of the Ministry of Health. Due to the different governance structure, the referral mechanisms between MNH and these sites are dysfunctional. MNH cannot mandate these sites to accept their patients. To further complicate the situation, the USG partners in Dar es Salaam, Columbia University and Harvard, have signed long-term implementation agreements with MNH and the city of Dar es Salaam respectively. Columbia University provides technical assistance and financial support to MNH, and has invested considerable time and effort in developing interdepartmental organizational systems. Harvard operates in the 3 district hospitals (Temeke, Amana and Mwananyamala hospitals) and the Infectious Disease Clinic (IDC), with plans to expand one health center in FY06. The existence of two partners poses severe challenges to coordination.

These district hospitals do not have the capacity to accept more patients, even with daily clinic hours. There has been some discussion of establishing Saturday clinics to meet the demand. It has been found that patients travel from all over the nation to receive HIV/AIDS care in Dar es Salaam. Some travel to avoid recognition and thus escape potential stigma from their home communities. There are ever increasing waitlists. The existing structure will soon be overwhelmed.

To relieve the burden on these higher level facilities, the obvious solution would be

down referral to the health centers and even the dispensaries. A complicating factor is that currently, there are no health centers or dispensaries on the list of 200 sites that the MOH/NACP has indicated for scale-up of ARV services.
The USG realizes that despite these obstacles, there is great need here, and has decided to dedicate resources to this effort. The involvement of the three District Medical Officers (DMO's) for the City of Dar es Salaam is critical, as these offices have authority over all levels of health care within the district. Discussions have been initiated with both MNH and the Regional Medical Officer (RMO), who serves as a technical and coordinating authority over all levels of health care within the city, excluding MNH.

To achieve the down referral of patients from MNH to the health centers, with close USG oversight, FY06 funds will be used to:
Develop referrals and linkages between MNH and six health centers. This will be accomplished by the hiring of referral coordinators whose main responsibility will be to visit the health centers to ensure that patients are referred successfully, and monitor patient record keeping and drug supply stocks. They will link with HBC providers who would conduct home visits to patients who default on therapy.

Conduct site assessments of the health centers. If needed, minor renovations will occur to ensure adequate space and safe storage of drugs.

Build the human capacity of the health centers to ensure that the staff are capable, at a minimum, of refilling ARV prescriptions for stable patients and recognizing adverse reactions. Health center staff will be trained in the basic management of HIV/AIDS and the recognition of the signs of treatment failure and toxicity. These didactic and practicum sessions will occur at MNH. Selected staff from MNH would then travel to the health centers to provide quarterly supportive supervision on site.

Provide administrative support to the existing Dar es Salaam Health Coordination Committee. This committee would facilitate the coordination of its stakeholders.

A memorandum of understanding will be created between MNH, Dar City Council and the 3 municipalities/districts that will include the delineation of the roles and responsibilities for each entity. Detailed work plans for these objectives will be developed with input from all parties. Key participants include the DMO's, the RMO, Columbia, Harvard, the administration and clinicians at MNH and community based organizations.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	18	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas

Dar es Salaam

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Deloitte Touche Tohmatsu
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3443
Planned Funds:
Activity Narrative: Deloitte has worked with Family Health International (FHI) during the last two years to capacitate the Government of Tanzania's Quickstart ARV Treatment Sites. Together they provide capacity building for the Tanzania national treatment program and strengthen the continuum of HIV care with ARV treatment. This activity will continue because of the favorable results to date with those four sites started with FY04 funds, and six new sites under development with FY05 funds. With technical support from FHI Tanzania, Deloitte will work towards the expansion of ART sites from the existing 10 sites to 16 sites using FY 06 funds. Deloitte's role is to provide the sub-grants to the hospitals/health centres that will be treatment sites for renovation, program start up, and expenses associated with on-going treatment. Deloitte will continue to ensure programmatic and financial accountability with these sub-grants, and will ensure that monitoring, evaluation, and reporting functions occur properly. Deloitte will continue to provide these services at the existing ART sites that were established in FY04 (Iringa Regional Hospital, Lugalo Military Hospital, and Mto wa Mbu Health Center and, if necessary, PASADA), and the sites initiated for FY05 (Mchukwi Mission Hospital in Rufiji; Hindu Mandel Hospital in Dar es Salaam; Dodoma Regional Hospital in Dodoma; Mafinga District Hospital in Iringa; Geita District Hospital in Mwanza; and Karatu Mission District Designated Hospital in Manyara). Because of the regionalization of ARV Treatment sites initiated by the National AIDS Control Programme, these sites may change due to reassignment of FHI/Deloitte, which will be focusing their activities in Iringa, Dodoma, and Morogoro. In that case, the groundwork done by FHI/Deloitte would be taken on by another USG partner.

The ten sites are expected by the September 30, 2006 to have approximately 5,400 patients receiving general HIV clinical care and support, of whom 4,300 will be on ART. By the end of FY07 when the six new sites will be in operation, 8,250 patients will be receiving general HIV clinical care and support, of whom 5,500 will be on ART. Approximately ten percent will be children and infants under 14 years, and approximately 60% will be women. Of the 10 sites already chosen, one site will be a military hospital, 3 sites will be mission hospitals, two sites will be private hospitals and four sites will be public hospitals. Stigma and discrimination will be addressed by actively involving individual PLWHAs and PLWHA support groups in care and treatment service provision. Additional space at all supported CTCs will be made available to address needs for patient volume and privacy. A critical piece of achieving the anticipated numbers will be the ability to get government approval to apply innovative approaches to recruit/retain new hospital staff. These possibilities will be a part of the recommendations made under the USG-funded Human Capacity Development activities.

In providing the Grant Management services Deloitte will be actively involved in carrying out the budget reviews of all sites, undertaking all pre-award assessments, and ensuring that all the necessary financial controls and systems are put in place before the grants are awarded. In addition, Deloitte shall enter into contracts will all new sites.

Through these grants, FHI and Deloitte will be able to provide TA training and supervision to the sites. This will consist of facilitating the sites' training of the provider team, providing mentoring/precepting at sites with national and international clinical preceptors, assisting with data management and reporting using a standardized patient and program clinical monitoring software program, piloting modes of community preparation, ensuring functional referrals with community care programs across a continuum of care and providing low literacy patient educational materials. With greater geographic focus, FHI and Deloitte will be able to put more concentrated emphasis on strengthening the continuum of care, linking especially

with the Tumaini Home-based Care activity (see Palliative Care: Basic Care and Support).

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	16	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,300	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	6,325	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	5,500	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	128	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
International counterpart organizations
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Dar es Salaam

Dodoma

Iringa

Manyara

Morogoro

Mwanza

Geita

Rufiji

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3456
Planned Funds:
Activity Narrative: FHI has provided technical support to facilities to initiate Quickstart Care and Treatment Centres (CTC) with previous USG support through FHI and Deloitte. This includes four sites initiated with FY04 funds, and an additional six that were added with FY05 funds (total of ten). This support includes staff training and community mobilization, supervision and quality assurance, financial support for renovations, and supplying of equipment.

During FY06, the support to these ten existing sites will continue. In addition, six new sites will be added with FY06 funds. FHI and Deloitte may also have to adjust their locations, based on the regional approach that is being requested by the National AIDS Control Programme (NACP), which would result in partners having more specific geographic focus. Under this new approach, FHI and Deloitte will be especially working on sites in Iringa, Dodoma, and Morogoro in order to take advantage of opportunities related to geographic clustering.

The ten sites are expected by the September 30, 2006 to have approximately 5,400 patients receiving general HIV clinical care and support of whom 4300 will be on ART. By the end of FY07 when the six new sites will be in operation, 8,250 will be receiving general HIV clinical care and support, of whom 5,500 will be on ART. Approximately ten percent will be children and infants under 14 years, and around 60% will be women. Of the 10 sites already chosen, one site will be a military hospital, 3 sites will be mission hospitals, two will be private hospitals and four sites will be public hospitals. Stigma and discrimination will be addressed by actively involving individual PLWHAs and PLWHA support groups in care and treatment service provision. Additional space at all supported CTCs will be made available to address needs for patient volume and privacy. A critical piece of achieving the anticipated numbers will be the ability to get government approval to apply innovative approaches to recruit/retain new hospital staff. These possibilities will be a part of the recommendations made under the USG-funded Human Capacity Development activities.

At all sites, additional efforts will be made to decentralize routine follow-up and migrate refill visits to lower level facilities closer to patients' homes, such as health centers, dispensaries, or home care programs, pending adequate logistics and supervision. Important lessons learned from the initial four sites will inform and shape the establishment and operations of the six new sites. Mto wa Mbu health center will be further modeled as a pilot rural ART site for replication to other areas of the country. One private hospital will be strengthened to become a national training site for the private sector and innovative approaches with franchising care and treatment packages for the private sector will be explored.

FHI will continue to guarantee quality assurance through the placement of residential care and treatment facilitators at each site. In accordance with the standard CTC reporting forms, monitoring and evaluation training and data quality standards will be implemented to improve monitoring and evaluation/strategic information. In addition, efforts will be made to strengthen the capacity of facilities to staff programs appropriately and monitor program performance at site level through the employment additional temporary project staff.

The FHI/Deloitte partnership will be responsible for 5,500 patients on ART by the end of FY07, though Deloitte will report the direct target accomplishments, and FHI will report only on indirect achievements.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Workplace Programs	10 - 50

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Other health care workders (Parent: Private health care workers)

Key Legislative Issues

Stigma and discrimination

Gender

Twinning

Coverage Areas

Dar es Salaam

Arusha

Dodoma

Iringa

Mwanza

COAST

Table 3.3.11: Activities by Funding Mechanism

Mechanism: UTAP
Prime Partner: Columbia University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3461
Planned Funds:
Activity Narrative: Columbia University (CU), through the International Center for AIDS Care and Treatment Programs (ICAP), with CDC and USAID funding, has provided technical assistance to 12 zonal, regional, and district health facilities in several regions in mainland (Dar es Salaam, Kagera, Mwanza and Kilimanjaro) and Zanzibar. The scope of activities in these sites includes: PMTCT, PMTCT-Plus, and care and treatment services. Conceptually and programmatically, CU has divided these into 3 distinct areas (primarily along the previous funding lines), but moving into FY06, the activities will form a more comprehensive program, allowing for a seamless integration of all three elements within a service delivery point.

In July 2004, CU was one of the USG partners supporting the Ministry of Health's (MOH) initial three month pilot care and treatment program at Muhimbili National Hospital (MNH). Since antiretrovirals became available in January 2005, they have expanded into their current 12 sites. At these sites, service provision includes the enhancement of PMTCT services, implementation of a PMTCT-plus model, strengthening HIV care activities, as well as providing anti-retroviral therapy to those eligible for treatment. CU has so far enrolled 2801 persons in care and initiated 1684 persons on ART.
CU has faced severe expansion challenges at their main ART site, MNH. Inadequate infrastructure, staff shortages and severe bureaucratic limitations have hindered rapid service roll-out. Consequently, CU will examine the extent of their investment in MNH and determine if some of those funds can be better utilized elsewhere.

With FY06 funding, in alignment with the MOH geographic strategy, activities will continue in Zanzibar and will expand from Dar es Salaam into the Coast Region. CU will continue to work in the Kagera Region (Lake Zone) and will closely coordinate with AIDSRelief on referral activities associated with their work in other regions in the Lake Zone. Negotiations are on-going to determine the scope of USG support to be provided to MNH in FY06 and to ascertain whether the Ocean Road Cancer Institute in Dar es Salaam, supported with rapid-expansion funds in FY05, will continue as part of CU's program.

In FY06 CU's objectives are two fold, to develop the capacity of current PMTCT sites to provide care and treatment and build the capacity of new, integrated PMTCT and adult and pediatric treatment sites. CU's work in pediatrics has 4 program elements: 1) increasing availability of infant HIV diagnostics; 2) enhancing pediatric case finding and referral to care and treatment services; 3) ensuring comprehensive care and treatment services for HIV-exposed infants and for HIV-infected infants and children; and 4) increasing access to pediatric ART.

In current and planned sites, CU will first carry out a detailed assessement of laboratory capacity for pediatric diagnostics and if needed, design capacity building plans. Staff capacity will be assessed for pediatric ART delivery and targeted supplementary trainings will be provided. In addition, CU will provide specialized training and mentorship to 1-2 pediatric providers at designated sites, and promote preceptorship through site exchange visits. To expand the number of children counseled and tested, entry points to pediatric services will be diversified and strengthened, to inpatient wards, pMTCT programs, hospital-based VCT programs, adult ART clinic, and under-5 clinics. Once children are identified, comprehensive care services (including cotrimoxazole prophylaxis, nutrition and growth monitoring, and parental counseling) for all HIV-exposed and HIV-infected children will be offered. Moving forward, CU will explore innovative infrastructure development options such as the feasibility of co-located services for HIV-positive women and their children and coordinated scheduling of appointments for the mother, child, and other family

members.

The delivery of ART to HIV-infected women identified via pMTCT programs has been a major area of emphasis for CU since the beginning of the MTCT-Plus Initiative in 2002. In implementing care and treatment activities,, the treatment of pregnant women has been emphasized, both because of the importance of their treatment needs, and so that their treatment can open access to treating their children and other infected family members.
CU will focus on ensuring that women enrolled in pMTCT are routinely and effectively referred for ART services. HIV-infected pregnant women will be promptly assessed for ART eligibility, will receive routine CD4 testing, and be provided with services apropriate to their disease stage, including ART when indicated. These women will be actively encouraged to bring their children and other family members to the facility for testing, thus promoting a family-centered care model. For the success of this system, patient tracking to build linkages within facilities (from pMTCT to ART clinics, for example) and to evaluate the uptake of family members is critical. C U will actively build effective referral linkages between pMTCT and TB, STI, FP, and ART clinics and support access to appropriate pre-natal care, including nutritional counseling and multivitamins, facilitate access to IPT and bednets.

At all sites, targets will be reached through the formation of multi-disciplinary care teams in each facility, with representation from the pMTCT service, and by Septemebr 30, 2006, CU will have started 5000 persons on treatment with a rapid increase to over 8,000 by September 30, 2007.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	17	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	3,825	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	8,825	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	8,000	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	75	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Kusini Pemba (Pemba South)

Mjini Magharibi (Zanzibar West)

Mwanza

Dar es Salaam

Kagera

Kilimanjaro

Kaskazini Pemba (Pemba North)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

COAST

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Elizabeth Glaser Pediatric AIDS Foundation
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3473
Planned Funds:	
Activity Narrative:	This prime partner is one of the four central ART awardees that are operating in Tanzania. The country team has supplemented their central award with in-country funds. Please refer to the eponymous entries within the ARV services program area for a full description of this partner's FY06 activities

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Target Populations:

People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)
Public health care workers

Coverage Areas

Dar es Salaam

Kilimanjaro

Morogoro

Pwani

Shinyanga

Tabora

Arusha

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Columbia University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3474
Planned Funds:
Activity Narrative: This prime partner is one of the four central ART awardees that are operating in Tanzania. The country team has supplemented their central award with in-country funds. Please refer to the eponymous entries within the ARV services program area for a full description of this partner's FY06 activities.

Targets are covered under country-funded activity narrative

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

People living with HIV/AIDS
HIV positive pregnant women (Parent: People living with HIV/AIDS)
HIV positive infants (0-5 years)
HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Dar es Salaam

Kagera

Kilimanjaro

Same

Mwanza

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Chake Chake District

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Town District

COAST

Bagamoyo

Kisarawe

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Harvard University School of Public Health
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3475
Planned Funds:	
Activity Narrative:	This prime partner is one of the four central ART awardees that are operating in Tanzania. The country team has supplemented their central award with in-country funds. Please refer to the eponymous entries within the ARV services and Palliative Care: TB/HIV program areas for a full description of this partner's FY06 activities Targets are covered under the country-funded activity

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Private health care workers

Coverage Areas

Dar es Salaam

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	*N/A*
Prime Partner:	*Catholic Relief Services*
USG Agency:	*HHS/Centers for Disease Control & Prevention*
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3476
Planned Funds:	
Activity Narrative:	This prime partner is one of the four central ART awardees that are operating in Tanzania. The country team has supplemented their central award with in-country funds. Please refer to the eponymous entries within the ARV services and Palliative Care: TB/HIV program areas for a full description of this partner's FY06 activities

Emphasis Areas	***% Of Effort***
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

People living with HIV/AIDS

Key Legislative Issues

Gender

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Manyara

Tanga

Mwanza

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Bugando Medical Centre
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3484
Planned Funds:
Activity Narrative: A program announcement for building the capacity of referral hospitals to provide a continuum of HIV/AIDS services in the areas of PMTCT, ARV services, counseling and testing and laboratory infrastructure was made in FY05. The recipients of these funds have just been determined and the notice of grant award has just been received. Bugando Medical Center (BMC), in Mwanza, in the Lake Zone, has been awarded $700,000 in FY 05 funds for the scale-up of services in all these program areas.

The Lake Zone is comprised of six regions, and is larger than the state of Minnesota. These are Mwanza, Shinyanga, Tabora, Kagera, Kigoma, and Mara. The Lake Zone is the catchment area for BMC, a zonal referral and University teaching hospital with a bed capacity of 850. BMC also oversees MOH programs in the zone and provides technical support for their implementation.

The Lake Zone is a very high HIV-burden area in Tanzania. It has an aggregate population of 13 million, which is about a third of the country's population. It borders with Uganda to the north, on the north east is Kenya, northwest is Burundi, and on the west is the Democratic Republic of Congo, all high-burden countries. It has refugees from Burundi, Rwanda and Congo. The first AIDS case was reported in Kagera region in 1983. The HIV prevalence in the Lake Zone ranges from 5% to 19.4%. Extrapolating from national figures, the estimated number of PLWHA in the Lake Zone is over 700,000, and of these, 100,000 require antiretroviral treatment. The grim HIV/AIDS statistics in the Lake Zone justify the need for a zone-wide program to scale-up the continuum of HIV/AIDS prevention, care and treatment through the network model. BMC started offering free ARVs in Jan 2005, and to date supports over 2000 PLWHA on care and more than 500 on antiretroviral treatment within the facility alone.

AIDSRelief, another USG partner, supports treatment services within the ART clinic. This direct funding to BMC will help execute the hospitals mandate to provide ART training, technical support, supportive supervision, preceptorship and outreach to the lower level health facilities in other regions in the Lake Zone.

The lack of highly trained care givers in primary health care facilities is a major obstacle to rolling out ART services to primary health centers in the Lake Zone. For this reason, the first year ART work plan will focus on capacity development. A fundamental aspect of building capacity includes taking steps to support the decentralization of the national National AIDS Control Program (NACP) HIV/AIDS training. Using the national curricula, BMC will train zonal master trainers and regional trainers. These master trainers will then train district level health care workers with BMC's supervision to ensure quality. This way, knowledge and skills will be passed on to lower levels in order to increase their ability to address HIV/AIDS diagnosis and treatment and deliver community support. The proposed plans also include developing a model of ART/PMTCT service delivery which does not depend on highly-trained doctors at the primary health facilities. In this model, routine aspects of managing ART will be shifted to clinical officers and nurses trained in HIV/AIDS management. A supportive supervision program headed by skilled physicians will be implemented to ensure best practices and a preceptor will provide on-site mentoring. This model will possibly be adopted by the MOH for replication throughout the country.

There are few linkages between health institutions that provide ART and communities. Strong linkages from BMC and other facilities to communities, community based organizations, home-based care programs and PLWHA networks

will be developed to ensure continuum of care and to maximize adherence to opportunistic infections prophylaxis, antiretroviral and anti tuberculosis treatment support. For effective roll out of HIV/AIDS treatment, community acceptance and preparedness is critical, so funds will be used by BMC create outreach programs. This will allow PLWHA, community leaders, and health care providers to conduct advocacy, education and stigma reductions meetings in the communities. This will pave the way for increased uptake of HIV/AIDS treatment services. At BMC, there are models being developed to ensure tracking of patients to maximize adherence to care and treatment regimens and if scaled up, these models can be a national example for best practices. The inclusion of PLWHA and their families and communities will help to overcome the obstacles to an effective response, including denial, stigma and discrimination.

Since the supply chain management of drugs and supplies related to HIV/AIDS services is done by the Medical Stores Department (MSD), concrete linkages to MSD will be established. Basic training on the technicalities of drug quantification and ordering to prevent stock outs, maintain proper records and reporting is critical, and will be conducted. "SWAT" teams, consisting of a clinical expert and a pharmacy expert,(refer to the JSI/ARV drug activity narrative for more information) will operate in the Lake Zone to establish linkages between the MSD and BMC and other health facilities in the area to help develop a seamless supply chain management system in the Lake Zone.

To implement these activities as rapidly as possible, and thereby build treatment capacity and an integrated roll out plan, discussions will be initiated with the District Medical Officers, USG partners working in these sites, (particularly AIDSRelief and Columbia University (CU)), and other stakeholders. AIDSRelief will continue to provide direct technical assistance to BMC and CU will support sites in surrounding regions.

Building on Tanzania's network model, this referral hospital, with its strengthened clinical staff and capacity, will become a focus of capacity building for lower level health facilities.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	1	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	500	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Kagera

Kigoma

Mara

Mwanza

Shinyanga

Tabora

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	Project HEART
Prime Partner:	Elizabeth Glaser Pediatric AIDS Foundation
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	3494
Planned Funds:	[redacted]
Activity Narrative:	The funding for the activities described here includes central funds [redacted] and planned in-country supplementation of [redacted]

In its first year of implementation, despite delays in receipt of ARV's, EGPAF's Project HEART supported four ART sites: Muhimbili (Dar), Morogoro Regional Hospital (Morogoro), Kilimanjaro Christian Medical Centre (KCMC) and Mawenzi (both in Kilimanjaro). In the second year, EGPAF received [redacted] through the in-country FY05 COP to support four additional sites: Village of Hope (Dodoma), Kibongoto TB Hospital (Kilimanjaro), Tumbi Regional Hospital (Pwani/Coast), and Kitete Regional Hospital (Tabora). With [redacted] in FY05 Rapid Expansion Funds, EGPAF proposed a Family Care Centre (FCC) within one of their current sites, KCMC, with the purpose of expanding pediatric AIDS care in the Kilimanjaro region and nationally. In concert with the new MOH strategy of regionalization of partners, EGPAF will focus and consolidate future PMTCT and ART programs in Kilimanjaro, Tabora and Arusha.

Although only four sites have been supported in the past one and half years, and four more sites have just begun treatment and care services in the past six months, over 4,600 patients have been provided care and treatment. Almost 40% are receiving ART and over 10% are children. In FY06, following the existing Government of Tanzania network model, EGPAF will expand to four lower level sites in the Kilimanjaro region: Hai District Hospital, Machame, TPC and Kibosho Mission Hospital. Although there are currently no Project HEART sites in Arusha, EGPAF plans to incrementally phase in care and treatment in Monduli, Ngorogoro District Hospital and AICC. By September 30, 2006, in all EGPAF sites, ART will be provided for an additional 4600 patients, and 20% of them will be children, with a higher proportion of less than 3 years olds compared to previous years.

In addition to ART funding, EGPAF also receives PMTCT funding for the Call to Action (CTA) program (see PMTCT EGPAF activity narrative). The ART program has focused at the tertiary and referral levels and CTA at the district and lower levels. PMTCT has been offered at the primary care level in antenatal care (ANC) and ART has been offered at the higher levels in part because of complex care and laboratory capacity required for ART. Among their sites, only in one site, KCMC, is EGPAF supporting both ART and PMTCT. Thus, great potential exists at several sites for creating linkages between adult, pediatric and PMTCT programs for the benefit of women, children, and their families. EGPAF will also ensure that support for basic quality PMTCT services are offered at its ARV sites. Through the CTA project and in collaboration with the ART program, EGPAF proposes to support 1000(800 adults and 200 children) on antiretroviral treatment at five PMTCT sites.
There are four sites in Tabora and one in Arusha, consistent with the regionalization of their efforts. In order to provide the technical and infrastructural support necessary for scale-up, EGPAF will provide training of health care providers, supportive supervision, infrastructure development, and community mobilization. A model for the integration of PMTCT and ART teams has been developed and will be piloted. In this model, both the exposed children and their HIV-infected mothers will be followed up at the Maternal Child Health (MCH) clinic for regular child care, vaccinations and non-ART HIV care, if necessary. The child will be tested at 15-18 months, unless either the mother or child is already eligible for treatment. If eligible, they will be sent to the ART clinic. An interdepartmental team of MCH and ART service providers will be formed to enhance referrals.
EGPAF has conducted training in pediatric AIDS care not only for health care providers in the sites it currently supports but also in non-EGPAF supported sites. Despite this effort, the enrollment of children into ART has remained low nationwide, and few are below 3 years of age. EGPAF has held discussions with the MOH and

other stakeholders on this issue, and is planning a targeted evaluation of why so few children are on ART within its sites. In FY06, EGPAF will continue training health workers in ART and specifically, with the support of Baylor, in pediatric ART. In collaboration with other partners, health care workers in non-ART facilities around the ART sites will be trained in basic pediatric AIDS care to improve referrals and provide preventive treatment for children identified early in the course of their illness. Training on collection of samples for early diagnostic tests, including the dried blood spot technique for specimens from distant health facilities will be conducted. However, formal training will be insufficient to increase the number of children on treatment; therefore, in collaboration with the African Network for the Care of Children Affected by AIDS (ANECCA), EGPAF will utilize regionally available pediatricians and nurses experienced in the care of HIV infected children to provide preceptorship to all sites. As local Tanzanian providers gain the requisite skills, they too will provide this mentorship.

With the support of JSI, an M&E and Quality Assurance Specialist has been recruited for the sole purpose of supporting the sites in continuous quality improvement. In particular, the sites will be assisted in developing systems for efficient data collection, on-site data utilization and dissemination including reporting to the MOH and supporting agencies.

Strategies to achieve these targets and project goals include intensive community sensitization programs to actively increase ART access and follow-up of patients in the community. HEART will develop/improve patient tracking systems, develop "treatment supporters" who will encourage community members to access ART and encourage ART compliance, and enlist the support of PLWHA that are already on treatment and willing to act as volunteers for both patient support and for patient tracking in communities. Health workers in non-ART departments as well as those in the lower health units that refer patients to the ART sites will be sensitized regarding ART and trained on non-ART care of PLWHA. In addition, Project HEART will facilitate regular meetings in the hospitals between the various departments and programs (VCT, PMTCT, Pediatric wards and other wards) to strengthen inter-departmental communication and referrals

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	16	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	6,400	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	13,418	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	12,747	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	1,011	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Arusha

Kilimanjaro

Morogoro

Tabora

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: University Research Corporation, LLC
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 3511
Planned Funds:
Activity Narrative: FY05, URC's Quality Assurance Program (QAP) implemented a Quality Improvement Collaborative to improve diagnosis, support, and care & treatment of children with HIV and other severe illnesses in the Dar es Salaam region.

FY05 major accomplishments included strengthening pediatric components of National HIV/AIDS Care & Treatment Guidelines, adaptation of WHO Referral Care Manual for first-referral level facilities, and Management of the Child with Serious Infection or Severe Malnutrition. This process included significant additions to the chapter on the management of HIV/AIDS in children relative to a Tanzanian context.

In the area of patient care and systems strengthening, activities included training on Emergency Triage Assessment & Treatment (ETAT) of critically ill children in facilities to address high mortality of children less than 5 years, case management of seriously ill children to reduce mortality from common childhood conditions such as pneumonia, malaria, fever, diarrhea, and malnutrition, and the identification and coordination of care for HIV patients.

Additionally, due to lack of information and stigma, health workers avoid addressing issues of HIV in pediatric patients. Facility teams have been trained in an HIV screening algorithm so that they can identify potential pediatric HIV patients. Mechanisms for counseling, testing and referral to the Care and Treatment Teams have been set up in these facilities. All facilities supported are also tracking indicators for both clinical management of patients and coordination of care for HIV patients. Quality improvement cycles are being used to implement change.

Building on the success of FY05, in FY06 URC will consolidate achievements in patient care and coordination of care by strengthening programs of ETAT and increasing numbers of individuals trained in ETAT as well as reducing <5 years mortality from common illnesses by focusing on case management of common causes such as malaria, pneumonia, fever, diarrhea, malnutrition and HIV/AIDS. Activities will also track improvements in case management by introducing Critical Care Pathways which must be completed for every patient and can be reviewed at the end of the month for quality of admission diagnosis, treatment, and further in-patient care.

URC activities will also scale up sites in the Northern Zone and Southern Highlands Zone utilizing existing Zonal Training Centers, as well as hand over existing sites in Dar es Salaam to the facilities themselves. We expect that limited follow up will be required after finalizing the collaborative training schemes.

Additional activities in FY06 include addressing the continuum of pediatric care (Household to Hospital) for pediatric HIV and severely ill patients. To do this we will select one site (possible Morogoro Urban) as a model to institutionalize the continuum pediatric care. We will also address opportunities to scale-up the collaborative in the following areas: Kinondoni, Ilala, Temeke, Kibaha, Manyara, Arusha, Moshi, and Muheza. Also Iringa, Makete and Mbeya (where the MOH is planning a PHI Collaborative).

Lastly, QAP will continue to strengthen linkages and partnerships with other implementing partners such as Harvard, EGPAF, Columbia, and AXIOS who are providing ART and PMTCT in facilities in which we work as well as local institutions working in pediatric care.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Orphans and vulnerable children

People living with HIV/AIDS

Children needing ARVs

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Dar es Salaam

Morogoro

Pwani

Arusha

Iringa

Kilimanjaro

Manyara

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	US Department of Defense
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	4939
Planned Funds:	
Activity Narrative:	This activity relates to activities in treatment (Mbeya Referral Hospital, Mbeya Regional Medical Office, Rukwa Regional Medical Officer, Ruvuma Regional Medical Office, PharmAccess).

The US Department of Defense (DoD) will provide technical and managerial support to two primary programs: the Walter Reed HIV/AIDS Care Program in the Southern Highlands and activities with PharmAceess International and the Tanzanian Peoples Defense Forces (TPDF). The DoD, has been working directly with the Mbeya Referral Hospital since June 2004 in rolling out treatment throughout the Southern Highlands. Initial efforts were focused towards the Referral Hospital itself and by September 2007 it will span three regions (Mbeya, Rukwa and Ruvuma), over 10 facilities with more than 4,500 on treatment and another 9,000 with care. In support of this effort, staff and technical assistance (TA) specifically dedicated to the treatment program area are included in this submission.

The Clinical Care Program Director directly supporting the US Department of Defense's Walter Reed HIV/AIDS Care Program in the Southern Highlands, is a US physician, retired Army, with over 20 years of experience in providing ART to HIV positive individuals. This individual works as a member of the Mbeya Referral Hospital, fully accredited to practice medicine in Tanzania. He has worked with the Department of Internal Medicine at this facility to help establish its HIV Care and Treatment Center (CTC) as well as help maintain its day-to-day operations. Along with MOH employees at the facility, he also works directly with the three regional medical offices listed above to adapt CTC standard operating procedures to their particular needs. With the assistance of three FSN equivalent technical advisors, hired by the DoD (one physician, clinical officer and nurse), and Mbeya Referral Hospital personnel, the Walter Reed Program undertakes supportive supervision throughout the Southern Highlands for all CTCs. Where there is overlap with TPDF facilities in the Southern Highlands (Mbilizi in Mbeya and Songea in Ruvuma), this team will also be involved in providing on the ground assistance.

In addition to in country personnel, the DoD offers excellent US based TA in this area. Clinicians and laboratory personnel for support of treatment efforts make routine visits to Tanzania primarily in support of military-to-military efforts with the TPDF. This technical assistance includes, but is not limited to, development of quality assurance/quality control measures for care and monitoring, standard operating procedures in both clinic and supporting lab services, and patient record management. This TA will require on average quarterly visits by two personnel for approximately one week each trip. The cost estimate of each TA visit will include airfare, per diem and lodging.

Funding under this submission will support salary and benefits for the Clinical Care Program Director as well as all US-based TA.

Emphasis Areas	**% Of Effort**
Human Resources	51 - 100
Local Organization Capacity Development	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mnazi Mmoja Referral Hospital
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5318
Planned Funds: [redacted]
Activity Narrative: A program announcement for building the capacity of the referral hospitals to provide a continuum of HIV/AIDS services in the areas of PMTCT, ARV services, counseling and testing and laboratory was made in FY05. The recipients of these funds have just been determined and the notice of grant award has just been received. The Mnazi Mmoja Hospital (MMH), in Zanzibar was awarded [redacted] for the combined scale-up of services in these program areas in FY05. The planned funding above is to continue this program into FY06.

Zanzibar is made up of the two sister islands of Unguja and Pemba with a total population of 984,625. HIV/AIDS has been prioritized by the government in Zanzibar since the identification of the first three cases in 1986. MMH is linked to the College of Health Sciences as a teaching hospital as well as serving as a referral hospital for both islands. A notable milestone in their history has been in their pioneering the provision of supportive care and management of opportunistic infections even when HAART was still unavailable.

The availability of ART, and provision of laboratory monitoring equipment with the ongoing support from the USG and other partners, has increased the potential for MMH to be a model for comprehensive ARV service provision. The Ministry of Health and Social Welfare (MOHSW) has identified the MMH as an entry to the expansion of ART services scale-up. With prior USG support, the identification and training of ART trainers has laid a strong foundation for the institution to be the centre of training a within Zanzibar. The recently developed partnership with Columbia University, Clinton Foundation and WHO in developing internal human resources and building capacity for the provision of ART/PMTCT to Zanzibar gives MMH the lead in offering training to other institutions in the country. Based on this, the MOHSW through ZACP fully intends to develop MMH into a centre of excellence that will provide training opportunities to other institutions (public and private hospitals) in the country.

Creating a continuum of care is a multi-faceted and multi-dimensional intervention that requires well orchestrated coordination and harmonization. Therefore, in collaboration with the USG and other partners, particularly the Clinton Foundation, MMH will introduce its patients to a continuum of care. MMH will work under the guidance of the Zanzibar AIDS Control Program (ZACP), the coordinator of all HIV health sector interventions as it implements this continuum of care.

In FY06, given the country context, the goals for this award will be to reduce stigma and create demand for care and treatment services. The activities will focus on four areas: 1)establishing a comprehensive counseling and testing service at MMH, 2)strengthening community home based care interventions, 3)establishing linkages with faith based institutions, civil service organizations and community based organizations and 4) offering ART/PMTCT training and guidance to lower level ART sites.

In support of the ART program goals, the rolling out of ART/PMTCT trainings will be organised and conducted by ZACP. Through their care and treatment unit (CTU), MMH will ensure the scale up training. Therefore, this award to MMH only supports the programmatic component of implementation. These activities will be conducted under the auspices of the MMH with technical guidance from the ZACP CTU. Therefore, MMH's first year plan is to build consensus amongst all stakeholders and organize the development of the national training plan for continuum of care. To this end, they will schedule and convene quarterly meetings and annual reviews; finalize, print and distribute guidelines and manuals and other related teaching aids; conduct

regular monitoring and evaluation of each program component and generate reports and analyses to improve program effectiveness. Through these activities, MMH will support the training of 270 health providers within 15 MTCT+ and ART sites by September 30, 2006 and 570 health providers in 22 sites by September 30, 2007.

Building on Tanzania's network model, this referral hospital, with its strengthened clinical staff and capacity, will become a focus of capacity building for lower level health facilities.

Emphasis Areas	% Of Effort
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	22	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	570	☐

Target Populations:

Community-based organizations

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health - Zanzibar, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5319
Planned Funds:
Activity Narrative: HIV/AIDS has been acknowledged as a priority on the national agenda since the identification of the first three cases in 1986. The current HIV prevalence in Zanzibar is 1%. Currently 10,000 people are living with HIV/AIDS on the island, of which approximately 3000 may require antiretroviral (ART) by 2006.

The Health sector of the Zanzibar AIDS Control Program (ZACP) has been the hub of coordination for all HIV interventions related to the HIV/AIDS health response. ZACP's primary objective is to coordinate and develop quality and sustainable national HIV/AIDS interventions, including the provision of treatment and care for patients with HIV/AIDS Zanzibar. The over all objective of ZACP is to reach at least 80% of PLWHA with care and to provide treatment for those in need by 2008. To date through USG support, ZACP has established a Care and Treatment (C&T) Unit within the ZACP; the unit has a national coordinator and support staff. This unit is responsible for the development of national C&T systems including training manuals, protocols/guidelines, monitoring system and the overall C&T services coordination.

With FY05 funding, ZACP focused on building the capacity of the C&T coordinating unit to manage the national HIV/AIDS response effectively. However, the unit still requires more organizational management and capacity development.

In FY06, funding will support ZACP the development and institutionalization of the national C&T system. This will include the ART management guidelines, pediatric care and treatment protocols, HIV/AIDS IEC training manuals and a drug management logistics system. The C&T unit will form a technical working group that will develop, review and finalize the content of these systems. This unit will organize and facilitate quarterly meetings for the recently developed national care and treatment steering committees and will develop national C&T roll out plans. In addition, a critical activity that FY06 funding will support includes the development of national facility accreditation tools and the formation of teams to carryout site readiness assessments for ART service initiation. This team will also provide supportive supervision and technical assistance to all ART implementing sites. Furthermore, the C&T unit will train trainers of trainers to work closely with referral hospitals to ensure adequate training for service providers.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	20	☐

Target Populations:

People living with HIV/AIDS

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American International Health Alliance
USG Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5344
Planned Funds:
Activity Narrative: This activity links to other activities under ART service/treatment and ARV drugs.

The Ministry of Health (MOH) in Tanzania has set an ambitious goal for national expansion of ART services over the next several years. With one main facility providing treatment to only 700 patients just over a year ago, the MOH's National AIDS Control Programme (NACP) looks to expand services to 200 sites supporting a total of 100,000 patients on ART by December 2006. Combined efforts of the NACP, USG and other bi-lateral donors have seen the introduction of services in 96 hospitals and growth of the patient population to over 14,000 in just the past 12 months. USG partners directly support treatment of over 75% of the patient population though only working in 25% of these sites. Though the increase in services has been encouraging, the rate of expansion is insufficient to reach the large HIV+ patient population desperately requiring treatment as well as meet NACP goals within the given time frame. In addition, though the large part the USG partners are playing in roll out is impressive, it is also daunting as funding levels and management capacity may limit the ability of these partners to expand substantial support directly to multiple sites.

Many of the remaining 75% of the hospitals and facilities considered accredited to provide treatment by the NACP, and which are already receiving ARVs, have either not enrolled significant patient populations or have refused to begin treatment. This is in large part due to the lack of experience and comfort of the medial teams at these facilities in staging, enrolling and monitoring patients on ART. As one of the major contributors to HIV treatment in Tanzania, the USG has been working with the NACP to determine a mechanism(s) by which support can be provided to maximize the roll out and the development of local capacity required for sustainable services. In an effort to support the rapid expansion of ART services in Tanzania and support many of these sites, we intend to develop a corps of preceptors who will work at treatment sites which otherwise would not receive direct support from the USG. These individuals, provided through the Twinning Center, will be a physician/clinician who has experience in the provision of HIV palliative clinical care and ART. The role of the preceptor will be to serve as on-site guidance for staff within the facilities, supporting up to three sites each. He/she will provide supportive supervision and mentoring for staff.

There are two models which we are exploring for these preceptors: Model 1 has them based in a Regional or Referral Hospital, thus allowing HIV/AIDS trained existing local staff to more freely provide support to other treatment facilities lacking support in their zone or region. The benefit of this model is that it would allow Tanzanian staff with language skills from higher-level facilities to provide technical assistance to lower level facilities. The preceptors would then serve as back-ups at the higher-level facilities for the local staff who would be supporting the new facilities. Model 2 has preceptors teaming with local clinical staff and together, they would support new facilities. The model that will actually be implemented may differ by zone and may depend on the type of staff available to serve as preceptors. Ideally, we would like to find preceptors with some knowledge of the local language. Given that this may be challenging, the first option may be more feasible. In addition, we would not want to drain local staff at the exact time that we are seeking to build up capacity in all sites.

Regardless of which scenario is chosen, we expect the rollout of these activities will take place in conjunction with the creation of the zonal SWAT Teams (these teams work on supply chain management, with a focus on creating linkages between zonal Medical Stores Departments and health facilities; see the JSI/ARV Drugs activity

narrative for more information) and will work through similar infrastructure and transport (such that a team consisting of logistics and clinical staff will concurrently provide technical assistance, providing a full range of support services). This enhanced team will work in concert when feasible, although the preceptors may assume a prolonged role at a site, spending a week or more at a time to provide adequate supervision and mentoring.

The rationale behind the preceptorship is to increase coverage of services across the country for patients requiring ARVs. We expect to employ a mixed model consisting of direct service provision in some sites in addition to preceptors in other sites. The model will be supported with training, logistics, drug procurement and information system development for sites where we are do not have a USG partner on site.

Through this twinning we expect to bring on a consortium of technical partners who will collectively provide between 25 and 50 staff over the course of the year. Given the level of expertise requested, it may not be realistic to expect any given individual to remain in-country for more than three to six weeks at a time; however, we will strive for maximum availability. The longer that staff are available in-country, the more services they can provide, and the more comfortable they will be in the surroundings.. Regardless of the exact amount of time spent, we believe the high level of expertise brought into Tanzania will allow us to further support the governments plan to place 100,000 on ART by the end of 2006, particularly in the more difficult to reach sites where, anecdotally, we have heard the current staff feel inadequately trained to initiate complex treatment regimens.

Emphasis Areas	% Of Effort
Local Organization Capacity Development	51 - 100
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	50	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,528	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	10,000	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	10,000	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	250	☐

Target Populations:

Doctors (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
Public health care workers
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Private health care workers
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Other health care workders (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Harvard University School of Public Health
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5384
Planned Funds:
Activity Narrative: This activity relates to the scale-up of the Muhimbili University College of Health Sciences (MUCHS)-Dar es Salaam City Council (Dar City) -Harvard School of Public Health (HSPH) Program (The MDH Program). Between the start of the program in November 2004 and August 2005, 4096 patients have been enrolled in care and treatment, including 412 children, 34 pregnant women, and 175 TB patients. Of these, 2111 are on ART, and more than 50% of the remaining patients on care are eligible for ART and will be initiated as more drugs become available. Over the last two years, by building on the strengths of the collaboration between MUCHS, Dar City and HSPH in Dar-es-Salaam, capacity and quality of the program has increased to cover all aspects of HIV care and treatment. The current program will expand from 4 district hospitals, Amana Hospital, Mwananyamala Hospital, Temeke Hospital, and Infectious Diseases Center (IDC) to 7 health centers in all 3 districts of Dar es Salaam, leading to a significant and rapid increase in the number of patients on care and treatment.

Activities proposed at these health centers include clinic-based counseling and testing, evaluation of patient eligibility for ART, pediatric care and treatment, treatment of opportunistic infections, laboratory services, strengthening of home-based care, training, quality assurance and monitoring and evaluation components. In addition to sustaining activities for the patients enrolled by the end of the implementation year, MDH will expand services to an additional 1600 patients on care and another 1600 on treatment. To build a more comprehensive program, MDH will also scale up activities in the area of TB/HIV integration focusing on one TB clinic for the proposed period. MDH will also develop a strong PMTCT component (for more information, see Harvard activity narratives in the PMTCT and TB/HIV program areas). As the program expands, there are plans to develop greater capacity to serve non-MDH programs in Dar es Salaam and other parts of Tanzania in the areas of laboratory quality and diagnostic services as well as training in care and treatment.

To implement this activity, discussions have been initiated with the District Medical Officers in all three districts regarding initiating care and treatment at the following 7 sites: Sinza, Mbagala Rangitatu, Buguruni, Tabata, Tandale, Kigamboni, and Mnazi Moja. These health centers focus on urban and semi-urban populations of the City of Dar es Salaam and cater to an important segment of the HIV positive population which has limited access to care and treatment and hence have a great demand for such services.
Infrastructure at these sites will be strengthened by training existing staff and recruiting additional personnel. All new and current staff will be trained on various aspects of HIV care and treatment. Training sessions will be planned for medical doctors, nurse counselors, home based care providers, and pharmacy and lab personnel. The existing training facility will accommodate 20 people at each session. Not all sessions will be providing training to new staff, since there is a strong program for continuing training for all cadres of health care workers to maintain quality care and treatment.

Limited renovation of physical structures is planned to ensure optimal utilization of space and resources. Furthermore, there will be a strong focus on the development of networks, linkages and referral systems among various stakeholders. This will be achieved using specific referral forms and educating patients and providers on the importance of referrals and follow-up. To that effect, a strong link will be put in place between the proposed health centers and current MDH sites, and between the health centers and community-based networks. The MDH home based care (HBC) program will be strengthened. The HBC providers who are part of the city will be

trained and new personnel hired. This will further develop the existing systems. There will be specific counseling for defaulters to ensure that they understand the importance of treatment. Basic service needs will continue to be provided by HBC personnel. Measures will be taken to ensure that by strengthening existing health systems the foundations of a locally sustainable program will be built in the long run.

Special efforts will be made to counsel patients, and train health care personnel and the community in general to ensure proper adherence to ART and to the elements of monitoring and care. This will include training sessions for health care workers, IEC activities and counseling for patients and community members. Laboratory capacity at the proposed health centers will be developed in a similar way to what has been completed for the district hospitals. This involves purchasing, upgrading and maintaining essential equipment if necessary, training laboratory personnel on appropriate procedures and ensuring quality control through proficiency testing. Thus, the health centers will be able to undertake hematology, clinical chemistry tests and possibly CD4 tests. The MDH central lab at Muhimbili will provide quality assurance using a training scheme and a proficiency testing program (including blinded specimens). In order to reduce stigma and discrimination (key legislative issue) towards PLWHA, the number of community care and support groups for PLWHA will increase and the existing system will be used to actively mobilize the community to seek VCT and services at all MDH sites.

Through these activities, MDH will enroll and maintain a total of 5000 PLWHA on treatment by September 30, 2006 and will scale-up to a total of 6600 by 2007. Planned funds include USD 254,000 for capital costs to support the development of infrastructure at the proposed additional clinic. The balance of 701,000 will be used to initiate 1600 patients on ART and provide care for an additional 1600 patients. This translates to a cost per patient of USD 438 factoring in only the 1600 on ART; or USD 219 if the total of 3200 patients on care and treatment are used in the calculation.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	8	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,600	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	6,600	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	6,600	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	240	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Public health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Dar es Salaam

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	AIDSRelief Consortium
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	5505
Planned Funds:	[redacted]
Activity Narrative:	Planned funding for this activity is in addition to [redacted] in central funds that will be awarded in March 2006.

AIDSRelief, as a faith-based consortium, has the ability to harness not only the secular health system but also the extensive network of faith-based institutions in Tanzania for scaling up ART services. These faith-based institutions provide between 40-50% of all health services in the country. They are firmly embedded into communities, and from current activities, have the proven ability to develop strong outreach models to support patient adherence to ART. One of the reasons for AIDSRelief's success is that it builds upon previous relationships with these communities through the Interchurch Medical Assistance (IMA), and Catholic Relief Services (CRS).

Within their current sites, PASADA (Dar Es Salaam), Selian (Arusha), Haydom (Manyara), St. Elizabeth (Arusha), Muheza (Tanga), Bugando Medical Center , (Mwanza) and Mvumi (Dodoma), AIDSRelief is currently supporting 2700 patients on ART in seven points of service (POS) in six regions. Their initial year one (February 2004 to March 2005) target was 3,000 patients and their revised year two (February 2005 to March 2006) target is 3800. By September 06, these POS expect to place 5772 patients on ART, of which 13% will be children.

Under the Ministry of Health (MOH) strategy of a geographic focus for all ART partners, AIDSRelief will eventually move towards a concentration of effort in the Lake Zone (not including Kagera), Manyara and the Tanga region. However, AIDSRelief will fully support 7 POS through September 2006. In FY06, Pasada and Selian will receive direct USG funding. The remaining 5 POS will continue to receive support from AIDSRelief until such a time that 2 of their POS, St. Elizabeth and Mvumi Hospitals, can be supported by other partners under the geographic realignment strategy.

AIDSRelief's comprehensive quality care and treatment for HIV infected people will continue through institutional support and technical assistance. Their approach in FY06 will focus on 4 major areas: 1) Building community outreach and program integration: Within their POS, AIDSRelief will continue to advance integrated service delivery. Through links with CRS, IMA and other Home Based Care (HBC) and community outreach programs; they will expand the network of ART treatment helpers to support adherence and secondary prevention. Through a family centered approach and integration within primary pediatric health care, AIDSRelief will continue to focus on increasing the number of children diagnosed, counseled and tested and the development of staff capacity to provide pediatric ART. 2) Developing linkages with TB/HIV co-infection: AIDSRelief began establishing linkages FY05 between voluntary counseling testing centers (VCT) and TB and their HIV clinics. These will be strengthened in order to ensure that TB patients are screened for HIV and HIV patients are screened for TB. Six of the seven current POS (all except Haydom) have VCT and TB linkage projects. These activities are described in more detail within AIDSRelief Palliative Care: TB/HIV activity narrative. 3) Strengthening ART Monitoring and Evaluation: The Institute of Human Virology, with the support of Futures group, will continue to provide onsite technical assistance (TA) to POS to strengthen their capacity to fulfill reporting requirements and monitor program success. MOH data collection tools will be incorporated into an AIDSRelief software package for easy monitoring and reporting. The TA will include quality improvement and tracking

identified health indicators that affect a patient's long-term treatment outcome. 4)Wrap around services: As is widely recognized, the Emergency Plan encourages leveraging of other resources, as Emergency Plan funds are for targeted assistance that may not always support a comprehensive package of care for ARV clients. In recognition of that fact, AIDSRelief has actively sought out other resources to complement the activities supported by the Emergency Plan. AIDSRelief members do so through their links with small Christian communities, PLHWA groups and their HBC programs. Wrap around efforts include a World Food Program (WFP) nutrition program targeting ARV clients at Selian and Muheza, and a newly initiated agro-enterprise intervention targeting BMC clients through the USAID Economic Growth unit. More opportunities will be sought for leveraging of resources.

By September 30, 2006, AIDSRelief will place 5772 patients on ART, with an average loss of 7% due to mortality and loss to follow-up. By September 2007 an additional 1950 will have been initiated on treatment to achieve a target of 5832 patients ever receiving ART. The reduction in targets between 2006 and 2007 is due to the transition of AIDSRelief out of PASADA and Selian at the end of FY06, where they have supported a large number of PLWHA on treatment

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	5	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,950	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	5,832	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	5,425	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	33	☐

Target Populations:

Faith-based organizations

HIV/AIDS-affected families

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Religious leaders

Public health care workers

Private health care workers

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Manyara

Mwanza

Tanga

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Country staffing and TA
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5506
Planned Funds:
Activity Narrative: During the next fiscal year, HHS/CDC will continue to collaborate closely with the Government of Tanzania, Ministry of Health (MOH), and other key partners to further strengthen technical and program capacity for implementing the Emergency Plan. This will include the establishment and expansion of quality-assured national systems in the areas of surveillance, prevention of mother to child transmission (PMTCT), laboratory services, blood safety and blood transfusion, antiretroviral treatment, care and TB/HIV programs.

HHS/CDC provides direct technical support for all of its HIV/AIDS programs through US and Tanzania based organizations, which manage and implement in-country activities. These activities are funded through cooperative agreements and are performed at the field level in direct partnership and collaboration with Tanzanian governmental and non-governmental organizations. The non-governmental implementing partners have considerable experience in the field of HIV/AIDS and have established offices in Tanzania to carry out these activities. The technical assistance (TA) and support provided by HHS/CDC through our cooperative agreements will ensure a long-term sustainable system for providing HIV/AIDS services to Tanzanians.

In FY06, this funding will support in-country ARV services program staff and fund TA from CDC Headquarters. These staff will provide technical assistance to the Government of Tanzania and oversee the work of four central CDC cooperative agreement awardees working in Tanzania. These awardees will implement care and treatment activities based on the latest relevant science, translated into program guidelines and practices for both antiretroviral (ARV) implementation and prophylaxis of opportunistic infections (OI). Staff will provide TA in developing program plans and reviewing and evaluating program implementation.

Emphasis Areas	% Of Effort
Human Resources	51 - 100

Target Populations:

USG in-country staff

USG headquarters staff

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mbeya Referral Hospital
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5507
Planned Funds:
Activity Narrative: This activity also relates to activities in counseling and testing (Mbeya Referral Hospital and Mbeya Regional Medical Office), palliative care (KIHUMBE and HJFMRI), treatment (Mbeya, Rukwa and Ruvuma Regional Medical Office, DoD TA), Lab (Mbeya Referral Hospital, AMREF, ASCP, CDC TA, RPSO), and SI (DoD).

The Mbeya Referral Hospital (MRH) is one of five zonal hospitals in Tanzania. Its function in the Southern Highlands is to provide training, to coordinate and oversee the quality of treatment and to establish health service referral systems among four regions (Mbeya, Iringa, Rukwa and Ruvuma) serving a catchment population of over six million people. Emergency Plan support through the US Department of Defense is assisting this facility in realizing it role as a zonal center of excellence in clinical prevention, care and treatment. Initiated in FY05, under Emergency Plan funding and multiple donor support, an extensive infectious disease medicine clinic/training facility and a referral level laboratory at this hospital are being developed. Under this submission, funding will support the referral hospital in its role as a training center for HIV care, technical supervisor for the services in the Mbeya, Rukwa and Ruvuma Regions, and provider of direct patient treatment.

In FY06, the Mbeya Referral Hospital will have established a regional and national, certificate level training program at this facility based on the current national curriculum in close concert with the National AIDS Care Programmme's (NACP) Care and Treatment Unit. Over 300 clinicians, pharmacists and laboratorians have been trained at this facility to date through the NACP's six-day quick start course. Funding under this submission will assist in the training of an additional 150 medical personnel representing the Southern Highlands and other regions of Tanzania in comprehensive HIV care by September 2007. The training curriculum to be implemented as part of the new certificate course is a result of a collaborative effort between the German Technical Cooperation (GTZ) and the NACP with the USG offering technical assistance in implementing the training.

In FY06, the USG will complement clinical training with instruction for laboratory technicians in the zone on required safety labs and advanced monitoring techniques for HIV-positive individuals. This will be linked to the submission under Lab and include collaborative efforts among the Referral Hospital, American Society for Clinical Pathology (ASCP), African Medical and Research Foundation (AMREF), CDC and the U.S. Department of Defense (DoD) – its main US Agency partner. All of the training at the referral hospital will be directly linked and integral to service provision at this facility. In partnership with CDC and the central laboratory in Dar es Salaam, the lab at the referral hospital will execute a quality assurance program and supervision of regional health facilities.

The Mbeya Referral Hospital serves not only as a referral and training center but also as a primary care facility. With assistance from the MOH and direct Emergency Plan FY05 funding, the Referral Hospital has been able to initiate a large scale ART program. Though it was only able to begin full recruitment of patients in January 2005, it now boasts a patient-load of over 800 on ART and 2,000 on care. Though it experienced a slow start, it is well on its way to meeting its September 2006 ART targets of 2,000, enrolling over 200 new patients a month. In FY06, it will continue to expand direct ARV treatment to reach an additional 1,000 individuals, bringing the total under ART at this facility to 3,000 and under care to 4,500 by September 2007.

Currently, the referral hospital provides technical supervision to four additional hospitals in the Mbeya Region supporting a total patient population of 1,200 on ART

and another 3,000 with care. The number of facilities under its supervision will expand to an additional six in FY06 and by at least another three in FY07. Supervisory teams from the referral hospital consisting of a medical officer, clinical office and nurse attend clinic days at lower level facilities once or twice a month overseeing patient enrolment, initiation of treatment and continued monitoring. As treatment is expanded in the Southern Highlands, the referral hospital will help establish supervisory teams out of the regional hospitals which will in turn take over supervision of the district and mission hospitals within that region.

HIV-positive children are identified through PMTCT programs supported at Meta Hospital, the zonal referral maternal child health facility, as well as smaller health centers in the Mbeya Municipality. Through these sites, the pediatric ward at the referral hospital, and linkages with over ten NGOs and FBOs providing support to OVCs in the Municipality, pediatric cases are identified and evaluated for treatment. Currently over 11% of the ART and care population is between the ages of zero to 14 years. Experience from other USG partners focusing on the family care model will be used to inform program elements in improving the percent pediatric caseload and treatment in the Southern Highlands.

As part of ensuring the continuum of care, the Mbeya Referral Hospital works in close concert with several NGOs and FBOs in the Municipality. These organizations not only assist in patient identification and referral to the HIV Care and Treatment Center (CTC) at the hospital but provide at home follow up of patients under treatment. These referrals are supported through a social worker placed at the CTC. Mentoring of these organizations with medical officers from the CTC provides additional capacity for these groups in this role.

Funding under this submission will support continued development of the hospital in its role as a zonal center for training of clinical personnel, reagents for continued monitoring of patients, drugs for OI prophylaxis (including cotrimoxazole) and treatment, ART, supportive supervision to the zone, strengthening of zonal referral mechanisms and patient tracking (linked to SI section), and expansion of the community referral system and technical support to participating NGOs and FBOs. ARVs will be supplied by the MOH and funding under the JSI/USAID submission.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	1	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	1,300	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	3,300	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	3,000	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	150	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Coverage Areas

Mbeya

Table 3.3.11: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Pastoral Activities & Services for People with AIDS
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	5560
Planned Funds:	
Activity Narrative:	The Pastoral Activities and Services for People with AIDS Dar es Salaam Dioceses (PASADA), has been operating since 1992, when a small group of people with HIV gathered to seek mutual aid and support. It has grown rapidly to meet the exploding demands of the HIV pandemic in urban Dar es Salaam. Operated under the auspices of the Roman Catholic Church, services offered by PASADA are available to all individuals without discrimination of any sort and completely free of charge. PASADA provides a wide range of HIV/AIDS services: voluntary counseling and testing (VCT) – including training and continuous supervision of new VCT counselors assigned to both church and government health facilities; home-based care (HBC) – including training and supervision of new HBC providers assigned to both church and government facilities; educational, psychological, social, nutritional, and economic support to families with orphans (at present over 2,000 orphans), and vulnerable children; health education and prevention in the communities, mainly through regular school classes based on the "Stepping Stones" curriculum; diagnosis and treatment of opportunistic infections; prevention of mother-to-child transmission (PMTCT), using a standard protocol applied in more than half of the 15 existing Diocesan Health Facilities. All of the above activities are carried out in accordance with the National Policy on HIV/AIDS with the Tanzania Commission on AIDS (TACAIDS) Multisectoral Strategic Framework on HIV/AIDS and in collaboration with Regional/District Health Authorities. The catchment area for PASADA Upendano Clinic and the 15 diocesan health facilities is 800,000 individuals. The staff at PASADA consists of 53 Tanzanian nationals and four expatriate missionaries, each with expertise and training in providing health care and social services to people living with HIV/AIDS. PASADA has received additional recognition for the quality and range of their services, most recently during the visit of First Lady, Mrs. Laura Bush, who pledged continuing support to the site in order to allow them to continue their important mission. Activities in FY06 will include the expansion of anti-retroviral services. As of the end of FY05, PASADA provided services to 420 patients. This is expected to increase to 600 by the end of the calendar year. By the end of FY07 fully 1,200 patients are expected to be under treatment at PASADA. This level of expansion will push the boundaries of the capacity of the center, but as patients continue to arrive at PASADA, services must be provided. PASADA's clinical services are linked with home-based care providers who serve as volunteers to the site. Currently, there are over 150 volunteers, and the number continues to grow. In this way, the PASADA activities contribute to the continuum of care, allowing one site to provide the range of community and clinic based services.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Local Organization Capacity Development	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	1	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	700	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)	1,300	☐
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)	1,200	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	*10*	☐

Target Populations:

People living with HIV/AIDS

HIV positive pregnant women (Parent: People living with HIV/AIDS)

HIV positive infants (0-5 years)

HIV positive children (6 - 14 years)

Key Legislative Issues

Gender

Twinning

Volunteers

Stigma and discrimination

Wrap Arounds

Coverage Areas

Dar es Salaam

Table 3.3.11: Activities by Funding Mechanism

Mechanism: USAID TBD (former BBC)
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 5567
Planned Funds:
Activity Narrative: The new TBD will implement a mass media radio campaign which aims to deliver demonstrable improvements to knowledge, attitudes and behaviors relating to HIV/AIDS. Guided by the National Multi-Sectoral Strategic Framework on HIV/AIDS (NMSF) and the National Care and Treatment Plan, activities look to increase the number of Tanzanians seeking treatment, address stigma and discrimination and reduce the number of new HIV infections using entertainment formats to promote acceptance and recall of messages on sexual and reproductive health. The project is designed to run for 3½ years and consists of a variety of radio formats to broaden its appeal to a large number of Tanzanians, while allowing flexibility to address issues and concerns of specific population groups. An advantage to this type of programming is rapid adaptation of messages to incorporate emerging issues, which also benefits Tanzania's scale-up of available ARV services.

As demonstrated in Nigeria, Angola, India, and Cambodia, the TBD's approach to large-scale health campaigns will be based on a 'production partnership' model that forges alliances between government ministries and public and private broadcasters to create highly synergistic campaigns that benefit both public health and broadcasting objectives. In exchange for training and capacity building, local broadcasters donate airtime for all of the campaign's outputs. In Tanzania, outputs are delivered in Kiswahili under the guidance of the NACP and TACAIDS.

Radio listening is the most popular media outlet in Tanzania. In a 2002 survey, 81% of respondents claimed to have listened to radio within the past day. It is anticipated that the project will reach at least 10,000,000 Tanzanians (one-third of the national population), with important messages regarding comprehensive services across the prevention-to-care continuum. Radio broadcasters playing important roles in Tanzania include:
1) Radio Tanzania Dar es Salaam: A very strong rural audience.

2) Radio Free Africa and Radio One: Cover 75% of the country on FM and AM, with significant audiences in both urban and rural areas; RFA has the widest reach with 67% of potential listeners tuning in every week.

3) Additional partnerships with radio broadcasters and community radio stations will be forged if research indicates that specific messages are needed in key urban or rural areas.

Under FY06 Emergency Plan funding, the new TBD will build upon FY05 programming achievements to improve linkages within the prevention to care continuum through specific promotion of PMTCT services. In the ongoing effort to increase numbers of Tanzanians on treatment, assuring an understanding of the possibilities of preventing mother to child transmission among pregnant women is a vital issue. There is little understanding among women of reproductive age as to the possibilities of preventing transmission to their unborn children through delivery and breast milk and these are important messages to pass on. Understanding what is possible, and more specifically what is not is very important. Thus, the goal will be to develop messages specifically oriented to dispelling myths, misconceptions and stigma as related to PMTCT messages and concerns. Messages will focus on fostering improved understanding of what PMTCT services are, where they are located and how to access them.

PMTCT funding for FY06 will support a variety of media formats. Campaign outputs will target different population groups within Tanzania and will include:

1) A variety of radio spots and mini-dramas for segmented audiences will be produced and broadcasted frequently on partner radio stations through donated time. Radio spots of 30-60 seconds and mini-dramas of 60-120 seconds constitute a key component of the campaign as they can be carefully and rapidly targeted to address specific audiences and messages using drama, testimonies, comedy, music and celebrities to address the pertinent subject.

2) A weekly radio drama will deepen the linkages of all messages, enabling modeling of relevant life skills and positive behavior change. The serial drama formula is an excellent vehicle through which to explore the complex issues surrounding human relationships, life skills, societal norms and social environments that all have an impact on HIV epidemics. Through its characters such a drama can show the benefits of adopting certain behaviors and demonstrate that change is possible, increasing the sense of self-efficacy necessary for the adoption and sustaining of new behaviors. A key component to the drama is a follow-up interactive discussion program to be broadcast after each episode; Based on listener letters and input from a studio audience the intent is to explore the issues raised by the drama and to drive home the messaging of each episode.

3)Training of radio broadcasters to increase quality programming.

4)10,000,000 people reached.

The flexibility of community-based radio communications allows the weaving of multi-pronged messages into programming. Working together with NACP, TACAIDS, and other Emergency Plan partners to assure messages are appropriate, support policies, and are linked to services, the new TBD will work to strengthen links between local radio broadcasters and GOT thus enabling more effective health campaigning both during a project lifetime and in the future by increasing media skills in the Government sector and by working closely with local broadcasters to enhance their commitment and capacity to produce health programming. The new TBD, local radio broadcasters and GOT are developing a strong working relationship to provide a mechanism that will be responsive to Tanzanians needs for information across the full spectrum of prevention, care and treatment issues within the Emergency Plan.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Information, Education and Communication	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		☑
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		☑

Target Populations:

Adults

Business community/private sector

Commercial sex workers (Parent: Most at risk populations)

Community leaders

Community-based organizations

Faith-based organizations

Military personnel (Parent: Most at risk populations)

Truck drivers (Parent: Mobile populations)

Orphans and vulnerable children

Partners/clients of CSW (Parent: Most at risk populations)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.12: Program Planning Overview

Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12

Total Planned Funding for Program Area:

B5

Program Area Context:

There has been significant progress toward building a strong national laboratory program. In 2004, with USG participation and support, the MOH adopted the Laboratory Quality Systems principles as a framework for Tanzania. In FY05, the USG is supporting the renovation of the National Laboratory Quality Assurance and Training Centre initiated at the National Institute for Medical Research (NIMR). The Centre, to be completed by December 2007, will provide capacity in assessing and improving the quality of testing nationally and will serve as a national training institute. In the interim, the USG is supporting a MOH collaboration with NIMR and the African Medical and Research Foundation (AMREF) to renovate and equip a smaller laboratory at AMREF to perform these functions. Upon completion of the Center, AMREF will serve as the Dar es Salaam Regional Laboratory.

In addition to activities at the national level, in FY05, 32 of 96 laboratories serving the ART sites have *been/or are being renovated. Equipment for CD4 testing has been provided to all 21 regional* laboratories, chemistry, and hematology equipment have been procured for 10 regional and 13 district *hospitals. Coordinated with ART roll out, the USG will have directly supported the renovation of 18 of* these laboratories including outfitting of the six referral laboratories with high volume CD4, hematology and chemistry equipment. In support of the national laboratory strategy, the MOH, in collaboration with AMREF, NIMR, and the American Society for Clinical Pathology (ASCP), conducted a training program with USG support for a training of trainers in basic laboratory procedures for CD4, chemistry, and hematology. Twenty-five laboratory technologists working in all five zonal and eight regional laboratories were trained.

In addition to USG support, the MOH receives support for building laboratory, technical and financial capacity from other partners and the WHO, renovation of labs and equipment from Axios International, and procurement of reagents and test kits by the Japanese International Cooperation Agency (JICA). The Clinton Foundation provides technical assistance for implementation of the national laboratory strategy. Also, the MOH receives direct budget support from bilateral donors contributing to the Sector Wide Approach (SWAP) Basket Fund, the World Bank and the Global Fund.

Although much has been accomplished, fully functional and sustainable laboratory services for *supporting the national HIV care and treatment program still require significant development. In FY06,* the MOH, with USG support, will initiate and expand collaboration with several American professional laboratory organizations. Through these organizations, the USG will assist the MOH in collaboration with ASCP, NIMR, and AMREF to develop laboratory standards and guidelines for the spectrum of HIV/AIDS-related laboratory tests and supervisory teams to support regional efforts. The priority will be the development and implementation of standard operating procedures, developing external quality assessment and quality control activities, and framing a national standard. The USG will continue to assist MOH as part of this collaboration, providing additional training in use of HIV rapid tests and by equipping the Quality Assurance and Training Centre five regional and 15 district laboratories with similar direct USG support of thee military facilities. The USG will assist in developing and implementing a functional laboratory information system. As part of this assistance a document of system requirements will be completed, an implementation plan developed, and equipment will be purchased for use at the national and zonal levels. These activities, in conjunction with site-specific infrastructure and capacity development tightly linked to ART roll out, represent a comprehensive approach meeting MOH requirements, to support its national treatment targets and contribute to Emergency Plan goals.

Program Area Target:

Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	161
Number of individuals trained in the provision of lab-related activities	2,017
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	0

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National Institute for Medical Research
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3408
Planned Funds:
Activity Narrative: This activity relates to activities in lab (MOH, AMREF, CLSI, APHL, RPSO, BMC Mnazi Mmoja), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI) and counseling and testing (Crown Agents)

The National Institute for Medical Research (NIMR) in collaboration with Muhimbili University College of Health Sciences (MUCHS) Department of Microbiology and Immunology, the Clinical and Laboratory Standards Institute (CLSI), African Medical and Research Foundation (AMREF), and the Association of Public Health Laboratories (APHL) will support MOH efforts to introduce, develop, and implement a program to build the capacity of HIV/AIDS laboratories using the quality systems approach. This includes conducting quality assessment of HIV/AIDS testing at district, regional and zonal laboratories, developing training materials, and training of trainers in HIV/AIDS-laboratory related testing and specific quality assurance testing. The National Quality Assurance and Training Center will be renovated and equipped with a reference supra public health laboratory for HIV and related testing and as a training and national External Quality Assessment (EQA) center and resource center.

With the recently awarded FY05 funding, NIMR will collaborate with AMREF and other partners to hire a lab manager and senior lab technologist. NIMR will be responsible for developing and implementing the national quality assurance program and strengthening the capacity of national external quality assessment scheme (NEQAS) to provide HIV EQA materials to 4 zonal labs and Zanzibar, regional and district laboratories, and all HIV testing sites. They will also evaluate other EQA program that may serve as a model for Tanzania, support enrollment of zonal and regional laboratories in CD4 EQA from external sources, develop EQA plan for chemistry and hematology, institute a plan in the 4 zonal labs and Zanzibar referral labs, and develop national Quality assurance guidelines for HIV testing. A small trained work group will be established for the purpose of developing standard operating procedures (SOPs) for HIV, EIA, HIV rapid testing, CD4, automated hematology and chemistry procedures.

With FY06 funding NIMR in collaboration with AMREF and other partners will develop a training program to support quality systems with emphasis on specimen management, equipment maintenance, quality control, documentation and recording, and EQA program as a monitoring and evaluation tool. NIMR will also collaborate with AMREF and partners to implement the National HIV/AIDS Quality Assurance program which will involve preparation of HIV EQA sample panel, chemistry and hematology basic monitoring tests, and distribution, analysis and monitoring of QA activities at all levels. Computers will be provided to zonal labs, and a computerized EQA system will be developed.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Community Mobilization/Participation	10 - 50
Needs Assessment	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	27	☐
Number of individuals trained in the provision of lab-related activities	54	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Muhimbili National Hospital
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3411
Planned Funds:
Activity Narrative: This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

In order to expand HIV/AIDS lab capacity and benefit from the network model for continuum of prevention, care, and treatment services, the MOH will decentralize HIV/AIDS-related training to zonal referral hospitals. Central lab activities will be decentralized to Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC) and Mbeya Referral Hospital (MRH). In Zanzibar, the Ministry of Health and Social Welfare (MOHSW) will decentralize laboratory capacity building activities to the Mnazi Mmoja hospital. These five zonal reference laboratories in Mainland and Zanzibar will apply the centre of excellence approach to support a network of regional, district, faith-based, and private laboratories supporting HIV/AIDS prevention, care, and treatment in their catchment areas. In order to perform this task, the zonal referral hospitals will equip staff at zonal laboratories to perform laboratory testing for HIV diagnosis, disease staging and treatment monitoring in order to optimize HIV/AIDS prevention, care and treatment services. The zonal referral hospitals will also train laboratory and non-laboratory staff in other facilities to provide similar services, and will provide supportive supervision for monitoring lab related activities.

USG has a two-pronged approach to providing laboratory support to HIV/AIDS interventions in the country: 1) work with the GOT and other partners on overarching laboratory issues at the national level and 2) directly and indirectly support laboratories that provide services at point-of-care settings. The USG supports the GOT "Quality Systems Approach" to providing laboratory services. This follows the "network model," which ensures that laboratory services are designed to support levels of care provided in various program settings (zonal, regional, district and primary health care units). In 2005, the USG supported laboratory training of more than 500 national staff. The zonal referral laboratory for the Eastern and Southern Zones, based at Muhimbili National Hospital in Dar es Salaam, will collaborate with AMREF and ASCP to expand access and reliability of HIV testing. Areas of expansion include adult and infant diagnosis, CD4 tests for disease staging, and basic chemistry and hematology tests to monitor therapy. Funds planned for this activity in FY05 were not awarded before the end of the fiscal year and were carried over for implementation in FY06.

In FY06, (using FY05 funds) MNH will recruit 4 laboratory technologists and procure staff, equipment, reagents and test kits in order to expand capacity and reliability of HIV testing to meet the needs for adult and infant diagnosis served by the MNH Zonal Reference Laboratory. This will ensure that the zonal reference laboratory, municipal and regional laboratories in Ilala, Temeke, Kinondoni, Pwani (Coast), Morogoro, Lindi and Mtwara can reliably perform HIV enzyme immunoassay testing, have an uninterrupted supply of HIV test kits, have and follow standard operating procedures, and maintain a system of records and reports for monitoring and evaluation. In addition, as a zonal reference laboratory, MNH will provide leadership and quality assurance support for all laboratories in the zone, and assure that all regional laboratories successfully participate in the NELQAS. The MNH zonal reference laboratory will participate in implementing the national HIV reference laboratory HIV nucleic acid amplification testing for diagnosing HIV infection in newborns.

The MNH zonal laboratory will assist regional, district, faith-based, and private health facilities providing ART services in the zone with access to adequate and safe

laboratories with the required capacity to carry out testing for disease staging and ART Monitoring. The MNH will assist the 7 regional hospital laboratories (Morogoro, Lindi, Mtwara, Tumbi, Mwanaayawde, Temeke, Amana) and selected district, faith-based, and private laboratories to achieve this capacity including ensuring the availability of equipment and routine maintenance, reagents, and supplies at points of service for testing. MNH will assist the MOH to follow-up and provide technical assistance in the renovation of laboratories supporting ART sites in the zones, and provide tools and training to strengthen the capacity of the zonal healthcare technical service workshops that will provide first-line support for maintenance and troubleshooting.

With support from MOH and AMREF, MHN will organize 4 training workshops of 25 participants each (total 100 trainees) for HIV testing, CD4 testing, and basic hematology and chemistry. MNH will collaborate with and assist AMREF in providing training on HIV rapid testing and basic laboratory operations to 100 non-laboratory staff from VCT, PMTCT, TB/HIV and other clinical settings where provider initiated "opt out" HIV counseling and testing is conducted or needed. (Note: This target is covered under AMREF to avoid double counting). MNH will support 10 laboratory staff and managers from the Eastern and Southern Zones to participate in professional development activities including study visits, national and regional meetings. Criteria for nomination and selection will be developed in collaboration with MOH and CDC.

MNH will support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision and implementing a zonal external laboratory quality assurance scheme (ZELQAS).

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	8	☐
Number of individuals trained in the provision of lab-related activities	110	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas

Dar es Salaam

Lindi

Mtwara

Pwani

Dodoma

Morogoro

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: African Medical and Research Foundation
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3455
Planned Funds:
Activity Narrative: This activity links to activities under lab (AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

The Ministry of Health (MoH) has identified the African Medical and Research Foundation (AMREF) and the Muhimbili University College of Health Sciences (MUCHS) as key partners in implementing HIV/AIDS Laboratory training and education activities. AMREF will be responsible for training laboratory directors, specialists, technologists and technicians to perform essential HIV screening and confirmatory tests, CD4 test for disease-staging, and basic chemistry and hematology tests to monitor therapy. This activity relates to laboratory infrastructure activities of MOH, RPSO, CLSI, ASCP, APHL, to ART activities of AIDSRelief, Columbia University, DoD, EGPAF, FHI/DT, Harvard University and to CT activity of Crown Agents.

In FY05, AMREF collaborated with MOH, WHO, ASCP, NIMR and MUCHS to adapt ASCP training modules for CD4, chemistry and hematology training to the Tanzanian context. They also pre-tested the modules and trained of 25 laboratory experts to be trainers. AMREF also collaborated with the same partners and referral hospitals in Mwanza, Mbeya, Moshi, Dar es Salaam and Zanzibar to conduct rapid test training to 100 staff, majority being non-laboratory staff involved in VCT, PMTCT, TB/HIV and blood safety programs. Earlier plans to train 400 laboratory staff in FY05 were not accomplished due to delayed awarding of funds to AMREF. The program funding announcement was made in August 2004 and funding was expected to be awarded in October 2005. Implementation of FY05 activities will be implemented together with activities to be funded in FY06.

In FY06, AMREF will complete training of trainers and supervisors in Laboratory Quality Management, HIV testing, CD4 testing; and basic hematology and chemistry. AMREF will also train laboratory technologists and technicians in HIV testing, CD4 testing, and basic hematology and chemistry, and basic laboratory operations. Through the cooperative agreement with CDC, professional development opportunities will be provided to MOH lab staff and managers through participation in national and regional meetings. In addition, AMREF will support MOH to conduct supportive and follow up supervision, to organize refresher training based on the findings of quality assurance results and supportive supervision visits, and to provide oversight to training activities performed by zonal hospital laboratories.

In order to expand training capacity and decentralize laboratory training, in FY06 AMREF will complete training of trainers and supervisors in Laboratory Quality Management, HIV testing, CD4 testing, and basic hematology and chemistry. Fifty trainers will be trained in two training workshops each of 25 participants. The workshops will target 10 trainers from each of the 5 zones. The trainers will be used by AMREF and the 5 zonal referral hospitals to train 500 laboratory technologists and technicians. Each of the 5 zones will conduct 4 training sessions of 25 participants *each (This target of 500 trained is captured in the targets of the referral hospitals to* avoid double counting). AMREF will also conduct training of 500 non-laboratory staff involved in VCT, PMTCT, TB/HIV and blood safety programs. This training will be conducted in 5 zones, with each zone conducting 4 training sessions of 25 participants each. AMREF will procure reagents, test kits, and equipment maintenance service for laboratory equipment used in the training of staff at the AMREF laboratory.

In order to provide professional development opportunities for laboratory staff and managers, AMREF will participate and support participation of best performing

trainees to national, regional and international meetings, study visits and advanced training. Assessment criteria for selecting such participants will be developed to address performance in the training and innovative application of knowledge and skills gained during the training. In FY06, AMREF will support 10 participants to national, regional and international meetings to be agreed with MOH and HHS/CDC.

In order to ensure adherence to uniform quality standards, AMREF will support MOH to conduct supportive supervision to all training events and conduct follow up supervision and support to trainees at their places of work to see how theory is put to practice. AMREF will also assist MOH in organizing refresher training, based on findings of quality assurance results. In FY06, two refresher training will be conducted for a total of 60 participants.

In addition, a sub award will be given to Muhimbili University College of Health Sciences (MUCHS) to provide support to AMREF in national level evaluation of HIV test kits and in establishing of HIV testing algorithm. MUCHS will also provide general support to AMREF and will serve as a national HIV reference laboratory for unusual specimens. To strengthen pre-service training, MUCHS will begin planning to improve the curriculum of university students training in the laboratory sciences. In order to support this initiative, a Twinning partnership will be established between MUCHS and a university-affiliated laboratory in the US. This partnership will give MUCHS laboratory faculty opportunities to travel to the US to further develop their current knowledge and skills base, and to enhance their teaching skills.

AMREF will also support and collaborate with MOH and NIMR in implementing the laboratory quality system training and external quality assurance while the National Laboratory Quality Assurance and Training Centre, at the NIMR/HQ, is still under renovation.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	1	☐
Number of individuals trained in the provision of lab-related activities	620	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Regional Procurement Support Office
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3478
Planned Funds:
Activity Narrative: This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

Quantities and specifications of equipment and reagents required to support the National Care and Treatment plan for treating up to 60,000 patients by September 2006 are detailed in the National Laboratory Operational Plan for HIV/AIDS. In this plan, a number of equipment and reagent procurement principles are recommended including renting and bulk purchase. In the plan it is recommended that the Ministry of Health enters into equipment placement or rental agreements with manufactures/suppliers of certain testing equipment, e.g. large and small volume CD4 count instruments, chemistry and hematology analyzers instead of purchasing such equipment. This will provide the flexibility to upgrade equipment when volumes increase and to replace non-performing equipment. For CD4 count equipment in particular, it is significantly more cost-effective to rent than purchase both large and small instruments. Conversely, it may be more cost-effective to purchase than rent small hematology and chemistry instruments. It is recommended that a limited number of manufacturers and models of equipment be purchased to avoid a proliferation of multiple different pieces of equipment, which will result in fragmented reagent purchasing in the future. Consolidated purchasing will be used in order to access bulk purchase discounts. Reduced pricing structures should also be accessed wherever feasible, e.g. under the Clinton Foundation reagent agreements and WHO bulk purchasing mechanisms.

With the FY06 funding USG will place [redacted] for negotiation of placement, contract and/or equipment rental agreements and sustainable maintenance contracts purchase for laboratory services equipment for the MOH. This activity is planned for the 21 regional, 3 military, 15 district laboratories in Tanzania mainland and 2 in Zanzibar where medium volume CD4, Chemistry and Hematology analyzers will be placed.

Preparations for renovation of the National HIV Laboratory training and Quality Assurance Centre initiated in FY04 were finalized in FY05 with the identification of a contractor through RPSO. When completed, equipped, and staffed, the laboratory will support MOH to introduce, develop and implement HIV/AIDS laboratory quality systems in Tanzania. Also the laboratory would conduct quality assessment of HIV/AIDS testing at Regional and district laboratories, develop HIV laboratory training materials, train trainers in HIV/AIDS related testing and testing specific quality assurance, establish a central area for receiving and delivering distance-based training, and provide technical assistance for external quality assessment (proficiency testing) programs.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Infrastructure	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	41	☐
Number of individuals trained in the provision of lab-related activities	82	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Kilimanjaro Christian Medical Centre
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3483
Planned Funds:
Activity Narrative: This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

In order to expand HIV/AIDS lab capacity and benefit from the network model for continuum of prevention, treatment, and care services, the MOH will decentralize HIV/AIDS related training to zonal referral hospitals. Central lab activities will be decentralized to Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC), and Mbeya Referral Hospital (MRH). In Zanzibar, the Ministry of Health and Social Welfare (MOHSW) will decentralize laboratory capacity building activities to the Mnazi Mmoja hospital. These five zonal reference laboratories in Mainland and Zanzibar will apply the centre of excellence approach to support a network of regional, district, faith-based, and private laboratories supporting HIV/AIDS prevention, care and treatment in their catchment areas. In order to perform this task, the zonal referral hospitals will equip staff at zonal laboratories to perform laboratory testing for HIV diagnosis, disease staging, and treatment monitoring in order to optimize HIV/AIDS prevention, care and treatment services. The zonal referral hospitals will also train laboratory and non-laboratory staff in other facilities to provide similar services, and will provide supportive supervision for monitoring lab related activities.

USG has a two-pronged approach to providing laboratory support to HIV/AIDS interventions in the country: 1) work with the GOT and other partners on overarching laboratory issues at the national level and 2) directly and indirectly support laboratories that provide services at point-of-care settings. The USG supports the GOT "Quality Systems Approach" to providing laboratory services. This follows the "network model," which ensures that laboratory services are designed to support levels of care provided in various settings (zonal, regional, district and primary health care units). In 2005, the USG supported laboratory training of more than 500 national staff in areas of adult and infant diagnosis, CD4 tests for disease staging, and basic chemistry and hematology tests to monitor therapy. Funds planned for this activity in FY05 were not awarded before the end of the fiscal year and were carried over for implementation in FY06.

In FY06 (using FY05 funds), KCMC will recruit 4 laboratory technologists and procure staff, equipment, reagents, and test kits in order to expand capacity and reliability of HIV testing to meet the needs for adult and infant diagnosis served by the KCMC Zonal Reference Laboratory. This will ensure that the zonal reference laboratory and regional laboratories in Kilimanjaro, Arusha, Manyara, Tanga, and Singida can reliably perform HIV enzyme immunoassay testing, have an uninterrupted supply of HIV test kits, have and follow standard operating procedures, and maintain a system of records and reports for monitoring and evaluation. In addition, as a zonal reference laboratory, KCMC will provide leadership and quality assurance support for all laboratories in the zone, and assure that all regional laboratories successfully participate in the NELQAS. The KCMC zonal reference laboratory will participate in implementing the national HIV reference laboratory HIV nucleic acid amplification testing for diagnosing HIV infection in newborns. This will include providing training support and oversight for collection of dried blood samples from health facilities providing ART and PMTCT services in the zone and transporting samples to a laboratory with such testing capacity until the KCMC has developed its own capacity for such testing.

The KCMC zonal laboratory will assist regional, district, faith-based and private health facilities providing ART services in the zone with access to adequate and safe

laboratories with the required capacity to carry out testing for disease staging and ART Monitoring. The KCMC will assist the 5 regional hospital laboratories (Kilimanjaro, Arusha, Manyara, Tanga, and Singida) and selected district, faith-based and private laboratories to achieve this capacity including ensuring the availability of equipment and routine maintenance, reagents, and supplies at points of service for testing. KCMC will assist the MOH to follow-up and provide technical assistance in the renovation of laboratories supporting ART sites in the zone and provide tools and training to strengthen the capacity of the zonal healthcare technical service workshops that will provide first-line support for maintenance and troubleshooting.

With support from MOH and AMREF, KCMC will organize 4 training workshops of 25 participants each (total 100 trainees) for HIV testing, CD4 testing, and basic hematology and chemistry. KCMC will collaborate with and assist AMREF in providing training on HIV rapid testing and basic laboratory operations to 100 non-laboratory staff from VCT, PMTCT, TB/HIV and other clinical settings where provider initiated "opt out" HIV counseling and testing is conducted or needed. (Note: This target is covered under AMREF to avoid double counting). KCMC will support 10 laboratory staff and managers from the Northern Zone to participate in professional development activities including study visits, national and regional meetings. Criteria for nomination and selection will be developed in collaboration with MOH and CDC.

KCMC will support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision and implementing a zonal external laboratory quality assurance scheme (ZELQAS).

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	6	☐
Number of individuals trained in the provision of lab-related activities	110	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Coverage Areas

Arusha

Kilimanjaro

Manyara

Singida

Tanga

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Bugando Medical Centre
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 3487
Planned Funds:
Activity Narrative: This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

The MOH is decentralizing HIV/AIDS related training to zonal referral hospitals to expand HIV/AIDS lab capacity and to embrace the network model for a continuum of HIV/AIDS prevention and care services. With USG support, the MOH will decentralize lab training to zonal referral laboratories in Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC) and Mbeya Referral Hospital (MRH). In Zanzibar, the Ministry of Health and Social Welfare (MOHSW) will decentralize to the Mnazi Mmoja hospital. These 5 zonal reference laboratories will apply the centre of excellence approach to support a network of regional, district, faith-based, and private labs supporting HIV/AIDS prevention, care and treatment in their catchment areas. The zonal referral hospitals will equip staff at zonal laboratories to perform testing for HIV diagnosis, disease staging and treatment monitoring in order to optimize prevention, care and treatment services. The zonal referral hospitals will also train laboratory and non-laboratory staff in other facilities to provide similar services, and support and help monitor performance through supportive supervision.

USG/T has a two-pronged approach to provide laboratory support to HIV/AIDS interventions in the country: 1) work with the GOT and other partners on overarching laboratory issues at the national level, and 2) directly and indirectly support laboratories that provide services at point-of-care settings. The USG/T supports the GOT "Quality Systems Approach" to providing laboratory services. This follows the "network model," ensuring that laboratory services are designed to support levels of care in various settings (zonal, regional, district and primary health care units). In 2005, the USG/T supported laboratory training of more than 500 national staff. The zonal referral laboratory for the Lake Zone based at Bugando Medical Centre, Mwanza will collaborate with AMREF and ASCP to expand access and reliability of HIV testing to meet the needs for adult and infant diagnosis, and to expand the number of safe, adequate laboratories with testing capacity. Lab personnel will also be trained to perform essential HIV screening and confirmatory tests including CD4 tests for staging disease, basic chemistry and hematology tests to monitor therapy, and to ensure that all laboratories in the Lake Zone take part in National External Laboratory Quality Assurance Scheme (Tanzania NELQAS). Funds planned for this activity in FY05 were not awarded before the end of the fiscal year and were carried over into FY06.

In FY06 (using FY05 funds), BMC will recruit 4 lab techs and procure staff, equipment, reagents, and test kits to expand capacity and reliability of HIV testing to meet the needs of individuals served by the BMC Zonal Reference Laboratory. This will ensure that the zonal reference laboratory and regional laboratories in Mwanza, Mara, Kagera Shinyanga, Kigoma and Tabora can reliably perform HIV enzyme immunoassay testing, have a steady supply of HIV test kits, follow standard operating procedures, and maintain a system of records and reports for monitoring and evaluation. BMC will assist these 5 regional labs and select district, faith-based and private labs to achieve this capacity, ensuring availability of equipment, routine maintenance, reagents, and supplies at points of service for testing. In addition, as a zonal reference lab, BMC will provide leadership and quality assurance for all laboratories in the zone. The BMC zonal reference lab will participate in implementing the national HIV reference laboratory HIV nucleic acid amplification testing for diagnosing HIV infection in newborns. This will include providing training support and oversight for collection of dried blood samples from health facilities providing ART and

PMTCT services in the zone and transporting samples to a lab with sufficient testing capacity until the BMC develops its own capacity for such testing.

BMC will assist the MOH to follow-up and provide technical assistance in the renovation of laboratories supporting ART sites in the zone and provide tools and training to strengthen the capacity of the zonal healthcare technical service workshops that will provide first-line support for maintenance and troubleshooting.

BMC will collaborate with AMREF and ASCP to provide laboratory training and education to staff at BMC and other health facilities within the zone. BMC will be the zonal centre for training laboratory personnel in the Lake Zone to perform essential HIV screening and confirmatory tests, CD4 tests for disease staging, and basic chemistry and hematology tests to monitor therapy. With support from MOH and AMREF, BMC will organize 4 training workshops of 25 participants each (total 100 trainees) for HIV testing, CD4 testing, and basic hematology and chemistry. BMC will collaborate with and assist AMREF in providing training on HIV rapid testing and basic laboratory operations to 100 non-laboratory staff from VCT, PMTCT, TB/HIV and other clinical settings where provider initiated "opt out" HIV counseling and testing is conducted or needed. (Note: This target is covered under AMREF to avoid double counting). BMC will support 10 laboratory staff and managers from the Lake Zone to participate in professional development activities including study visits and national and regional meetings. Criteria for nomination and selection will be developed in collaboration with MOH and CDC.

BMC will support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision and implementing a zonal external laboratory quality assurance scheme (ZELQAS).

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Logistics	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	7	☐
Number of individuals trained in the provision of lab-related activities	110	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Laboratory workers (Parent: Public health care workers)

Coverage Areas

Kagera

Kigoma -

Mara

Mwanza

Shinyanga

Tabora

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	*N/A*
Prime Partner:	Mbeya Referral Hospital
USG Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	*HLAB*
Program Area Code:	12
Activity ID:	3491
Planned Funds:	
Activity Narrative:	This activity links to activities under lab (MOH, AMREF, ASCP, CLSI, APHL, RPSO) treatment (Mbeya Referral Hospital, Mbeya, Rukwa and Ruvuma Regional Medical Offices and FHI), and counseling and testing (Mbeya Referral Hospital, Mbeya, Rukwa and Ruvuma Regional Medical Offices and Crown Agents). *In order to expand HIV/AIDS lab capacity and benefit from the network model for* continuum of prevention, care, and treatment services, the MOH will decentralize HIV/AIDS-related trainings to zonal referral hospitals. Central lab activities will be decentralized to zonal referral laboratories at Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC) and Mbeya Referral Hospital (MRH). In Zanzibar, the Ministry of Health and Social Welfare (MOHSW) will decentralize laboratory capacity building activities to the Mnazi Mmoja hospital. These five zonal reference laboratories in Mainland and Zanzibar will apply the centre of excellence approach to support a network of regional, district, faith-based and private laboratories supporting HIV/AIDS prevention, care and treatment in their catchment areas. In order to perform this task, the zonal referral *hospitals will equip staff at zonal laboratories to perform laboratory testing for HIV* diagnosis, disease staging, and treatment monitoring in order to optimize HIV/AIDS prevention, care and treatment services. The zonal referral hospitals will also train laboratory and non-laboratory staff in other facilities to provide similar services, and *support and help monitor performance of HIV/AIDS related laboratory testing* services through supportive supervision. USG has a two-pronged approach to providing laboratory support to HIV/AIDS interventions in the country: 1) work with the GOT and other partners on overarching laboratory issues at the national level and 2) directly and indirectly support laboratories that provide services at point-of-care settings. The USG/T supports the GOT "Quality Systems Approach" to providing laboratory services. This follows the "network model," which ensures that laboratory services are designed to support levels of care provided in various program settings (zonal, regional, district and primary health care units). In 2005, the USG/T supported laboratory training of more than 500 national staff in areas of adult and infant diagnosis, CD4 tests for disease staging, and basic chemistry and hematology tests to monitor therapy. Funds planned for this activity in FY05 were not awarded before the end of the fiscal year and were carried over for implementation in FY06. Funding in FY06 under this submission will expand technical support for the activities under a coordinated effort among the MRH, American Society for Clinical Pathology (ASCP), African Medical and Research Foundation (AMREF), CDC and the U.S. Department of Defense (DoD). This award will allow the MRH to support zonal efforts in strengthening lab capacity accessing ASCP and AMREF training with technical *assistance from DoD (its USG Agency partner) in collaboration with CDC.* Using these funds the MRH will recruit two laboratory technologists and procure equipment, reagents, and test kits in order to expand capacity and reliability of HIV testing to meet the needs for adult and infant diagnosis served by the MRH Zonal Reference *Laboratory. This will ensure that the zonal reference laboratory and regional* laboratories in Mbeya, Iringa, Rukwa and Ruvuma can reliably perform HIV enzyme immunoassay testing, have an uninterrupted supply of HIV test kits, have and follow standard operating procedures, and maintain a system of records and reports for monitoring and evaluation. In addition, as a zonal reference laboratory, MRH will provide leadership and quality assurance support for all laboratories in the zone, and assure that all regional laboratories successfully participate in the NELQAS. The MRH zonal reference laboratory will participate in implementing the national HIV reference laboratory HIV nucleic acid amplification testing for diagnosing HIV infection in

newborns. This will include providing training support and oversight for collection of dried blood samples from health facilities providing ART and PMTCT services in the zone and transporting samples to a laboratory with such testing capacity until the MRH has developed its own capacity for such testing.

The MRH zonal laboratory will assist regional, district, faith based and private health facilities providing ART services in the zone with access to adequate and safe laboratories with the required capacity to carry out testing for disease staging and ART monitoring. The MRH will assist the four regional hospital laboratories (Mbeya, Iringa, Rukwa and Ruvuma) and selected district, faith-based, and private laboratories to achieve this capacity, including ensuring the availability of equipment and routine maintenance, reagents, and supplies at points of service for testing. MRH will assist the MOH to follow-up and provide technical assistance in the renovation of laboratories supporting ART sites in the zone, and to provide tools and training to strengthen the capacity of the zonal healthcare technical service workshops that will provide first-line support for maintenance and troubleshooting.

With support from the MOH and AMREF, MRH will organize four training workshops of 25 participants each (total 100 trainees) for HIV testing, CD4 testing, and basic hematology and chemistry. MRH will collaborate with and assist AMREF in providing training on HIV rapid testing and basic laboratory operations to 100 non-laboratory staff from VCT, PMTCT, TB/HIV and other clinical settings where provider initiated "opt out" HIV counseling and testing is conducted or needed. (Note: This target is covered under AMREF to avoid double counting). MRH will support 10 laboratory staff and managers from the Southern Highlands Zone to participate in professional development activities including study visits and national and regional meetings. Criteria for nomination and selection will be developed in collaboration with MOH and CDC.

MRH will support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision and implementing a zonal external laboratory quality assurance scheme (ZELQAS).

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	6	☐
Number of individuals trained in the provision of lab-related activities	100	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas

Iringa

Mbeya

Rukwa

Ruvuma

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Ministry of Health, Tanzania
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	3499
Planned Funds:	
Activity Narrative:	This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

Since 2004, the Ministry of Health (MOH) with support from USG, WHO, and other bilateral and multilateral development partners, has implemented activities to strengthen laboratory capacity for HIV diagnosis, disease staging, treatment monitoring. and strategic information. Within these activities, the MOH collaborates with various implementing partners including CDC, DoD, the National Institute for Medical Research (NIMR), the African Medical and Research Foundation (AMREF), the Association of Public Health Laboratories (APHL), the Clinical and Laboratory Standards Institute (CLSI), the American Association for Clinical Pathology (ASCP), JICA, AXIOS, Clinton Foundation and Track 1 ART partners. The role of the ministry is to coordinate the planning and execution of laboratory infrastructure activities implemented by all partners.

The inadequate capacity of laboratories has been identified as a major obstacle in achieving the Emergency Plan's care and treatment goals for Tanzania. Given the critical needs in building adequate laboratory services and the enormity of the tasks, many development partners and implementing agencies are now increasing their attention to support laboratory capacity strengthening for care and treatment. The MOH has articulated the way forward within the "Tanzania Operational Plan for the National Laboratory System to Support HIV/AIDS Care and Treatment," which was collaboratively developed between MOH and USG partners in 2004. Since the MOH has limited capacity to perform all the roles effectively, it will focus on policy development, process planning, and coordination and technical guidance on provision of laboratory services in Tanzania. In FY06, the MOH will operationalize the national HIV/AIDS laboratory subcommittee that will be responsible for providing leadership and oversight in developing plans and reviewing progress in implementing the national laboratory operational plan and for advising the National HIV/AIDS task force/steering committee on HIV/AIDS laboratory issues. The MOH will also convene and lead the coordination of all development partners and implementing agencies who contribute to laboratory infrastructure building for HIV/AIDS in Tanzania. Finally, the MOH will convene laboratory collaborating partners and stakeholders biannually to assure program coordination and for sharing lessons learned and best practices.

The MOH will finalize and approve the terms of reference and scope of work of the national HIV/AIDS laboratory subcommittee. Once operational, the laboratory subcommittee will establish technical task forces to oversee specific program activities and report quarterly to the Laboratory subcommittee. Initially technical task forces will be established for completing the evaluation of rapid test kits and formulating a new testing algorithm, training and oversight for rapid HIV testing in VCT, PMTCT, and other settings where rapid testing is done by non-laboratory staff. Their tasks will also include validation of new laboratory testing technologies and processes, training for CD4, hematology and chemistry testing, HIV diagnosis in infants and young children, laboratory record and documentation, strengthening the national external quality assurance scheme (NEQAS), and establishing planned preventive maintenance for laboratory equipment. The sub-committee will establish a process for providing leadership and oversight to all agencies and partners implementing the national laboratory operational plan, including review of all plans and progress reports submitted to MOH. This will include development of standard operating procedures and manuals as may be needed. The laboratory subcommittee will prepare and, through its representatives, report to and advise the National HIV/AIDS task force/steering committee on HIV/AIDS laboratory issues.

In order to strengthen the coordination of all development partners and implementing agencies who contribute to laboratory infrastructure building for HIV/AIDS in Tanzania, the MOH will also convene and lead quarterly meetings of all partners to coordinate plans, activities and resources invested in the laboratory sub sector. Technical task forces for specific activities and program areas will be required to present their reports for discussion and to provide guidance on implementing recommendations. The MOH will conduct supportive supervision to health facilities, health training facilities and partner agencies to identify achievements, best practices, and challenges faced in achieving goals of the national care and treatment program and the Emergency Plan. The MOH will ensure that laboratory capacity building for HIV/AIDS interventions is linked with the overall strategy for National Laboratory reform in Tanzania.

Finally, in order to assure program coordination and for sharing lessons and best practices, the MOH will convene a meeting of laboratory collaborating partners and stakeholders biannually. The MOH will also support study visits and participation in national and international meetings and training for 9 staff (MOH, referral laboratories, and regional hospitals). Travel will be planned carefully to ensure that staff are not kept away from work places longer than necessary in order not to affect laboratory work at sites. Priority will be given to programs to develop human resources and capacity to manage the laboratories. Specifically, the MOH will organize a laboratory management training for all 26 regional laboratory technologists and heads of 5 zonal referral laboratories.

Emphasis Areas	% Of Effort
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities	40	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	Country staffing and TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	3520
Planned Funds:	
Activity Narrative:	This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents). HHS/CDC will continue to provide technical assistance to MOH and its partners in building capacity of laboratory services to support HIV/AIDS care and treatment. This support will be provided by in-country and Atlanta-based laboratory support teams. In order to provide this support, and to facilitate the achievement of Emergency Plan goals, CDC-Tanzania in FY06 will recruit a senior laboratory specialist *in addition to the existing senior laboratory technologist. These CDC Tanzania* laboratory staff will collaborate and work closely with DoD and CDC-Atlanta lab teams as well as other non-USG organizations that support the national laboratory plan such as WHO, AXIOS, JICA and the Clinton HIV/AIDS foundation. The senior laboratory specialist will coordinate technical assistance to MOH from the US-based partners (CLSI, APHL, FHI/DT, and ASCP) and the Tanzania-based partners (NIMR, AMREF, and Track 1). The CDC Tanzania laboratory staff will assist MOH in building capacity of the zonal labs as Centers of Excellence; provide expertise in the renovation and development of equipment needed for the Quality Assurance and Training Center; and coordinate implementation of the Laboratory Information Management System and the HIV/AIDS External Quality Assurance Program. Proposed activities include the provision of technical assistance from USG to the MOH and other partners for implementing HIV prevention, care and treatment. This includes supporting the development of the National Laboratory Quality Assurance and Training Centre protocols, training curriculum, and monitoring and evaluation system for all program areas. The CDC Atlanta-based laboratory support team will support the field staff to develop systems including introduction of the Laboratory Quality System and expansion of HIV/AIDS testing to ensure that all ART sites access *high quality laboratory services.* This activity will contribute the overall human and institutional capacity building to combat the epidemic in line with the Five Year Strategy.

Emphasis Areas	**% Of Effort**
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities		☑
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American International Health Alliance
USG Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 4946
Planned Funds:
Activity Narrative: This activity links to activities under lab (AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

While the Ministry of Health (MOH) has authority for policy development, process planning, and technical guidance on provision of laboratory services in Tanzania, it has limited capacity to perform all the roles effectively. Moreover, the decision to decentralize HIV/AIDS related training to zonal referral hospitals will further stretch the capacity of MOH and MOHSW (Zanzibar) to meet the requirements for increased technical and administrative oversight. In FY06, USG will assist the MOH and MOHSW in working with the Twinning Center to strengthen the human and organizational capacity of the zonal referral hospitals and to scale up HIV/AIDS prevention, care and treatment services through volunteer-driven twinning partnerships. The Twinning Center will establish bilateral twinning relationships between the zonal referral hospitals in Tanzania with similar organizations in the U.S. on a peer-to-peer relationship.

In FY05, the USG planned to support the MOH efforts to decentralize HIV/AIDS related training to zonal referral hospitals by establishing cooperative agreements with the five zonal referral hospitals at Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC), Mbeya Referral Hospital (MRH) and the Mnazi Mmoja Hospital in Zanzibar. Due to delay in awarding the funds implementation of the planned activities will start in FY06. Laboratory training will be decentralized to the five zonal referral laboratories. These laboratories also have the responsibility to implement the Laboratory Quality Systems principles which will form the framework for laboratory development in Tanzania. However, since these laboratories have little practical experience in implementing this approach, USG will assist the MOH to utilize resources available through the Twinning Center to establish volunteer-driven twinning partnerships with state public health laboratories in the U.S. Such partnerships will strengthen human and organizational capacity of the zonal referral hospitals.

In FY06, AIHA will organize assessment visits based on needs identified by MOH and the zonal referral hospitals. These include but are not limited to: institutionalization of service laboratory training in zonal training centres associated with the referral hospitals; implemention of the laboratory quality systems approach; initial planning to improve the curriculum of university students training in laboratory sciences; and provision of professional development opportunities for laboratory staff and managers through national, regional, and international training. In the assessment visits, the Twinning Center will make recommendations about the partners, scope of partnership, length of partnership and potential activities. AIHA will then work with the country team (referral hospitals, MOH and USG) to negotiate a final partnership recommendations. AIHA will manage the partnership, provide technical assistance, monitor and evaluate and provide regular reports to the country team.

This activity will be beneficial to other components and program areas of the Emergency Plan that will be decentralized to the zonal referral hospitals such as Counseling and Testing, PMTCT, and ART services.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		☑
Number of individuals trained in the provision of lab-related activities	25	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Association of Public Health Laboratories
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	4962
Planned Funds:	
Activity Narrative:	This activity links to activities under lab (AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents). The Association of Public Health Laboratories (APHL) will lead the collaboration with the Clinical and Laboratory Standards Institute (CLSI) and with the National Institute for Medical Research (NIMR) to support MOH efforts to develop and implement a functional laboratory information system. Laboratory Information System (LIS) resources are vitally needed to be able to monitor the volume of testing being done through Tanzania, the use of reagents and supplies, the quality of testing, and the distribution of test results. Whether paper-based or electronic, strengthening LIS is an important requirement for Emergency Plan focus countries so as to capture laboratory data as evidence of whether the Emergency Plan effort is being successful in turning the tide of the HIV/AIDS epidemic. APHL has substantial experience developing systems requirements for laboratory information systems and collaborating with the World Health Organization (WHO) on the development of requirements in international settings. Moreover, APHL members have extensive experience developing, implementing, and using laboratory information systems in highly complex laboratories and connecting these to less complex laboratories. Using FY 2005 resources, APHL will begin providing technical assistance in the development of systems requirements. Since the systems requirements must be built from an operational system of documents, records, reports, and information, in FY06 APHL will provide technical assistance in strengthening the current paper-based system. Zonal, regional and district level facilities will be targeted for paper-based LIS method, and the zonal hospitals of KCMC, Bugando, and Mbeya will implement electronic LIS. Secondly, APHL will assist in developing system specifications to include identification of equipment, materials, and technical support resources required for LIS development and implementation. Equipment and supplies unique to the LIS will be purchased by APHL. Thirdly, APHL will provide technical assistance to MOH to coordinate the efforts of other partners working on LIS to develop an implementation strategy. The role of each partner will be defined and implementing phases will be agreed upon for zones, regions, and districts. By end of FY 2006 the work plan to implement a LIS will be completed and LIS connectivity among the reference laboratories initiated.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Strategic Information (M&E, IT, Reporting)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	5	☐
Number of individuals trained in the provision of lab-related activities	50	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Laboratory workers (Parent: Private health care workers)

Key Legislative Issues

Twinning

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American Society of Clinical Pathology
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 4966
Planned Funds:
Activity Narrative: This activity links to activities under lab (AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

The Association of Public Health Laboratories (APHL) will lead the collaboration with the Clinical and Laboratory Standards Institute (CLSI) and with the National Institute for Medical Research (NIMR) to support MOH efforts to develop and implement a functional laboratory information system. Laboratory Information System (LIS) resources are vitally needed to be able to monitor the volume of testing being done through Tanzania, the use of reagents and supplies, the quality of testing, and the distribution of test results. Whether paper-based or electronic, strengthening LIS is an important requirement for Emergency Plan focus countries so as to capture laboratory data as evidence of whether the Emergency Plan effort is being successful in turning the tide of the HIV/AIDS epidemic.

APHL has substantial experience developing systems requirements for laboratory information systems and collaborating with the World Health Organization (WHO) on the development of requirements in international settings. Moreover, APHL members have extensive experience developing, implementing, and using laboratory information systems in highly complex laboratories and connecting these to less complex laboratories. Using FY 2005 resources, APHL will begin providing technical assistance in the development of systems requirements. Since the systems requirements must be built from an operational system of documents, records, reports, and information, in FY06 APHL will provide technical assistance in strengthening the current paper-based system. Zonal, regional and district level facilities will be targeted for paper-based LIS method, and the zonal hospitals of KCMC, Bugando, and Mbeya will implement electronic LIS.

Secondly, APHL will assist in developing system specifications to include identification of equipment, materials, and technical support resources required for LIS development and implementation. Equipment and supplies unique to the LIS will be purchased by APHL. Thirdly, APHL will provide technical assistance to MOH to coordinate the efforts of other partners working on LIS to develop an implementation strategy. The role of each partner will be defined and implementing phases will be agreed upon for zones, regions, and districts. By end of FY 2006 the work plan to implement a LIS will be completed and LIS connectivity among the reference laboratories initiated.
While preparations for renovation, equipping, and staffing of the National HIV Laboratory training and Quality Assurance Centre are ongoing, ASCP (American Society of Clinical Pathologists, the world's largest professional laboratory society providing training and education) will collaborate with the National Institute for Medical Research (NIMR), the Clinical and Laboratory Standards Institute (CLSI), African Medical and Research Foundation (AMREF), and the Association of Public Health Laboratories (APHL) to support MOH efforts in laboratory training and quality assurance. In FY05, ASCP and partners conducted training on specialized HIV/AIDS laboratory tests for 25 laboratory personnel in Tanzania. In FY06, ASCP will continue to develop more laboratory task-specific training materials (e.g., troubleshooting and quality control for chemistry and hematology) including educational design elements that are tailored for Tanzania. In addition, ASCP will assure that equipment and supplies purchased with FY 2005 funds for the reference laboratories are installed and on-site training provided.

The need for scale-up in laboratory capacity is enormous. For HIV diagnosis alone, Tanzania will have to scale up from providing less than 100,000 tests per year to

more than 1,000,000 in order to meet the current goals. Another major challenge is transitioning from traditional manual laboratory methods to automated equipment for CD4, chemistry, and hematology, while at the same time introducing and maintaining international laboratory standards necessary for management of AIDS patients. Non-laboratory workers will be trained to perform simple rapid HIV tests to ease the burden from laboratory workers who are needed to take on high volumes of much more sophisticated tests such as CD4 tests and chemistry and hematology. Laboratory workers will need substantial training in use of new tests, use of automated procedures, and all aspects of work required of a functional laboratory (inventory management, quality assurance and quality control, documents and records management, information management, trouble shooting and problem resolution, safety, laboratory management, and customer service). ASCP will collaborate with partners in Tanzania to adapt its courses for training Tanzanian pathologists, laboratory personnel, and non laboratory personnel.

ASCP will work with MOH and in collaboration with AMREF and other partners to adopt and customize ASCP-developed training materials for Tanzania. ASCP will then provide support to in-country trainers to execute Training of Trainers in zonal laboratories training centres. ASCP will apply its expertise and resources to educational design and evaluation; training course development; competency assessment development; technical assistance with training delivery; provision of equipment, reagents, and supplies for training; and technical assistance with development of the National HIV Laboratory Training and Quality Assurance Center. Benchmarks for 2006 are to assure that training and education is provided to 50 laboratories so that all 22 regional laboratories (including Chake Chake in Pemba island) and the 5 zonal laboratories (including Mnazi Mmoja Hospital in Zanzibar) are providing basic HIV, CD4, chemistry, and hematology testing services for those being tested for HIV infection and those placed on anti-retroviral drug therapy.

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	27	☐
Number of individuals trained in the provision of lab-related activities	50	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Laboratory workers (Parent: Private health care workers)

Key Legislative Issues

Twinning

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Clinical and Laboratory Standards Institute
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	4974
Planned Funds:	
Activity Narrative:	This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

CLSI is the world's foremost global, nonprofit, standards-developing organization that promotes the development and use of voluntary consensus standards and guidelines within the healthcare community. It is also the international organization serving as Executive Secretariat for ISO's medical laboratory technical. CLSI will collaborate with the American Association for Clinical Pathology (ASCP), the National Institute for Medical Research (NIMR), the African Medical and Research Foundation (AMREF), and the Association of Public Health Laboratories (APHL) in support of MOH efforts. With the enormity of the scale up required in terms of numbers of laboratory tests to be performed, the numbers of laboratories needed to perform the tests, and the number of non laboratory and laboratory staff needed to perform and manage testing, there is an urgent need to develop and implement standard operating procedures, national standards, and guidelines to assure reliable testing no matter where and no matter who performs testing.

CLSI will provide technical assistance in the development and implementation of standard operating procedures and national standards and guidelines and will provide assistance to MOH and NIMR in strengthening their infrastructure to carry out this work through direct technical assistance and through bilateral twinning opportunities. Using FY 2005 resources CLSI is working with the Tanzania partners to develop nationally acceptable customized laboratory standard operating procedures (SOPs) for HIV, CD4, chemistry, hematology and dried blood spot (DBS) for PCR infant diagnosis testing. Continuing into FY 2006 and with FY 2006 resources, CLSI will assist the MOH to develop guidelines, and general laboratory standards which address the essential components of a functional laboratory system (for example, inventory management, quality assurance and quality control, documents and records management, information management, trouble shooting and problem resolution, safety, laboratory management, and customer service). CLSI will also provide assistance to the newly formed National HIV Laboratory Quality Assurance and Training Center to develop and sustain up-to-date standards and guidelines and to assure that standards and guidelines are implemented into routine practice. Twinning arrangements will help increase clarity about policies, processes and procedures that are essential for a functional national laboratory network.

Emphasis Areas	% Of Effort
Quality Assurance and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	25	☐
Number of individuals trained in the provision of lab-related activities	500	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Private health care workers

Key Legislative Issues

Twinning

Volunteers

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Mnazi Mmoja Referral Hospital
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 4988
Planned Funds:
Activity Narrative: This activity links to activities under lab (MOH, AMREF, CLSI, APHL, RPSO, BMC, Muhimbili National Hospital), treatment (Columbia University, AIDS Relief, Mbeya Referral Hospital, FHI), and counseling and testing (Crown Agents).

In Zanzibar, the Ministry of Health and Social Welfare (MOHSW) will decentralize laboratory capacity building activities to the Mnazi Mmoja hospital (MMH). These five zonal reference laboratories will apply the centre of excellence approach to support a network of regional, district, faith-based and private laboratories supporting HIV/AIDS prevention, care and treatment in their catchment areas. In order to perform this task, the zonal referral hospitals will equip staff at zonal laboratories to perform laboratory testing for HIV diagnosis, disease staging, and treatment monitoring in order to optimize HIV/AIDS prevention, care and treatment services. The zonal referral hospitals will also train laboratory and non-laboratory staff in other facilities to provide similar services, and to support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision.

USG/T has a two-pronged approach to providing laboratory support to HIV/AIDS interventions in the country: 1) Work with the GOT and other partners on overarching laboratory issues at the national level and 2) Directly and indirectly support laboratories that provide services at point-of-care settings. The USG/T supports the GOT "Quality Systems Approach" to providing laboratory services. This follows the "network model," which ensures that laboratory services are designed to support levels of care provided in various program settings (zonal, regional, district and primary health care units). In 2005, the USG upported laboratory training of more than 500 national staff. The zonal referral laboratory for Unguja and Pemba Islands based at Mnazi Mmoja Hospital will collaborate with AMREF and ASCP to expand the follwing activities: access and reliability of HIV testing to meet the needs for adult and infant diagnosis in Unguja and Pemba Islands; the number of adequate and safe laboratories with testing capacity; to train laboratory personnel to perform essential HIV screening and confirmatory tests including CD4 tests for staging disease, as well as basic chemistry and hematology tests to monitor therapy; and to ensure that all laboratories in Unguja and Pemba Islands participate in National External Laboratory Quality Assurance Scheme (Tanzania NELQAS). Funds planned for this activity in FY05 were not awarded before the end of the fiscal year and were carried over for implementation in FY06.

As a zonal reference laboratory, MMH will provide leadership and quality assurance support for all laboratories in Unguja and Pemba and assure that all regional laboratories successfully participate in the NELQAS. The MMH zonal reference laboratory will participate in implementing the national HIV reference laboratory HIV nucleic acid amplification testing for diagnosing HIV infection in newborns. This will include providing training support and oversight for collection of dried blood samples from health facilities providing ART and PMTCT services in Unguja and Pemba and transporting samples to the Central Pathology Laboratory at MNH or any other laboratory with such capacity. It is not cost effective to develop such capacity in Zanzibar due to the low volume of tests to be conducted.

The MOHSW/MMH zonal laboratory will assist all health facilities providing ART services in Unguja and Pemba to access adequate and safe laboratories with the required capacity to carry out testing for disease staging and ART Monitoring. The MOHSW will assist MMH and Chake Chake hospital laboratory to achieve this capacity including ensuring the availability of equipment and routine maintenance, reagents, and supplies at points of service for testing. MOHSW will strengthen the capacity of the healthcare technical service workshop at MMH that will provide first-line support for

maintenance and troubleshooting.

With support from Columbia and AMREF, MOHSW-MMH will organize 2 training workshops of 20 participants each (total 40 trainees) for HIV testing, CD4 testing, and basic hematology and chemistry. MOHSW/MMH will collaborate with and assist AMREF in providing training on HIV rapid testing and basic laboratory operations to 100 non-laboratory staff from VCT, PMTCT, TB/HIV, and other clinical settings where provider initiated "opt out" HIV counseling and testing is conducted or needed. *(Note: This target is covered under AMREF to avoid double counting).* MOHSW/MMH will support 6 laboratory staff and managers from Unguja and Pemba Islands to participate in professional development activities including study visits, *national and regional meetings. Criteria for nomination and selection will be developed* in collaboration with MOH and CDC.

MOHSW/MMH will support and help monitor performance of HIV/AIDS related laboratory testing services through supportive supervision and implementing the zonal external laboratory quality assurance scheme (ZELQAS).

Emphasis Areas	**% Of Effort**
Commodity Procurement	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	2	☐
Number of individuals trained in the provision of lab-related activities	46	☐
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		☑

Target Populations:

Public health care workers

Laboratory workers (Parent: Public health care workers)

Private health care workers

Laboratory workers (Parent: Private health care workers)

Key Legislative Issues

Twinning

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.13: Program Planning Overview

Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13

Total Planned Funding for Program Area:

B5

Program Area Context:

The USG will continue to strengthen the capacity of the Tanzania Commission on AIDS (TACAIDS), the MOH, the Social Welfare Department (charged with orchestrating the OVC response) and other implementing partners, to monitor and evaluate the progress of the national response to HIV/AIDS and Emergency Plan activities. These efforts will be directed at strengthening the Health Management Information System (HMIS) for both program reporting and patient tracking and ensuring that HIV/AIDS surveillance, population-based and facility based surveys, as well as targeted evaluations are strengthened.

The USG and Government of Tanzania (GOT) recently established a Technical M&E Working Group that will continue to operate in FY06 and will provide strategic direction to all M&E activities. Other key donors that support the GOT through the Working Group and M&E activities are the World Bank, UNAIDS, and UNDP. The USG and GOT will build on several important initiatives that began in FY05, namely the computerization of the M&E system and development of a national training curriculum for M&E.

With Emergency Plan funding, spatial analysis of HIV/AIDS programs and survey data was gathered through a Geographic Information System (GIS) and was fully mapped. This exercise enhanced the USG's ability to strategically plan activities in all program areas. In addition, a Service Availability Mapping (SAM) survey is in progress under USG and WHO funding and preparations are underway for the 2005/2006 facility-based Service Provision Assessment (SPA) with USG technical assistance. The results of a USG supported 2003/04 ANC sentinel surveillance survey covering 57 sites in 10 regions are currently available and another ANC sentinel surveillance survey will commence in October 2005. This survey will cover 93 sites in 15 regions, and will be accompanied by a HIV drug-resistance survey in the Dar es Salaam region. The Tanzania HIV/AIDS Indicator Survey was completed and the data will continue to be disseminated and utilized while the M&E training curriculum is developed in FY06.

To facilitate a more productive exchange of reporting information between the USG team and its implementing partners, reporting guidelines and templates for the partners are being further developed. A database system that collates and houses each partner's information was piloted in October 2004; and this database will be fully operational in FY06 and all partners will be trained to use it.

In FY06, the USG will continue to provide financial and technical assistance to strengthen other strategic information systems as well as the capacity of TACAIDS, the MOH, the National AIDS Control Programme (NACP), and the Social Welfare Department. This capacity will include monitoring and evaluating the progress of programs and strengthening M&E systems to enable the collection, analysis and use of data for programming both at the national and regional levels and for Emergency Plan reporting. The national Care and Treatment monitoring and reporting system is in use in 96 facilities and provides data at the program level for national monitoring. This system requires strengthening in order for it to be useful at the facility level to inform patient management. The USG, in collaboration with the WHO and other donors, will support the development of a paper based ART patient monitoring register. Longitudinal registers are being developed and will be piloted along with electronic medical records systems in a network of facilities to test the feasibility of scaling up such systems. The IT infrastructure at the MOH's headquarters and seven zonal hospitals has been strengthened and the pilot facility based PMTCT monitoring system within the HMIS will be expanded to three zones. Technical assistance will be provided to develop national monitoring systems for other program areas such as VCT and HBC and OVC, including addition of a community-based information system.

Program Area Target:

Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	2,934
Number of local organizations provided with technical assistance for strategic information activities	906

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National AIDS Control Program Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 3379
Planned Funds:
Activity Narrative: This activity builds on activities started using FY05 funds and is closely related to activity #5258

Care and Treatment of people living with HIV/AIDS (PLWHA) has been adopted as one of the interventions in the health sector's response to the HIV/AIDS epidemic in Tanzania. The Care and Treatment program was initiated in 2004 with 32 health facilities. The program was scaled up to 96 sites in June 2005. Scale-up to an additional 104 sites is expected in FY06.

Monitoring and reporting of Care and Treatment services is part of the responsibilities of the National AIDS Control Program (NACP) in coordinating the health sector response to the HIV/AIDS epidemic. In 2004, the NACP in collaboration with its implementation partners developed a program-level monitoring and reporting system for Care and Treatment. The system consists of 3 forms (CTC1, CTC2 & CTC3) developed to facilitate collection of patient information. CTC1 is a patient identification card that contains demographic information, point of service provision and date of enrolment into care. This card is retained by the patient and presented during every clinic visit. CTC2 is the patient management record. It contains *information such as patient demographic data, residential address, date of enrolment* into care, pre-ART treatment information, ART eligibility, date of ART initiation and the starting regimen. The CTC2 also records patient follow-up with a set of information collected at each clinical encounter. The CTC3 form which derives its information from the CTC2, is a listing of all clinical encounters at each facility, each month. CTC3 is filled in triplicate; 1 copy remains at the clinic, 1 copy is sent to NACP and 1 copy to the District Medical Office. Filled CTC3 forms flow from the facilities to NACP monthly and are entered into a database. Prior to the initiation of the program, Care and Treatment Unit (CTU) personnel were trained on the use of CTC forms. A two-hour session was conducted within the service provision training targeting service providers. The CTU staff trained were not necessarily the ones who are actually involved in completing the CTC forms at the facilities.

This national monitoring and reporting system experienced several challenges including poor data quality due to lack of training of actual data recorders and lack supportive supervision; slow data flow from the facilities to NACP. The CTC system was designed to monitor program-level indicators and does not meet the needs of the facilities, i.e. the information is not collected in such a way that it could inform patient management decisions and thus improve quality of care. This may have contributed to CTU staff ambivalence towards the quality and flow of the CTC3, which is required by the NACP for national indicator reporting.

In FY05, the USG supported the NACP, (technical assistance and funding) to strengthen their central office to handle CTC3 data. Activities included technical assistance to develop a CTC3 database in February 2005. FY05 funding has just come through and will be used to hire a data manager to receive and manage the CTC3 forms, supervise data entry and synthesize the information into required indicators. These funds will also be used to develop training guidelines and train facility data personnel in filling the CTC3, as well as sensitize the CTU staff, facility and CTU in-charge on the need for program-level reporting.

Activities to strengthen the CTC system are also being supported by PharmAccess International through the Netherlands Embassy. This support is being used for the printing and distribution of CTC forms and hiring of 5 staff (one national M&E officer and 4 zonal M&E supervisors). The M&E zonal supervisors are providing supportive supervision to the facilities and ensuring data flow (CTC3 forms) to NACP. This

financial support continues in FY06, this time incorporating training of regional and district health management teams (RHMT & DHMT).

Additional funds requested in FY06 will be used for the development of a facility-based monitoring & reporting component to be added to the CTC system and demonstrating the system in a few selected facilities. Activities include development of tools, including adaptation of the WHO facility-based chronic HIV/AIDS care registers; development of facility summaries and national reporting forms; development of standard operating procedures; adapting the WHO training curriculum; training of data personnel from selected facilities on filling the registers and producing summary reports; training of regional supervisors on quality assurance and supportive supervision; and sensitizing the CTU staff, facility and CTU in-charge, DHMTs and RHMTs in selected regions. FY06 funds will also be used to maintain the staff hired with FY05 funds.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	288	☐
Number of local organizations provided with technical assistance for strategic information activities	97	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	National AIDS Control Program Tanzania
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	3380
Planned Funds:	
Activity Narrative:	Existing NACP surveillance personnel will be maintained and 3 new staff (2 drivers and a biostatistician) will be recruited. A surveillance advisory committee will be formed to advice the NACP on issues such as scaling up, data collection, data handling, analysis and reporting. The surveillance working group, formed during the 1st and 2nd surveys will be expanded to include more members in accordance with the increased number of participating regions. The main function of the workgroup is to maintain standards of data collection techniques as stipulated in the surveillance protocol. During the 3 months of specimen and data collection, members of this group will carry out supportive supervision at least once every month to all participating ANC. The purpose of supervision is to ensure that surveillance activities are carried out as per the protocol and training. In preparation for the next round (2006/07), 36 additional sites (6 sites each from Singida, Coast, Ruvuma, Rukwa, Manyara and Mwanza region) will be systematically selected. Other types of HIV/AIDS surveillance data will continue to be routinely collected throughout the year. NACP capacity to utilize routinely collected program data will be improved. These data include AIDS and HIV/TB case surveillance, HIV sero-prevalence among blood donors, and HIV prevalence among users of prevention of mother-to-child transmission of HIV and voluntary counselling and testing (VCT) services. Data analyses and report preparation will be done by the surveillance advisory committee and the findings disseminated to national and international forums. Because of the high mutation rate of HIV-1 and the necessity for lifelong treatment, it is expected that HIVDR will emerge in treated populations where antiretroviral treatment (ART) is being rapidly scaled up. In countries where only one standard initial ART regimen will be used with one alternate for patients failing therapy, it is important to evaluate whether transmitted resistance has reached a level that would affect ART effectiveness. Tanzania has adopted Care and Treatment for PLWHA as one of its strategies in the health sector response to the HIV/AIDS epidemic, and has formulated the National Care and Treatment Plan, currently being implemented. Prior to the National Antiretroviral Therapy (ART) program, ARV drugs were only available to people who could afford them, particularly in the private sector and in major urban centers of Tanzania, such as Dar es Salaam, Arusha and Mwanza. Treatment regimens were not standardized or monitored efficiently, and services were provided without any reliable drug supply. These treatment conditions may have led to the occurrence of HIV drug-resistant strains. It is crucial to monitor the threshold of HIVDR as a baseline prior to scale up ART services. The HIVDR survey will be limited to Dar es Salaam region and carried out alongside the 2005/06 ANC sentinel surveillance survey. Specimens from pregnant women, aged less than 24 yrs in their 1st pregnancy will be collected in from all ANC sentinel sites in Dar es Salaam. Specific activities include training and supervision of data collectors; shipping of specimens to NACP and to CDC Atlanta (for laboratory testing), data analysis and dissemination of results. Additional funds are requested to support data collection in the 2006/07 round of ANC sentinel survey which will be conducted in 129 sites in all 21 regions of Tanzania. HIVDR surveillance will be conducted concurrently but limited to 3 regions (Dar es Salaam, Mbeya and Mwanza regions. All sentinel surveillance sites from these regions will participate in the drug resistance survey.

Emphasis Areas	% Of Effort
HIV Surveillance Systems	51 - 100
Other SI Activities	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	279	☐
Number of local organizations provided with technical assistance for strategic information activities	133	☐

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Kagera

Kigoma

Kilimanjaro

Lindi

Manyara

Mara

Mbeya

Morogoro

Mtwara

Mwanza

Rukwa

Ruvuma

Shinyanga

Singida

Tabora

Tanga

COAST

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National Institute for Medical Research
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: *13*
Activity ID: 3409
Planned Funds:
Activity Narrative: One of the long-terms goals of the Emergency Plan to strengthen the national capacity to monitor HIV/AIDS intervention. Monitoring and reporting systems can either be paper-based or electronic. However, with scaling up of services, it becomes increasingly difficult to track patients using paper-based systems and electronic systems are becoming increasingly necessary. Introduction of electronic patient tracking systems cannot be achieved without the necessary Information and Communication Technology (ICT) infrastructure. Such ICT infrastructure includes *hardware, software, local/wide area networks, internet connectivity, user support,* documentation and system security.

FY04 funds were used to implement local area networks (LAN), internet connectivity and procurement of computers at MOH, NACP and PMTCT headquarters and conducting ICT needs assessment in 21 regions. Based on this assessment, seven zonal referral hospitals in Mwanza, Kigoma, Kagera, Mbeya, Iringa, Mtwara, and Morogoro where HIV/AIDS services are being implemented were selected for ICT infrastructure development.

FY05 funds will be used to implement ICT infrastructure including LAN installation and internet connectivity in the selected hospitals. These hospitals will be used as centers for data collection from other regions within the zone and electronically transmit the data using Wide Area Network (WAN) link to NACP and MOH. An HMIS electronic database has been implemented in these hospitals and the PMTCT-MS system will be piloted in three of the 7 zonal referral hospitals.

There are no plans for further expansion in infrastructure development. The funds requested in FY06 will be used for: system maintenance, internet connectivity at MOH, NACP and 7 zonal centers, procurement of hardware and training staff on email and application software usage.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
Information Technology (IT) and Communications Infrastructure	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	20	☐
Number of local organizations provided with technical assistance for strategic information activities	*10*	☐

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Coverage Areas

Dar es Salaam

Iringa

Kagera

Kigoma

Mbeya

Morogoro

Mtwara

Mwanza

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Macro International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 3453
Planned Funds:
Activity Narrative: This activity consists of three surveys that MEASURE DHS is implementing in Tanzania: Tanzania Service Provision Assessment Survey (TSPA), Tanzania HIV/AIDS Indicator Survey (THIS) and the 2004 Tanzania Demographic and Health Survey (TDHS). The activity also includes dissemination and data utilization activities related to these surveys.

TSPA is currently in the planning stages. It will address the monitoring and evaluation needs of HIV/AIDS and maternal and child health programs by evaluating the services provided at a sample of health facilities throughout Tanzania. The survey, addressing the emphasis area- facility survey, will cover government, non-government, and private health facilities. The data to be collected includes a listing of personnel working at each facility, an inventory of equipment, supplies, and medicines, observation of client-provider interactions, and possibly exit interviews with clients. There will also be an assessment of the facility's ability to provide such services as VCT, PMTCT, and anti-retroviral therapy. Interviewees for the survey will include adults, women and men, pregnant women, as well as children, including orphans and vulnerable children. The National Bureau of Statistics will conduct the survey. However, the Ministry of Health is playing a major role in design, implementation, and analysis. The importance of the survey to the country is evidenced by the fact that the entire local cost of implementation is being covered by the Government of Tanzania through its 'basket' of donor funds. FY06 funds will be used to complete the data analysis and report writing, to publish the final report (2,000 copies), the Key Findings report (4,000 copies) and the separate HIV/AIDS report (4,000 copies) and to disseminate the publications.

THIS has been completed, with a final report released at a national seminar held in April 2005. The principal target population for this survey were adults (including 6,863 women and 5,659 men). This survey covered the full range of international HIV/AIDS indicators and including HIV testing. Survey results will be useful for planning, as well as monitoring and evaluating, health and HIV/AIDS programs. Activities for the coming year will cover further analysis and dissemination of the data. FY 06 Funds would be used to complete work on a study comparing the HIV prevalence levels from the survey with those generated from the antenatal sentinel surveillance system, to conduct 2 training of trainers workshops for civil society organizations using a HIV curriculum developed by Macro and Tanzanian counterparts and to print and disseminate more copies of the final report and the poster in Tanzania.

Data collection the 2004 TDHS, has been completed and a preliminary report is available. Work on the final report is progressing, with a national seminar planned for either late 2005 or early 2006. The data will address the monitoring and evaluation needs of health, family planning and HIV/AIDS programs and provide policymakers involved in these programs with information to effectively plan future interventions. The findings will provide information about trends in many demographic, health, and family planning indicators over time. The importance of the survey to the country is evident in the fact that the TDHS is an integral part of Tanzania's Poverty Reduction Strategic Plan and all the local costs of the survey are being covered by the Ministry of Finance through a 'basket' of donor funds. The target population of the survey included adult women, children and youth (under 5), however, the survey also covered a sub-sample of adult men. Data was collected in both urban and rural areas, will produce data at the national level, for 8 zones (groups of regions), as well as—for selected indicators—for each of Tanzania's 26 regions. The survey also included Zanzibar. In addition to a detailed final report and national seminar, other dissemination activities, such as regional seminars, production of other print materials,

press releases, presentations at other meetings, partially funded by MEASURE DHS core funds. No FY06 funds are being sought for this activity

Emphasis Areas	% Of Effort
AIS, DHS, BSS or other population survey	10 - 50
Facility survey	51 - 100
Other SI Activities	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	500	☐
Number of local organizations provided with technical assistance for strategic information activities	5	☐

Target Populations:

Adults

Orphans and vulnerable children

Pregnant women

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 3457
Planned Funds:
Activity Narrative: This activity is a follow-up on to the 2-year stigma-reduction activity that was approved in the FY05 COP. Funds allocated in FY05 were to cover activities for the first year. Funds requested in FY06 are for the final phase of the study.

Stigma and discrimination is a barrier to effective HIV programs, including uptake of VCT, PMTCT, ARV and opportunistic infection treatment, adherence to treatment, care and support for PLWHA and OVC, as well as behavior change. Reducing stigma and discrimination is essential to meeting the goals of the President's Emergency Plan. It will help create an environment that will support people to increase the uptake of services, such as seek HIV testing, disclose HIV sero status, access treatment, adhere to drug regimens, and assure care and support for PLWHA and OVC. The need to address HIV-stigma and discrimination has now been clearly recognized in Tanzania and by the President's Emergency Plan, and is a key cross-cutting issue that runs through all HIV/AIDS programming.

For the past four years the International Center for Research on Women (ICRW) and Muhimbili University College of the Health Sciences (MUCHS) have been working together to collect data to inform the design of stigma-reduction program, develop practical tools, adapt and translate those tools into Swahili and begin to develop a standard set of HIV stigma and discrimination indicators for measuring program success. In addition, we have worked closely with Kimara Peer Educators and Training Trust (Kimara Peers) during the data collection phase, in developing intervention tools and also in developing a community stigma reduction program.

Building on the foundation work done by ICRW and MUCHS in Tanzania, Kimara Peers is currently implementing a pilot model community-based stigma reduction program, through a grant from the REACH project. Intervention activities will continue until January 2006. It is critical that this first of its kind model program be systematically evaluated to examine whether it has had the intended impact in both the short-term (immediate effect) and longer-term (sustained effect), as well as to capture and document lessons learned to allow for feasible replication and scale-up of stigma-reduction. The study will use both quantitative and qualitative methods.

With FY05 funding, ICRW, MUCHS and Kimara Peers through FHI, will conduct the first phase of a targeted program evaluation of the ongoing Kimara Peers community stigma reduction program to assess short-term, immediate impact. In FY06, a second phase of evaluation will be conducted to examine the longer-term impact and whether the intervention has had lasting, sustainable effects.

The TE will examine whether there is a change in stigma and resulting discrimination at the population level within the communities that receive Kimara's enhanced stigma reduction programs. They will use a pre/post survey design triangulated with 2 rounds of qualitative data collection. This design will measure the change in stigma and discrimination at the community level over 20 months of implementation of the enhanced Kimara project (i.e., with the integration of stigma-reduction components into ongoing HIV and AIDS activities). A baseline survey on stigma (n=978) was conducted in Kinondoni as part of a project to develop and test indicators for stigma and discrimination. The first round of qualitative data will focus on documenting, from the perspective of PLWHA, their families, project staff and key community leaders, whether, and how, stigma may be changing over the course of the intervention and the role of the intervention (as opposed to other confounding factors) in any change that might be occurring.

Specific methods to be used to answer the four main research questions are: 1)

Analysis of baseline survey data (data collected as part of stigma indicators development project). 2) Qualitative data collection: In-depth interviews with PLWHA, affected family members, program staff and community leaders to collect information on their experience with stigma in the community. First round will collect perspectives going back to before the start of the intervention. The second round will capture experience as the intervention progresses. 3) End-line survey: The data collection will be done in collaboration with further work to test and validate indicators for stigma and discrimination (through HORIZONS). The analysis will compare baseline data with endline results, to evaluate the impact of the stigma-reduction program. Process indicators being collected by Kimara Peer Educators will also be included in the analysis.

Initial anecdotal evidence from the program indicates it is having significant impact. Kimara Peers have seen a significant increase in people using VCT since the activities began, an increase in PLWHA joining group counseling sessions, and community demand for expansion of the stigma-reduction programming. However, without targeted program evaluation, it will be difficult to distinguish whether these increases are all or partly due to the stigma activities, rather than to other possible confounding factors, like the expectation of ARV availability or media campaigns. In addition to assessing whether these immediate apparent impacts are due fully or in part to the intervention, it is also important to examine whether there are lasting impacts. Whether behavior change is sustained once the intervention ends.

Kimara's program is the first of its kind in Tanzania, and already being looked to as a model stigma reduction program. This is a unique and important opportunity to thoroughly evaluate what impact this program is having, both in the short and longer-term, and learn vital lessons for successful scaling up of stigma-reduction. Kimara Peers is also recipient of funding from the Foundation for Civil Society to support AIDS affected children through psychosocial interventions and IEC materials.

Emphasis Areas	% Of Effort
Targeted evaluation	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	90	☐
Number of local organizations provided with technical assistance for strategic information activities	2	☐

Target Populations:

Community leaders

Community-based organizations

Faith-based organizations

Non-governmental organizations/private voluntary organizations

People living with HIV/AIDS

Key Legislative Issues

Stigma and discrimination

Gender

Volunteers

Wrap Arounds

Coverage Areas

Dar es Salaam

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health - Zanzibar, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 3502
Planned Funds:
Activity Narrative: Zanzibar SITThe primary role of the Zanzibar AIDS Control Program (ZACP) under the Ministry of Health and Social Welfare is to ensure effective implementation and institutionalization of the National Health Sector HIV/AIDS Strategic Plan in Zanzibar. Areas covered in the national response to the HIV/AIDS epidemic include Prevention of Mother to Child Transmission (PMTCT), HIV/AIDS Care and Treatment including counseling and testing, enhancement of laboratory capacity and services, HIV/AIDS/STI surveillance and development and/or information management systems to monitor these interventions.

In FY05, the USG supported the ZACP in strengthening infrastructure & human capacity for strategic information activities. These activities include adaptation of the PMTCT Monitoring System (PMTCT-MS) used in the mainland of Tanzania, development Care & Treatment Monitoring System and strengthening of the existing VCT Monitoring System. FY05 funds will also be used to create a patient tracking system across the various HIV/AIDS intervention programs to reinforce referral linkages between programs. The FY05 funds have just arrived and these activities will be rolled over into FY06. Proposed funding in FY06 will be used to build onto these activities.

Specific activities to be started with FY05 funds and continued with FY06 funds include hiring and maintenance 6 new staff (an epidemiologist, a biostatistician/ programmer, 2 data entry clerks and M&E supervisors). ZACP Strategic Information and program personnel (current & new) will be trained on basic epidemiology, M&E and basic computer skills including use of Epi Info (Windows version). There will be training for M&E supervisors on paper-based systems for Care & Treatment, VCT & PMTCT. Other activities are procurement and maintenance of equipment and supplies for infrastructural strengthening.

In order to monitor and report PMTCT activities in Zanzibar, the PMTCT-MS used in the mainland of Tanzania will be modified to suit local needs. Activities will include adaptation of PMTCT-MS, printing and distribution (of training materials?) and training of site personnel on the paper-based system in 3 exiting sites and introduction to 10 new sites as they become operational. Other activities are: specialized training for Zonal PMTCT Coordinators & M&E supervisors on the paper-based system (registers, monthly summary forms etc); modifying and installing the computer-based system at ZACP offices at Unguja & Pemba; developing standard operating procedures for data collection (Monthly Summary Forms), data quality checks; data flow (from facility to ZACP offices), data entry cleaning, facility feedback from ZACP offices to facilities; training M&E officers, Zonal PMTCT Coordinators etc on usage. The PMTCT-MS in Zanzibar will be reviewed after 7 months in operation

Activities for the VCT Monitoring System will include: reviewing of the current Epi Info (Version 6) database at ZACP; updating the database to Epi Info -Windows version; introducing the paper-based system to the existing 20 sites and new sites as they become operational. All personnel using the system will be trained. Supportive supervision infrastructure developed and implemented by the M&E and zonal coordinators.

Care & Treatment services have begun in 2 facilities and there are plans to include 3 additional facilities. The existing facilities use the program-level Care & Treatment monitoring system used in mainland Tanzania. FY05/06 funds will be used to develop a national Care & Treatment Monitoring System for Zanzibar. Specific activities will be to review existing data collection system at Mnazi Mmoja Hospital: to adapt the WHO HIV chronic care registers to monitor patients before and after initiation of ART; to

develop and/or adapt instruments; to summarize the register data for periodic reporting (monthly, quarterly, semi annual or annual); to develop training guidelines; to train clinical and data staff; to develop of standard operating procedures for data management and data & report flow from facilities to NACP and vice versa. This new facility-based Care & Treatment system will be introduced at Mnazi Mmoja and Chake Chake hospitals and to other sites as they become operational. Staff hired with FY05 funds will include a biostatistician/data manager who will provide oversight in the development of an electronic medical record (EMR) system for managing the patient information at the Care & Treatment clinic at Mnazi Mmoja Hospital. The development of an EMR will be an opportunity for a more in-depth longitudinal analyses of and provide insight on the impact ART in this setting.

Laboratory services are closely associated with provision of HIV/AIDS care. The ZACP will use USG support in FY05/06 to establish Laboratory Information System to capture these services. Specific activities will be to conduct 3-day workshop to strengthen existing paper based information system by introduction standard forms, register books, dispatch of results and report forms at different levels and training 2 staff from Mnazi Mmoja Hospital on basic data management. The USG will provide technical expertise to assist the ZACP in the development of an electronic laboratory monitoring system for Mnazi Mmoja Hospital laboratory.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50
Proposed staff for SI	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	163	☐
Number of local organizations provided with technical assistance for strategic information activities	40	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: *University of North Carolina Carolina Population Center*
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 3512
Planned Funds:
Activity Narrative: Measure Evaluation will continue to provide technical assistance to the USG and its implementing partners, as well as to the Government of Tanzania (GoT) to strengthen strategic information systems in order to effectively monitor and evaluate the progress of the national response to HIV/AIDS and Emergency plan activities and to meet reporting requirements.

A Resident Advisor will continue to assist USG agencies in Tanzania and USAID particularly in maintaining and refining a system for data collation for purposes of tracking of Emergency plan activities and for generating required reports. MEASURE Evaluation will revise the data collection forms and reporting guidance for partners to incorporate the changes in the revised indicators and assist in data collation and aggregation for the quarterly, semi-annual and annual reports. Assistance will be provided in M&E training to strengthen the capacity of USG implementing partners and the GOT to monitor and evaluate their programs. The training will be aimed at creating or furthering a monitoring and evaluation work plan which is to serve as a guide for effective M&E systems in implementing agencies. The M&E workshops will focus on indicators, data quality, reporting, development of M&E work plans and data use for decision-making among USG implementing partners.

A great deal of data has been collected in recent years on HIV/AIDS, health, population, and AIDS-related behavior in Tanzania. Data has been compiled in different publications such as the national census in 2002, the Tanzania HIV/AIDS Indicator Survey (THIS) in 2003-2004, the 2004 Demographic and Health Survey (DHS), the HIV and STD Sentinel Surveillance Surveys conducted annually by NACP, and several Behavioral Surveillance Surveys (BSS). These data provide valuable information for planning, policy analysis and development, monitoring and evaluation, and setting national and district level priorities. At the request of TACAIDS and the MOH/NACP, a comprehensive curriculum on using data for decision-making (focused on District-level decision-makers) was developed and will be finalized. This curriculum will be used in 2 regional workshops in November 2005 and 3 regional workshops in 2006, for Regional and District Health Management Teams. Overall, the training components of the activity will provide on the spot M&E support to all USG/Tanzania implementing agencies and will be used in training these partners in M&E activities and in data use for decision-making.

Further, the GIS mapping of HIV programs shows how well HIV prevention, care and treatment interventions are distributed nationwide and whether certain areas are over served or underserved, especially areas with high prevalence. MEASURE Evaluation has begun mapping the USG HIV-related activities in Tanzania, and will continue to provide assistance with: regular updates on mapping information as new partner data becomes available; mapping of results and/or success stories and capacity building for implementing partners and GOT counterparts. The services availability mapping (SAM) tool which generates and maps information on the availability of specific health services in each district, provides a visual representation of health service gaps to be supported. Data will also be collected on the presence of key health personnel, and on the estimated coverage of selected interventions.

The information collected from the districts is linked to a GIS database containing the geographic coordinates of each health facility to produce maps showing the distribution of key health services across the districts. The long-term objective is to enable district and national planners to use SAM as a key tool for public health decision-making. The information generated will help identify where health system's gaps need to be most addressed in order to reach individuals in need of HIV/AIDS

services in the most equitable way possible.

A system to support data collation, reporting, management and planning for all USG activities in Tanzania is underdevelopment and will be ready for piloting in October 2005. The goal is to have a web-based database, which has some of the components of the COP and national level data, which the partners can use to enter data directly without using paper-based systems. All relevant M&E individuals of the USG agencies and implementing partners will be trained in the use of the database, including data entry and abstraction of reports and graphs. The database will facilitate use of information for program management.

To be able to implement the above mentioned activities, Measure Evaluation will train 40 people in the use of the USG Tanzania database for reporting and programming; provide technical assistance to 4 government departments (TACAIDS, NBS, NACP and HMIS), and train 20 individuals in GIS, and 25 individuals in SAM data collection, 120 individuals in data compilation and analysis, report writing and use of results.

Lastly, technical assistance will be provided to TACAIDS and MOH in leveraging of support for M&E from other donors such as the World Bank, Global Fund, WHO, and UNAIDS. This will involve assistance in writing funding proposals and negotiating for M&E support with donors.

The Service Availability Mapping (SAM) Survey is data collection methodology that identifies and maps all HIV/AIDS interventions currently undertaken in a given area. With FY 05 funding Measure/Evaluation provided technical assistance, while WHO covered implementation costs, for full facility SAM in Mwanza region and a representative sample in the rest of the country. With FY 06 funding MEASURE Evaluation will provide technical assistance as well as cover all implementation costs for an additional 5 districts. The total costs for the five district SAM is approximately

Emphasis Areas	% Of Effort
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100
Other SI Activities	10 - 50
Proposed staff for SI	10 - 50
USG database and reporting system	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	245	☐
Number of local organizations provided with technical assistance for strategic information activities	4	☐

Indirect Targets

Training in M&E, data use, GIS and use of the database could also occur informally through ad hoc requests from both USG agencies and implementing partners, and including international counterpart organizations. There is often a great deal of skill and knowledge transfers in such contexts, even though these are not documented. All such informal encounters constitute an indirect target. It is estimated thatan additional 20 individuals will benefit from ad hoc training in strategic information at different times.

Target Populations:

Community-based organizations

Faith-based organizations

Non-governmental organizations/private voluntary organizations

USG in-country staff

Host country government workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	Country staffing and TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	3519
Planned Funds:	
Activity Narrative:	CDC Staffing & SIProposed funding will be to support CDC Agency specific staffing needs as well as to complete USG/Tanzania Strategic Information team staffing to facilitate the achievement of Emergency Plan goals. FY06 funds will support 5 SI personnel including; (1) An SI program manager who will coordinate all CDC specific SI activities as well as serve as technical lead for surveillance and HMIS in the USG/Tanzania SI team. (2) An application developer/computer programmer who will provide support in systems development and maintenance within CDC, USG and to Government of Tanzania (MoH, NACP, MOHS, ZACP, TACAIDS) and other USG implementing partners. (3)Two Association of Schools of Public Health (ASPH) fellows, one each for surveillance and M&E; The ASPH fellowships are for people in mid-career who are sent to positions at CDC/GAP to train as well as serve in assisting/non-leadership positions. The M&E fellow will assist in CDC-related M&E functions while the surveillance fellow will assist in surveillance activities. (4) An USG SI liaison will be hired through CDC. Duties for the SI Liaison include coordinating the SI activities of the 4 USG agencies in Tanzania and liaising with OGAC on all SI related issues. This position will report to the Tanzania EP coordinator. The CDC SI personnel, listed above will provide continuous in-country technical assistance to the MOH and other partners for establishing and/or maintaining health information systems, monitoring and evaluation and HIV surveillance. This includes the development and/or maintenance of national and USG databases for HIV/AIDS and specifically for ART programs, protocols, training curriculum and monitoring and evaluation system for all program areas and design, implementation and data management and analyses of surveillance activities. The proposed funds will also support procurement of external temporary duty technical assistance (TDY) from CDC-GAP HQ and elsewhere to support the field staff in developing information systems for USG supported programs e.g. laboratory information System, counseling and testing, care & treatment (including ART), PMTCT etc. CDC-GAP HQ will also provide technical assistance for Zanzibar HIV/AIDS surveillance activities including ANC sentinel surveys and Most At Risk Populations (MARPS). Mainland surveillance activities such as ANC sentinel surveillance and HIV drug resistance will also continue to be supported. The travel budget includes both international travel (TDYs, training, meetings and conferences) and local travels (USG strategic planning meetings, partners meetings, workshops and site visits). This activity will contribute the overall human and institutional capacity building within CDC, USG and Ministry of Health Tanzania

Emphasis Areas	**% Of Effort**
Proposed staff for SI	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	200	☐
Number of local organizations provided with technical assistance for strategic information activities	10	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

USG in-country staff

USG headquarters staff

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: *Host country government* workers)

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	*Zanzibar AIDS Commission*
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	3522
Planned Funds:	
Activity Narrative:	This narrative describes activities utilizing FY05 to be carried out in FY06 and is related to all narratives for Zanzibar Island. This activity intends to scale up support by the USG to Ministry of Health in FY04 and FY05.

Zanzibar is part of the United Republic of Tanzania and consists of two sister islands, namely Unguja (1665 square kilometer) and Pemba (980 square kilometer) with estimated population of over a million inhabitant and annual growth rate of 3.1% (based on the 2002 Population and Housing Census).

Since identification of the first three AIDS cases in 1986, Zanzibar Revolutionary Govt. has acknowledged and provides leadership in placing HIV?AIDS among the highest priorities within the National agenda. The Zanzibar AIDS Control Program (ZACP) has been mandated to coordinate all HIV related health sector activities in the country.

In order to scale up the national response and participation of all sectors (public and private) in the fight against HIV/AIDS in the country, a national multi-sectoral coordinating body was established in year 2003, with the name of Zanzibar AIDS Commission (ZAC). ZACP is the secretariat of ZAC with the role of ensuring continuation of experienced gathered in past years as well as to create conducive environment and harmonization of institutional memories. Furthermore in order to set up sound platform that will ensure effective and participatory M&E for all health sector interventions, *there is need to synergize and amalgamate the health sector* response within the M&E framework recently developed by ZAC.

ZAC has recently finalised the formulation of the Zanzibar National multi-sectoral Strategic Plan (ZNSP) as well as the national HIV/AIDS policy where issues on the *introduction of the "three ones principles" have been strongly promoted. Also the* ZNSP has strongly underscored the need to strengthen the capacity of ZAC and its secretariat ZACP, so as to ensure effective implementation of the three ones principles on having one national coordinating body, one national plan and one *national Monitoring and evaluation (M&E framework). Similarly, the health sector* through ZACP has also finalised the health sector response HIV/AIDS strategic plan

Through USG support, the Ministry of Health and Social Welfare continues to strengthen the health sector response to HIV/AIDS in Zanzibar through various interventions such as provision of preventive, care and treatment services, building capacity for provision of services and for M&E.

Specific activities include; development of a Health Sector HIV/AIDS M&E Framework *with linkages to the national multisectoral M&E framework; development of a* framework to monitor community-based interventions; building/strengthening ZAC & ZACP institutional capacity for M&E; procurement of equipment and related infrastructure; development of electronic systems to track the national response to HIV/AIDS in Zanzibar

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100
Proposed staff for SI	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	100	☐
Number of local organizations provided with technical assistance for strategic information activities	2	☐

Target Populations:

Community leaders

Community-based organizations

Faith-based organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Program managers

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Private health care workers

Implementing organizations (not listed above)

District level staff

Private Sector

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4908
Planned Funds:
Activity Narrative: DOD Mbeya SITThis activity also relates to activities in treatment (Mbeya Referral Hospital and Mbeya, Rukwa and Ruvuma Regional Medical Office)

As part of FY04 and FY05 funding, the Mbeya Referral Hospital and the US Department of Defense have been working on the development of an electronic medical record system (EMRS) for patient management and program monitoring in support of ART roll out in the Southern Highlands. This Access-based system was derived from one developed and implemented by Indiana University (IU) at Moi Teaching and Referral Hospital in Eldoret, Kenya as part of their Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) program. The staff at the Mbeya Referral Hospital collaborated with the University of Dar es Salaam's University Computing Centre (UCC) to modify this database for the specific needs of the Southern Highlands and reporting requirements of the National AIDS Control Programme (NACP). It is currently one of only two electronic systems that can generate the NACP's patient record (CTC2) and National reporting forms (CTC3).

The current EMRS contains information on over 7,000 patients being served at five different facilities in the Mbeya Region. It can generate reports such as up-to-date *information on current ARV uptake, cumulative number of patients on treatment,* the number of patients in care not yet eligible for ART (e.g. those with CD4 >200), the number qualified but not yet on ART, as well as those lost to follow-up. It also allows close monitoring of patient referrals between facilities for HIV services. Its primary purpose is to support individual patient management at the facility level and has been used to generate intake and follow-up visit forms for both adult and pediatric patients. In addition, orphan and vulnerable children services and home-based care services linked to the facility can also be tracked using this database, providing the hospital with information on services provided and a point of contact for patient follow in their community.

This system is designed to utilize the Mbeya Referral Hospital as the central hub for data management in the Mbeya Region with plans to expand to support all of the Southern Highlands. Currently, patient records at the Referral Hospital are entered in the clinic immediately upon completion of the patient visit. The other four facilities (one regional and three district hospitals) supporting treatment in the Mbeya Region send copies of their paper-based intake or follow up forms to the Referral Hospital for entry into the database. Reports and facility feedback are generated and patient reports and current care and treatment figures are returned to the facilities.

In FY06, initiatives under this submission will pilot a roll-out of this system to the *network of facilities in Mbeya as well as the other regional hospitals of the Southern* Highlands in the Rukwa and Ruvuma Regions. This will involve modifying the design so that each facility can maintain its own stand-alone electronic database. Data will be transferred from the facilities to the central hub and vise versa on a monthly basis using flash disk/diskettes for management and monitoring of ART in the zone. This is the most applicable system at this time, as most of these facilities have no access to internet/network services.

Specific activities in the roll-out will include building the human capacity and necessary infrastructure of the zone, beginning at the regional hospitals in Mbeya, Ruvuma, and Rukwa, then down to districts facilities. Each site will receive the necessary hardware which will be programmed with the Access database (or suitable up grade). Fourteen MOH personnel in these hospitals (two per site of an original seven target facilities) will be trained in use of the database including data entry, analysis and production of reports. Report structures will continue to serve a dual purpose; to manage patient

care and to provide information to the NACP of the progress of treatment within the *zone, facility by facility.*

The second stage of system development will be to move from a stand-alone to a network (WAN) model building upon the infrastructure CDC is developing nationally. Discussions are under way between the DoD, Mbeya Referral Hospital and IU to determine if the updated system IU has started to use in Kenya as a replacement to their original Access database will be substituted for that in the Southern Highlands. Their new version uses MySQL as its database, is scalable, web adaptable and can handle larger amounts of and more complicated data sets. IU is set to pilot this database in three separate, stand-alone centers in Tanzania. Should IU's system be adapted, it will only require a simple up grade in software and some additional training for both UCC and Southern Highland's personnel in its operation and customization.

This roll-out is intended to provide important information to the NACP on the benefits and potential problems of regionalizing such an electronic patient record system. It is also an extremely valuable tool for monitoring patient referrals between facilities. This zonal initiative will provide lessons learned from immediate outputs as well as support long-term strategic initiatives in patient management, providing leverage to the current paper-based system.

This activity also provides a unique opportunity for interagency collaboration within the USG. The DoD and Mbeya Referral Hospital will receive additional technical assistance from CDC/GAP in Dar es Salaam in the form of data management and *analyses as well software maintenance. Funding in this request will cover the cost for* equipment, software up grades, personnel training, backup maintenance and repair, and local technical assistance (UCC). Support for maintenance of the hardware as well as the database itself will be based at the Mbeya Referral Hospital with assistance *from UCC, CDC and possibly Indiana University.*

Emphasis Areas	**% Of Effort**
Health Management Information Systems (HMIS)	51 - 100
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	14	☐
Number of local organizations provided with technical assistance for strategic information activities	7	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas

Mbeya

Rukwa

Ruvuma

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	National AIDS Control Program Tanzania
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	4909
Planned Funds:	

Activity Narrative: NACP VCTThe National AIDS Control Program (NACP) has the responsibility of monitoring and reporting all HIV/AIDS intervention programs in Tanzania. The Voluntary Counseling and Testing (VCT) program in Tanzania was initiated in 1989. There are currently 521 VCT sites in the country, of which 113 operate with direct support from USG. Information from counseling and testing sessions is collected through counseling registration forms. Every month, personnel from the sites compile (aggregate) the data based on the number of people counseled (by age and sex), the number tested (by age and sex), and HIV status (by age and sex). Quarterly reports containing these summaries are sent to NACP. Data is compiled at NACP and VCT indicator reports are produced. The NACP with USG support recently revised the National Guidelines for VCT. The revised guidelines included a chapter on M&E of VCT at the national level. The national level M&E may also be adapted to regional, district and even lower levels. This component will be initiated during 2005 fiscal year and rolled out during FY 2006. Funds requested will support activities including printing and distribution of the national VCT guidelines, developing data collection tools, training of VCT counselors and other personnel on the use of these tools and data flow from the sites to NACP.

With technical assistance from the USG, the NACP M&E unit will develop a VCT application based on Epi Info or another appropriate software. The technical assistance from USG will include building capacity for NACP by having an USG application developer assist the NACP personnel to develop the application and train other users. This VCT software will be used to manage and synthesize the monthly VCT summaries from the sites. Monthly summary data will be entered and data analyses performed periodically (monthly, quarterly, semi-annually or annually) as necessary and the indicator reports generated and disseminated as required. Additional analyses will be performed by the NACP personnel as required with assistance from USG SI personnel.

The national guidelines on the provision of Home-base Care (HBC) have also been revised and include a chapter on M&E. Requested funds will support the printing and distribution of the guidelines and data collection tools as well as training community HBC providers on HBC monitoring and reporting.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	643	☐
Number of local organizations provided with technical assistance for strategic information activities	522	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Ministry of Health, Tanzania
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 4910
Planned Funds:
Activity Narrative: HMIS PMTCT This activity is associated with the activity narrative on ICT strengthening for MoH and with the PMTCT Monitoring System within the PMTCT program area.

The long-term goals of the Emergency Plan include the strengthening of national capacity to monitor HIV/AIDS program effectiveness and the integration of HIV/AIDS information systems into the overall national Health Management Information System (HMIS). The activities outlined below, began in FY05 and are a starting point in addressing these long term goals in Tanzania.

As a cornerstone of national monitoring and evaluation strategy, the Ministry of Health Tanzania, with technical assistance from USG, developed a national facility-based PMTCT Monitoring System (PMTCT-MS). This system is based on registers and monthly summary forms that are manually filled out at the facilities and utilizes computers (at the appropriate facility level) to capture the monthly summary data, generate reports and tables and provide feedback to the facilities. The USG is proposing additional funds in FY05 & FY06 to facilitate the strengthening of MoH's capacity to monitor national PMTCT activities; to ensure the sustainability of monitoring efforts; to leverage the available technical resources within the MoH and to encourage collaboration between the PMTCT program and HMIS Unit.

As an initial step towards strengthening the national HMIS unit in Tanzania, funds were allocated in FY05. These funds, which are currently being obligated, will be used to strengthen IT infrastructure and supportive supervision capacity at the HMIS Unit by purchasing computer equipment and a motor vehicle, as well as to strengthen human resource capacity by training HMIS staff in data management, software use, hardware support and monitoring and evaluation skills.

Activities specifically geared to PMTCT monitoring and reporting include demonstrating "loose" integration of the PMTCT-MS and routine health information by using common personnel and IT infrastructure (district and regional HMIS). Specific activities include decentralizing the use of PMTCT-MS software to 3 districts by conducting site readiness assessments; identifying and training HMIS focal persons in these 3 districts in the use of the PMTCT-MS and to receive and manage data from all facilities located in these districts. Other activities by the HMIS personnel will include installing PMTCT-MS application and providing ongoing troubleshooting support of the application; training PMTCT facility staff in using the registers forms and monthly summary forms; developing and coordinating of standard operating procedures for data and report flow between the facilities, districts and central office in Dar es Salaam. Additional activities include building supportive supervision infrastructure for quality assurance of PMTCT data. The HMIS personnel will also participate in the evaluation of the expansion of the PMTCT-MS software to the district level.

Funds requested in FY06 will be used to scale up the decentralization of the PMTCT-MS to additional zones where FY05 funds were used to build the appropriate capacity All PMTCT facilities, districts & regions located within the selected zones will participate. In addition, linkages will be established with the zonal training centers to ensure decentralization of training activities as well.

FY06 funds will also be used to finalize, print and disseminate the National HMIS guidelines.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	170	☐
Number of local organizations provided with technical assistance for strategic information activities	5	☐

Target Populations:

Nurses (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Other health care workers (Parent: Public health care workers)

District level staff

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Zanzibar MARPS
Prime Partner: *To Be Determined*
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 5035
Planned Funds:
Activity Narrative: Zanzibar MARPSThe CDC/HHS in Tanzania has also been collaborating with WHO in providing technical assistance to Zanzibar AIDS Control Program (ZACP) of the Zanzibar Ministry of Health and Social Welfare to conduct surveillance activities. Zanzibar is considered a low prevalence country with an estimated 0.6% of the general population infected with HIV (Ministry of Health and Social Welfare validation survey, 2002). In the 2002 round of ANC sentinel surveillance, the prevalence of HIV infection among ANC attendees was found to be 1%. The HIV prevalence among blood donors has ranged from 0.7% to 1.5% (1996 to 2003). This disparity in prevalence between Zanzibar and mainland Tanzania (7% in general population and 10% among ANC attendees) is surprising in light of Zanzibar's proximity to Dar es Salaam and that several hundred people commuting between Zanzibar and mainland Tanzania every day. The prevalence in Zanzibar points to the importance of investigating the contribution of high-risk populations to HIV transmission. Suspected high-risk sub-populations include commercial sex workers, beach boys, IV drug users, men who have sex with men and other workers involved in the tourism industry. Little has been done to survey these populations and determine their HIV-related risk behaviors.

The FY06 funds will support (1) a pre-surveillance assessment to gain a better understanding of which high risk groups may exist on Zanzibar and how they might best be found and surveyed and (2)adopt an appropriate sampling method e.g. respondent driven sampling (RDS) 3) behavioral and biological (HIV) surveillance activities among the identified subpopulations.

Emphasis Areas	% Of Effort
Other SI Activities	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	10	☐
Number of local organizations provided with technical assistance for strategic information activities	3	☐

Target Populations:

Commercial sex workers (Parent: Most at risk populations)
Most at risk populations
Injecting drug users (Parent: Most at risk populations)
Men who have sex with men (Parent: Most at risk populations)
Military personnel (Parent: Most at risk populations)
Truck drivers (Parent: Mobile populations)
Prisoners (Parent: Most at risk populations)
Seafarers/port and dock workers (Parent: Most at risk populations)

Coverage Areas

Kaskazini Pemba (Pemba North)

Kusini Pemba (Pemba South)

Kaskazini Unguja (Zanzibar North)

Kusini Unguja (Zanzibar South)

Mjini Magharibi (Zanzibar West)

Table 3.3.13: Activities by Funding Mechanism

Mechanism: ART MIS
Prime Partner: To Be Determined
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 5258
Planned Funds:
Activity Narrative: This activity is closely related to activity #3379

Provision of ARVs must be accompanied by monitoring systems that in addition to providing indicator reports, must yield information that clinicians need to provide quality HIV/ART care to their patients the system must also provide program managers with necessary information to develop and refine successful HIV/AIDS treatment approaches. In sub-Saharan Africa standardized, national ART monitoring systems are often too simplistic to be useful to clinicians. The few examples of more advanced, clinician-responsive ART monitoring systems have only been implemented in selected, well-supported sites and have not been proven feasible for roll-out as a national system in a country with substantial resource, staffing, and infrastructure constraints.

The Care and Treatment program in Tanzania was initiated in 2004 at 32 health facilities and scaled up to 96 sites in June 2005. An additional 104 sites is expected in FY06. The number of patients on ARVs rose rapidly from 1,500 patients by end FY04 to almost 14,000 currently. The expected numbers by close of FY06 and FY07 are 45,000 & 90,000 respectively. In 2004, the NACP, in collaboration with its implementation partners, developed a national monitoring and reporting system for Care and Treatment consisting of a patient appointment card (CTC1), a medical chart (CTC2) and a summary (CTC3) of clinical encounters for each month. This system was designed mainly to meet the national reporting requirements and did not address the clinicians and program managers needs mentioned above. While all sites are required to fill out the national forms, many sites are developing additional, redundant forms to fill in the gaps in the clinical record or to aggregate facility level data. There is an urgent need to review and revise this system so that it can be used by all stakeholders to gather and/or use the information to rapidly scale up the treatment program.

Tanzania was one of three countries selected to receive USG ART HMIS technical assistance through OGAC central SI funds. Throughout FY05, the USG (in-country and HQ offices), WHO and other partners provided technical assistance to the MOH/NACP to move the ART monitoring agenda forward in a timely and effective way. This TA has had limited success due to duplicative efforts among partners. In FY06, there will be a deliberate attempt to coordinate various efforts to support the NACP/MOH, preferably through a relatively neutral organization such as the WHO. This activity builds upon those recent and ongoing efforts to identify the needs and deficiencies of the current ART monitoring systems in Tanzania. The next step with central funds is to gather stakeholders in a workshop to strategize short-term, medium-term, and long-term solutions for (1) how to revise the national system to gather core data elements that are more responsive to clinical and programmatic needs, and (2) how to allow at selected sites for complementary, innovative data collection systems that are necessary for to inform key questions about quality of care in the national program.

This activity will build upon the efforts initiated with central OGAC SI funds to implement and support the strategy for a national core ART monitoring system. The TBD partner(s) will provide technical assistance and support to the MOH/NACP to promote and coordinate the monitoring efforts of all ART treatment partners in Tanzania. This will include coordinating development, maintenance and use the national ART monitoring system; Liaison with representatives from the WHO, the World Bank, the Global Fund, and other donor countries which have direct or indirect interests in ART monitoring efforts in Tanzania.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	100	☐
Number of local organizations provided with technical assistance for strategic information activities	20	☐

Target Populations:

Doctors (Parent: Public health care workers)

Nurses (Parent: Public health care workers)

Pharmacists (Parent: Public health care workers)

National AIDS control program staff (Parent: Host country government workers)

Host country government workers

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Laboratory workers (Parent: Public health care workers)

Other health care workers (Parent: Public health care workers)

Coverage Areas:

National

Table 3.3.14: Program Planning Overview

Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14

Total Planned Funding for Program Area: [redacted]

B5

Program Area Context:

The USG is particularly concerned with policies that affect human resource development and strengthening of human resources systems. In early 2005, the shortage of trained health professionals was upgraded from "crisis" to "emergency" status, with enormous Human Resources for Health (HRH) shortages across all cadres. At best, only about 60% of positions are filled; at worst, fill rates are as low as 30%. In addition, the health care workforce is being depleted through HIV-related mortality, which adds to the already high attrition rates. This situation continues to limit all components of the HIV response, especially ART roll out. The human resource crisis is indeed Tanzania's greatest health challenge.

In recent months, the MOH's Department of Human Resources has written a Policy Guideline on HRH that will form the basis of a Strategic Plan for HRH. In the coming months, the USG will collaborate with the WHO to provide technical assistance to the MOH in the development of this Strategic Plan, which will inform all subsequent HRH programming. In addition, a comprehensive workforce assessment will be undertaken with USG support to provide a compelling case for scale up and to inform policy-level decisions about recruitment, retention, and training. Complementary plans in FY06 include the development of business plans and scaling up of staffing in Tanzania's eight zonal training centers, and development of an emergency action plan for placing unused skilled workers, such as retirees, in critical shortage areas. In addition, this year the USG will work with the MOH to develop twinning programs for high-priority areas such as strengthening health facility management capacity. USG will also continue support to on-going faculty and curriculum development in HIV education in public and private medical schools.

Recognizing the severe constraints in HRH, in May of 2005 Tanzania submitted a Global Fund Round 5 proposal for [redacted] over five years for HRH. Because it appears unlikely that the proposal will be funded, Emergency Plan funding will become even more critical. In addition, it is anticipated that other HRH stakeholders such as the Japanese International Cooperation Agency and the German Technical Cooperation will take on a more pivotal role in the expansion of human resource initiatives.

HIV policy support and development at both the national and organizational levels will help to bolster prevention, care, and treatment programs. In FY05, in collaboration with the Government of Tanzania and various NGOs, FBOs, and PLWHA groups, the USG has supported the establishment of a National Council of PLWHA and the development of a draft legislative bill on HIV/AIDS. In an effort to raise public awareness of national HIV/AIDS policies, user-friendly versions of the National Health Strategy on HIV and the Tanzania HIV/AIDS Policy were developed and widely disseminated. At the Tanzania Commission for AIDS and the Zanzibar AIDS Commission, emphasis has been placed on assistance with proposals, implementation plans, and coordination of Global Fund activities with Emergency Plan programs. In FY06, emphasis will be placed on ensuring passage of the draft AIDS bill and advocacy for and development of a legal and regulatory framework for OVC.

Although stigma remains a serious issue, progress has been made this year. With USG support, eight NGOs and networks have established HIV/AIDS policies and workplace interventions. Policies improving access to care and treatment have been developed within the FBO sector. In FY06 the USG will support Master Training-of-Trainers for other Emergency Plan partners in the use of the stigma toolkit to ensure a standardized approach to addressing stigma. The USG will also explore possibilities of developing a user manual for OVC-related stigma and strengthening the capacity of Tanzania's private sector to mobilize corporate social responsibility for HIV/AIDS in the workplace.

Program Area Target:

Number of local organizations provided with technical assistance for HIV-related policy development	262
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	157
Number of individuals trained in HIV-related policy development	773
Number of individuals trained in HIV-related institutional capacity building	1,282
Number of individuals trained in HIV-related stigma and discrimination reduction	8,280
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	520

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Pact Associate Award
Prime Partner: Pact, Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 3384
Planned Funds:
Activity Narrative: This activity links to activities in Orphans and Vulnerable Children, AB and Other Prevention, Home-Based Care, Treatment and Other Policy Systems Strengthening.

Pact Tanzania is currently implementing a grants and capacity building program for the reduction of stigma and discrimination to four Faith Based Networks, including the Christian Council of Tanzania (CCT), Christian Social Service Commission (CSSC), BAKWATA, and the World Council for Religion and Peace. The program has been operational since November 2004 and aims to train and mobilize faith-based leaders so that they educate their constituents and congregations on the negative affects of stigma and discrimination using faith-based messages. The program covers the whole country, including the isles to a limited extent, and uses the Stigma Toolkit on Understanding and Challenging HIV/AIDS Stigma, which Pact has adopted for faith based groups. This specially developed Tool Kit was originally designed for NGOs, community groups, and HIV educators to raise awareness and promote actions to challenge HIV-related stigma and discrimination. With the recently received FY05 funds, grants will be provided to the FBOs to support their master trainers to conduct workshops for other trainers within their own faith communities.

Given the USG approach of integrating stigma in all areas of ongoing activities, in FY06 PACT will support other USG-funded partners implementing HIV/AIDS programs in addressing stigma in their different programs. Components will include:

1.) Continued support in implementing Stigma Tool Kit Master Training of Trainers for other USG-funded Emergency Plan partners, who will be encouraged to use this tool kit at different levels. Trainers will be trained to understand how to plan their own courses for different target groups of both AIDS professionals and/or community groups. Pact will contribute to ensuring a standardized approach to addressing stigma and promote continuity with materials and approaches that were proven and tested by Pact in the first year of the Stigma Program. An estimated 100 people from 20 organizations will be trained as Master Trainers on using this Stigma toolkit. These 100 trainers will then train 2,500 people.

2.) Adaptation of the faith-based stigma toolkit into a user manual for reducing OVC-related stigma. This will be a simplified version of the Toolkit and will be developed through consultation with OVC and stigma professionals. The manual will be used in community-based training on OVC-related stigma and will help implementing partners to integrate stigma into other on-going OVC programs. The toolkit will address both OVC programming needs for partners designing OVC programs and OVC stigma awareness creation at the community level. An estimated 15,000 copies of this manual will be printed and distributed to implementing organizations and other interested institutions.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	20	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction	2,600	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Target Populations:

Community-based organizations

Faith-based organizations

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

Policy makers (Parent: Host country government workers)

Program managers

HIV positive children (6 - 14 years)

Caregivers (of OVC and PLWHAs)

Host country government workers

Implementing organizations (not listed above)

Key Legislative Issues

Stigma and discrimination

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: National Institute for Medical Research
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 3407
Planned Funds:
Activity Narrative: This activity also relates to other HCD activities, including CAPACITY, Deloitte, and AIHA/ Twinning Center. In the program area of ART Treatment, it relates to BMC, MMH, and NACP activities.

The National Institute for Medical Research (NIMR) was one of the first organizations in Tanzania to draw attention to glaring deficiencies in Human Resources for Health (HRH). In November 2004, NIMR held a conference to facilitate discussion on HRH needs. FY05 funds were awarded to NIMR on September 1, 2005 to begin activities on behalf of, and in collaboration with, the MOH-Department of Human Resources and in careful coordination with other USG implementing partners (CAPACITY and AIHA/ Twinning) and other donors investing in HRH.

Due to the late award, further dialogue with the MOH-Department of Human Resources has occurred, resulting in amendments to and elaborations on the FY05 activity description. There are three HCD components to this activity. The first component is to strengthen the faculty teaching skills and institutional capacities of Muhimbili University College of Health Sciences (MUCHS) and Aga Khan University as HIV/AIDS education leaders in Tanzania. A sub award has been given to UCSF to host a mini fellowship to enable selected MUCHS faculty to participate in a preceptor program at UCSF. UCSF will also provide a visiting basic science lecturer to facilitate curriculum change and model learner-centered HIV/AIDS resident teaching at both MUCHS and Aga Khan. FY06 funds will support expansion of current programs to develop a shared resource library of materials and teacher resources, to hire additional instructors, and to provide faculty release time to work on curriculum development.

The second component of this activity is to support the MOH in the development of national strategic plans for HRH. Elements of this component include: identification and collection of information which will facilitate the planning process, including operational research studies; technical assistance to the MOH in the creation of relevant and appropriate scopes of work for varying cadres of health professionals, and the definition of relevant career paths for each cadre; and emergency measures for recruitment, retention, and training.

Central to each of these elements is transitioning the existing Zonal Training Center programs to a formally recognized system of Zonal Health Training Institutes which will eventually coordinate and produce the majority of in-service trainings in Tanzania, including HIV/AIDS trainings. Currently, most of the ZTCs have a predominant focus on one or two aspects of pre-service or in-service training. In transitioning to Zonal Health Training Institutes (ZHTIs), investments will be made in infrastructural and human capacity at each centre to make possible a broader expansion of training programs. Plans developed through working group meetings in FY05 will be operationalized in FY06.

Intahealth-Nairobi will implement the third component of this activity. Intrahealth will collaborate with NIMR to support the MOH in the development of a phased implementation strategy for decentralizing NACP HIV/AIDS in-service trainings from the central to zonal level. Elements involved in strategy development include liaising with and ensuring linkages between Zonal Training Centres and Zonal Referral Hospitals in order to maximize usage of Referral Hospitals as venues for training practicum. TOT training activities will also be conducted for ZTC and MOH personnel, with emphasis on management of systems necessary to support recruitment, registration, and tracking of ART course attendees. Another element of the Intrahealth work scope is to review Clinical Officer (CO) training programs and

prepare a strategy to meet tutor and curriculum upgrade needs that will better enable CO students to complete their training with current and appropriate HIV/AIDS knowledge and skill. As Tanzania's ART program expands to the health centre and dispensary level, COs will become one of the primary ART prescribers, hence the need for enhanced training for COs.

The final component of this activity is to strengthen NIMR's institutional capacity to manage is cooperative agreements and support the implementation of HIV-related programs in Tanzania. In FY05, a management support function is being created to provide financial and administrative support for all HRH programs. An element of this is provision of a three month fellowship for a NIMR administrative officer at to attend advanced administrative training at UCSF. FY06 funds will be used for follow-on consultation and on-site review of systems for managing externally funded programs. A fellowship to an administrator in the MOH-Department of Human Resources may also be funded in FY06.

Other plans for expansion in FY06 include HIV/AIDS faculty development in all public and private pre-service schools to assure that every pre-service tutor has current HIV/AIDS training and the appropriate level of skill and knowledge. In addition, technical assistance will be provided in modifying curricula for targeted health cadres in order to fast track the emergency upgrading of selected cadres.

The results of NIMR's intense focus on human and institutional capacity building, though challenging to capture on paper, will have compelling qualitative implications for Tanzania's health care system and for the Emergency Plan prevention, care, and treatment targets as the overall health care system is strengthened. This project, coordinated carefully with CAPACITY, AIHA/ MUCHS-Twinning, and ART programs in large referral hospitals, addresses better coordination and quality assurance of HIV/AIDS training activities while simultaneously building the capacity of the larger health care system.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	11	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	13	☐
Number of individuals trained in HIV-related policy development	60	☐
Number of individuals trained in HIV-related institutional capacity building	180	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	60	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	60	☐

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Policy makers (Parent: Host country government workers)

Program managers

Teachers (Parent: Host country government workers)

University students (Parent: Children and youth (non-OVC))

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Twinning

Stigma and discrimination

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	M&L
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	3454
Planned Funds:	
Activity Narrative:	Management Sciences for Health has been the lead agency providing support and technical assistance to the country's two national coordination bodies, the Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC). Key areas of this technical assistance include strengthening national level leadership, accountability, coordination, and resource mobilization in the Tanzanian response to the HIV/AIDS epidemic. The first key component of the technical assistance to these two organizations is to engender bold leadership and strengthen accountability. The technical assistant provided to date has been much more focused on TACAIDS than ZAC, and the investment in TACAIDS is apparent when comparing the state of their organizational maturity. ZAC has not yet reached the same level or organizational maturity as TACAIDS in terms of their structure, management, and leadership. As a result, FY06 represents an appropriate timeframe for a responsible exit strategy for extensive technical assistance, while there will be greater focus on ZAC to be sure they are appropriately structured and empowered. At the institutional level, focus on technical assistance to TACAIDS during FY06 will be on helping to streamline both internal and external processes and ensuring that key staff at TACAIDS have the critical skills to function as an effective coordinating body, catalyzing the response to HIV/AIDS in mainland Tanzania and calling upon qualified local expertise to address their needs. This will include far more emphasis on TACAIDS' staff and a bevy of external local consultants handling the bulk of work, with MSH providing the supportive supervision to be sure there are no gaps in the implementation of TACAIDS programs, including the involvement of local government in the process. This may include some additional technical assistance for appropriate linkages with the President's Office for Regional and Local Government, the Ministry of Health, and the Ministry of Finance; all critical bodies whose efforts are coordinated through TACAIDS for the effective response to the AIDS epidemic. Technical assistance provided during FY06 will be focused on very targeted technical assistance to address specific needs, ensuring that TACAIDS' and ZAC's staffs are prepared to address them in the future. With both organizations, however, there will be considerable attention paid to the mobilization of resources and both fiscal and programmatic accountability for those resources. Through this ongoing technical assistance, MSH has been the lead provider of technical assistance to Tanzania Mainland's Global Fund (GFATM) Country Coordinating Mechanism, which has recently been reconstituted into the Tanzanian National Coordinating Mechanism (TNCM). The significant resources that have been awarded to Tanzania are matched with tremendous implementation challenges, starting with the need for a far more effective TNCM, with a higher level of expectation for results. Project monitoring tools and more comprehensive reporting practices will be developed during FY06 to enable more timely intervention when projects need attention to assist with their timely initiation and the achievement of the desired results. This will be far more complex and labor intensive than the present secretariat function that MSH provides. This support will also include assistance to ensure the preparation of strong and locally developed implementation plans for existing or new GFATM awards. The need is similar in Zanzibar, though the USG is presently not so involved in their CCM, and an upcoming review of needs in Zanzibar will inform how to best assist with the successful implementation of their Global Fund projects. An area of proven success in addressing HIV/AIDS in Tanzania has been the Rapid Funding Envelope (RFE), managed by TACAIDS and Deloitte, with MSH technical

assistance. The USG provides funding for this management support to leverage funds from several other donors. MSH will continue in their role of providing support to mobilize additional resources, assist civil society organizations in making application to the RFE, and reviewing applications for appropriateness.

The need for line ministries to mainstream HIV/AIDS requires that MSH also provide support to TACAIDS and the ministries, including working with senior civil servants on policies/procedures to identify the impact of HIV/AIDS on their respective ministries and of their sector on AIDS.

MSH will also work with TACAIDS to ensure that Regional Facilitating Agencies (RFAs), set up with funding from the World Bank MAP program, are operating effectively. The RFAs activities are intended to run the community AIDS Response Fund, and to serve as the agents of TACAIDS in supporting civil society to address HIV/AIDS, especially building the capacity of local government, the Community Multi-sectoral AIDS Committees (CMACS), and community-based organizations that provide HIV/AIDS services.

It will also be important to link with the policy work funded by the USG to ensure that messages for policymakers, clergy, and other influential bodies so that HIV/AIDS high on the national agenda. In addition, MSH will work with TACAIDS and ZAC to ensure that the linkages with organizations of People Living with HIV/AIDS (PLWHA) are appropriately organized, linked, and coordinated, and that their representation is heard.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50
Workplace Programs	10 - 50
Community Mobilization/Participation	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	5	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	5	☐
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building	400	☐
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	130	☐

Target Populations:

Country coordinating mechanisms

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

People living with HIV/AIDS

Program managers

USG in-country staff

Host country government workers

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	3458
Planned Funds:	
Activity Narrative:	This activity also relates to activities in HIV/AIDS Treatment/ARV Services, Orphans and Vulnerable Children, and Palliative Care: Basic Health Care & Support. This activity has two main components to strengthen systems at the national level. The first component is to strengthen the coordination, normative, and management capacity of both the Care and Treatment Unit (CTU) and the Counseling and Social Service Unit (CSSU) of the National AIDS Control Programme (NACP), Ministry of Health (MOH) by supporting existing coordination and normative guidance activities of the NACP, MOH, and implementing partners. FHI will continue to strengthen the formal coordination mechanism among the more than 13 organizations directly implementing care and treatment programs in the country. They will also initiate and facilitate the coordination of the organizations providing home-based care (the term used in Tanzania for the full range of palliative care). Under the umbrella of the "Three Ones" approach, FHI will strengthen the mechanisms to harmonize the variety of approaches, ideas, and plans. Formal and informal methods will be used to maintain this coordination, technical information sharing, and harmonization. FHI will support the CTU and CSSU through the assistance of its in-country, senior professional staff to identify gaps, facilitate communication, ensure regular monthly and ad hoc meetings, and provide guidance when requested. Critical components of this activity are: implementing the recently revised national standard protocols to guide Care and Treatment and Home-based Care implementing partners in order to establish, strengthen, and ensure the quality of an integrated Continuum of Care approach; and linking facility-based Care and Treatment Clinic (CTC) services with social support and home-based care in the community to ensure early access/quality follow-up and adherence. The activity will also support strengthening care and treatment by facilitating the integration of HIV care and treatment training curricula and materials in pre- and in-service training programs in national, zonal, and regional health and medical training institutions through advocacy and planning meetings, and assisting in development of palliative care courses and training programs to improve the quality of services provided. FHI will initiate and support regular review and revision of training materials for the national care and treatment and palliative care courses, refresher courses, and patient and provider learning materials. FHI will also propose concrete approaches to NACP and medical facilities to address the human resource crisis through piloting innovative approaches (e.g. retired nurses; student nurses/clinicians during practica, incentive packages, etc); and supporting NACP to develop mechanisms to ensure quality and uniformity in the provision and reporting of HBC services through Zonal Coordination meetings, advocacy, joint partner revisions of materials, and planning to minimize HBC volunteer "burnout" and increase retention. These activities will reach all current 96 CTC sites, the additional 105 sites for 2006 in Tanzania, and all USG funded HBC programs. The second component is critically needed capacity building to the Department of Social Welfare (DSW) at the Ministry of Labour, Youth Development, and Sports, to enable their response to the needs of orphans and most vulnerable children (OVC/MVC). DSW will orchestrate the implementation of the National OVC/MVC Plan of Action, including the decentralization of OVC/MVC services down through the district and community levels. The frailty of the DSW and the newly formed mechanisms to address OVC/MVC needs at the district and community levels, as well as the weakness of the training for the social workers who will be charged with the welfare of OVC/MVC at the local level will require significant national level intervention to ensure successful implementation of the National OVC/MVC Plan of Action. This includes assistance to develop data management systems and technical supervision and monitoring capacities of the DSW, and assisting with an upgrading of the curriculum for social workers to train qualified professionals to care for OVC/MVC needs in all districts. The Data Management System (DMS) data management effort is facilitated by a system developed in FY05 by FHI, and builds on the process of data

collection of vulnerable children already begun by the DSW with assistance from UNICEF under the Most Vulnerable Children (MVC) program in 17 districts, which is available in the department's archives. Most of this information will provide the initial raw material for the DMS. The system contains the ability to map the concentration of orphans, the most vulnerable children, and their service providers in terms of geographic location, services offered and beneficiaries served. The main focus of the system is to enable users to have a comprehensive picture of needs and service provision for OVC/MVC in the country. It will serve as an effective planning tool at the national and local level. Under this component, FHI will also support the *translation of the National OVC/MVC Plan of Action into specific district-based* activities in partnership with other stakeholders, especially those implementing the OVC component of USG- and Global Fund-supported initiatives. In addition, FHI will work with the organizations providing OVC/MVC services through USG, Global Fund, and other support to ensure technical integrity of programs, share tools, materials, best practices, and lessons learned.

FHI support to the National AIDS Control Programme, Ministry of Health and the Department of Social Welfare, Ministry of Labour, Youth Development and Sports will serve as an important overall coordination, integration, and quality control measure for all organizations involved in HIV Care and Treatment, HBC, and OVC services and will contribute to indirect targets, including It will also have further impact on all hospitals, HBC, and OVC programs in the country.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Target Populations:

Country coordinating mechanisms

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Policy makers (Parent: Host country government workers)

USG in-country staff

Other MOH staff (excluding NACP staff and health care workers described below) (Parent: Host country government workers)

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: CAPACITY
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: *3462*
Planned Funds:
Activity Narrative: This activity links to activities in Other-Policy-System Strengthening Activities: Human Capacity Development through NIMR, Deloitte, and AIHA Twinning Program-MUCHS

Estimates indicate that nearly 10,000 health workers are necessary to provide ARV treatment to the projected number of 440,000 people in Tanzania by 2008. Not only does this workforce not exist, but there are also tremendous gaps in human capacity in the hospitals and health facilities throughout Tanzania. This activity will focus on important components of laying the groundwork to recruit, train, and retain *the necessary manpower to meet ARV treatment needs.*

CAPACITY initiated its work in Tanzania in FY2005, participating in an assessment of human capacity development (HCD) needs that started with involvement in planning meetings for the Global Fund (GFATM) Round 5 application from Tanzania that was focused on system strengthening, especially human resources for health. Funds from FY2005 are now being focused on key steps to be put in place to either anticipate the GFATM Round 5 award, or adapt plans to do the essential pieces of what was proposed without the GFATM funds. The immediate interventions for FY05 include assistance with a synthesis of human resources assessments and a strategy for the Ministry of Health (MOH) to address urgent, short-term, medium-term, and long-term issues associated with human resources for health, especially to address the debilitating shortfall of health workers to provide ARV treatment to the projected number of 440,000. CAPACITY is helping the MOH and the National Institute of Medical Research (NIMR--their partner agency that is involved in HCD planning) develop an array of interventions that will help address the dramatic needs. A labor market analysis is also being done with FY05 funds, in order to identify reasons for vacancies, whether and where healthcare workers exist, and what is keeping them out of the field. This will be the basis of briefing and advocacy materials that will identify the range of issues and potential options to influence recruitment and retention.

FY06 funds will be focused on continuing to advocate for effective interventions to address this emergency situation. This requires advocacy at the highest level to make necessary changes in the system (e.g., Civil Service Commission, the Ministry of Health, and the President's Office for Regional and Local Government, all of which must approve hiring of clinical personnel). It also involves assistance with scaling up innovative methods of recruitment and retention that have been identified through an innovation fund small grants process (see entry for Deloitte under Other-Policy-Systems Strengthening) and working with a newly established National Working Group on Recruitment and Retention.

In addition, CAPACITY will work with WHO and other partners to develop and maintain a comprehensive annual national workforce assessment, providing technical assistance to develop a workforce database, maintaining an inventory of staff employed, their training and skills, and where they are located; staffing allocations and vacancies by district and health facility; and output of current and recent graduates from pre-service training. This will be linked with the reconstituted Zonal Training Institutes, which will be the sites for decentralized training and ongoing supportive supervision. Needs identified through this inventory will feed into the training priorities for the nation.

There are several other activities that will focus on underserved areas; improved workforce performance; and decentralized pre-service, in-service, and continuing education that have been included in the Global Fund Round 5 proposal. Because it appears unlikely that this proposal will be funded, the activities will be prioritized by

the MOH and NIMR to identify the key pieces for CAPACITY to address. There are critical pieces that will be more firmly determined after the MOH strategy development that will occur in early FY06.

It is expected that persons from each of the 129 districts in Tanzania and Zanzibar will be included in training that will do institutional capacity building and will mobilize the community to address their human resource needs. In addition, 11 major institutions will benefit from capacity building, with 9 of those benefiting from technical assistance for policy development.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Health Care Financing	10 - 50
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	9	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	11	☐
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building	260	☐
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	130	☐

Target Populations:

Doctors (Parent: Public health care workers)
Nurses (Parent: Public health care workers)
Pharmacists (Parent: Public health care workers)
Traditional birth attendants (Parent: Public health care workers)
International counterpart organizations
National AIDS control program staff (Parent: Host country government workers)
Policy makers (Parent: Host country government workers)
USG in-country staff
Laboratory workers (Parent: Public health care workers)
Other health care workers (Parent: Public health care workers)
Doctors (Parent: Private health care workers)
Laboratory workers (Parent: Private health care workers)
Nurses (Parent: Private health care workers)
Pharmacists (Parent: Private health care workers)
Traditional birth attendants (Parent: Private health care workers)
Other health care workers (Parent: Private health care workers)
Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	Country staffing and TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	3504
Planned Funds:	
Activity Narrative:	Funds in the amount of [redacted] will go to CDC to strengthen support the MOH in Human Capacity Development. Through in-country program support and TDY assistance, CDC will work with the MOH to develop and implement a national strategy for human resource strengthening in the health sector to improve the Government of Tanzania's capacity to provide adequate health service provision, particularly in prevention, care, and treatment of HIV/AIDS. Areas of focus include recruitment, retention, pre-service, in-service, and continuing education training systems. CDC will collaborate with the National Institute for Medical Research to develop the capacity of Tanzania's eight zonal training centers and strengthen faculty development in public and private health training institutions, and Muhimbili University College of Health Sciences- School of Nursing to integrate HIV/AIDS core curricula into all nursing programs nationwide. Funds will also be used to assure development of a sustainable mechanism for the coordination of CDC/USG-funded trainings in HIV/AIDS prevention, care, and treatment.

Emphasis Areas	**% Of Effort**
Human Resources	51 - 100

Target Populations:

National AIDS control program staff (Parent: Host country government workers)

Program managers

USG in-country staff

Health Care Trainers

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: American International Health Alliance
USG Agency: HHS/Health Resources Services Administration
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 5027
Planned Funds: [redacted]
Activity Narrative: This activity links to activities in policy analysis and system strengthening (NIMR and Capacity).

The University of Michigan School of Nursing and Muhimbili University College of Health Sciences (MUCHS) School of Nursing have partnered since 2003 to provide increased HIV/AIDS teaching resources to nursing faculty. In FY05, the partnership was formalized when [redacted] in Rapid Expansion funds was awarded to the American International Health Alliance/Twinning Center to support a twinning partnership between the two universities. It is expected that funds will arrive by the end of September, enabling project start-up in early October.

This three-year project will expand HIV education for teachers and students in all of Tanzania's 56 nursing schools, including 23 certificate programs, 22 diploma programs, seven advanced diploma programs, and four degree programs. When fully implemented, approximately 6,596 nursing students will receive increased HIV/AIDS instruction each year, and 2,091 will graduate annually with a strong foundation in HIV/AIDS prevention, care, and treatment, and equipped to help reduce HIV-related stigma in communities. The importance of this program should not be underestimated: until now, nursing schools have been bypassed by AIDS training and resources, which have flowed almost exclusively to in-service training.

This program will be achieved through the following phases: 1) definition of essential HIV/AIDS competencies for nurses in Tanzania; 2) creation or adaptation of training tools, including modules, slide sets, lectures, visual aids, and evaluation instruments; 3) training of a corps of HIV/AIDS master teachers to train and serve as resources for other teachers; 4) conducting of training courses for selected faculty from all nursing schools; 5) expansion and integration of HIV/AIDS content and clinical activities into the curriculum. Phases 1-3 will be accomplished with FY05 funds, while the remaining phases will be completed in FY06, with follow-up supervision, monitoring, and support to continue into FY07. The initial development of core HIV/AIDS competencies for nurses will form the back drop against which most of the monitoring and evaluation of the project will be measured by project officers at MUCHS and master trainers.

A special component of this project is the development and on-going operationalization of a Life Skills intervention for nursing students. In recent years, it has been recognized that within the social context of a university setting, students are at high risk for contracting HIV. As young, often single women who may struggle to make ends meet, nursing students are at particular risk of HIV infection. The Life Skills intervention will be an inexpensive, yet invaluable, aspect of this project as nursing students learn the communication, assertiveness, decision-making, and relationship skills that will empower them to make healthier life choices. This intervention will be carried out in collaboration with the Save Life Club of the University of Dar es Salaam. Within the three year implementation period, Life Skills will be rolled out to all 56 nursing schools.

Emphasis Areas	*% Of Effort*
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Training	51 - 100
Policy and Guidelines	10 - 50
Quality Assurance and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	56	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	56	☐
Number of individuals trained in HIV-related policy development	100	☐
Number of individuals trained in HIV-related institutional capacity building	80	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	4,500	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	80	☐

Target Populations:

Teachers (Parent: Host country government workers)

University students (Parent: Children and youth (non-OVC))

Nurses (Parent: Private health care workers)

Key Legislative Issues

Twinning

Volunteers

Gender

Stigma and discrimination

Coverage Areas

Arusha

Dar es Salaam

Dodoma

Iringa

Kagera

Kigoma

Kilimanjaro

Lindi

Manyara

Mara

Mbeya

Morogoro

Mtwara

Mwanza

Pwani

Rukwa

Ruvuma

Shinyanga

Singida

Tabora

Tanga

COAST

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Policy Project
Prime Partner: The Futures Group International
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Other/policy analysis and system strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 5087
Planned Funds:
Activity Narrative: This activity links to other activities in AB and Other Prevention, Palliative Care: Basic Health Care and Support, and Treatment.

The Policy Project has been operational in Tanzania since 2000 with the goal of improving the policy and legal environment for HIV/AIDS prevention, care, and treatment in Tanzania. Policy's objective is to build and strengthen capacity of the government, civil society organizations, particularly faith based organizations, and institutions across all sectors to advocate for policy change and to improve the design, implementation, and evaluation of HIV/AIDS prevention, care, and support programs and policies. Further, Policy Project provides technical assistance (TA) to the Ministry of Justice and Constitutional Affairs (MOJCA) to support legal and regulatory reforms, Tanzanian Parliamentarian AIDS Coalition (TAPAC), and to the National Coalition of People Living with HIV/AIDS (NACOPHA).

With FY04 funds, Policy Project support contributed to improvements in the policy and legal environment. Key achievements include the development of FBO HIV/AIDS policies and HIV/AIDS technical briefs that have been used by the government and NGOs to advocate for appropriate HIV/AIDS policies and services across the country. Through TA to TACAIDS and MOJCA, the Policy Project assisted in the establishment of NACOPHA and has helped TACAIDS to take into consideration a national budgeting process for the 2008-2012 national strategic framework and development of a draft HIV/AIDS bill, respectively.

With FY05 funds, Policy Project will continue its work in strengthening its partners' leadership capacity to improve the policy and legal environment, with a focus on building the leadership capacity of FBOs to play an active role in mobilizing the faith communities' response to HIV/AIDS and the support to MOJCA to put in place an AIDS bill.

In FY06, the USG will support the policy-related activities through Policy Development and Implementation (PDI), a new funding mechanism to replace POLICY Project II when it ends in February 2006. PDI will focus in four key areas:

1.) PDI will build on previous work and provide guidance to strengthen the leadership capacity of faith-based organizations (FBOs) so that they continue to play an active role in mobilizing the faith community's response to HIV/AIDS. Through this activity the project will partner with the Christian Council of Tanzania (CCT) and the National Moslem Council of Tanzania (BAKWATA) to develop appropriate and sustainable plans and programs related to HIV/AIDS. These groups will be part of all of the PDI activities, including OVC advocacy. Through these large networks it will be possible to build broad involvement with PLWHA issues, supporting HIV/AIDS legislation and developing evidence based strategies, especially related to advocacy for policies and legislation. The faith-based community is critical to ensuring that HIV/AIDS legislation and policies are adopted and implemented. PDI will work in partnership with CCT and BAKWATA to ensure that leaders and effective action plans are developed within these networks at the community, regional, and national levels. The key outcome will be that CCT and BAKWATA will be able to identify and promote solutions, and monitor their impact at community and regional levels.

2.) PDI will continue to provide technical support to NACOPHA to strengthen the voice of PLWHAs as advocates for effective HIV/AIDS policies and programming. PDI will organize fora and provide technical support to ensure PLWHAs are involved strategic planning processes at the district level. Because 60% of PLWHAs in Tanzania are women, PDI will conduct targeted training and support gender

integration and ensure that issues such as gender-based violence, legal rights, and other issues critical to women are heard and addressed by policy makers and communities.

3.) PDI will continue to provide technical support to MOJCA in the finalization and implementation of HIV/AIDS legislation. TA training will be provided to government lead agencies, FBOs, NGOs, and the media to ensure passage and implementation of the legislations currently under consideration. Evidence from other countries indicates that sensitization of parliamentarians and civil society greatly facilitates both the effective passage and enforcement of the legislation. There are on-going zonal meetings to inform and request feedback from the public about the draft AIDS bill. Sensitization meetings with parliamentary committee members and sessions with civil society will be held to ensure active involvement in the passage and implementation of the bill. Media groups will also be actively involved in informing the public and helping to monitor the passage and implementation of the bill. Two legal aid clinics will be established with the training of lawyers for providing HIV/AIDS legal aid services in support of the legislation.

4.) With increasing resources in Tanzania for responding to HIV/AIDS, there is a need for evidence-based decision making to support the implementation of the HIV/AIDS strategic plan. Often plans are made without adequate research-based information for sound programming. PDI will train Government agencies and CSOs will be trained and supported to use the results of the AIDS Impact Model (AIM) to measure the impact of HIV/AIDS and to facilitate strategic planning. Also, PDI will explore the possibilities of conducting an AIDS Program Effort Index (API).

The above activities will assist stakeholders in developing and implementing effective advocacy strategies. Training will be provided to 95 local organizations to strengthen their capacity for HIV/AIDS policy development and to 363 individuals to become effective advocates for the implementation of related HIV/AIDS policies.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	51 - 100

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	95	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	6	☐
Number of individuals trained in HIV-related policy development	363	☐
Number of individuals trained in HIV-related institutional capacity building	350	☐
Number of individuals trained in HIV-related stigma and discrimination reduction	120	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	120	☐

Indirect Targets

It is envisaged that PDI will reach over 3 million community members through the support provided to TACAIDS, MOH, MOJCA and civil society organizations in strengthening the policy and legal environment.

Target Populations:

Faith-based organizations

HIV/AIDS-affected families

International counterpart organizations

National AIDS control program staff (Parent: Host country government workers)

Non-governmental organizations/private voluntary organizations

Orphans and vulnerable children

People living with HIV/AIDS

Policy makers (Parent: Host country government workers)

Widows/widowers

Religious leaders

Public health care workers

Private health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Iringa

Kagera

Mbeya

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	AIDS Business Coalition Tanzania
Prime Partner:	To Be Determined
USG Agency:	Department of State
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	5255
Planned Funds:	
Activity Narrative:	This activity links to activities in AB (BBC, Youthnet) and other prevention (TCI, Police, PharmAccess).

As identified in both the National Multi-Sectoral Strategic Framework on HIV/AIDS and the National Care and Treatment Plan, the involvement of the private sector as a partner is an important strategy in the fight against AIDS. AIDS Business Coalition Tanzania (ABCT), initiated by Unilever in collaboration with interested peer businesses and partners, and was formally launched on August 19, 2004 and is uniquely placed to integrate HIV/AIDS issues into the private sector. ABCT's mission statement is "To contain the spread of HIV, control and manage AIDS through development and sharing of best practices, advocacy and creating synergies amongst Tanzanian employers." The basic objectives of ABCT are threefold: 1) to advocate for employer and private sector participation in the fight against HIV/AIDS, 2) to develop and encourage workplace programs and policies on HIV/AIDS, and 3) to provide expertise and assistance to member organizations through the development of partnerships with other organizations involved in the fight against HIV/AIDS both locally and internationally. ABCT's target audiences are businesses, their employees and families, and the surrounding communities.

ABCT is registered as an NGO in Tanzania, and its organizational structure consists of a two person secretariat, which reports to a management board as well as a members' advisory board. 29 companies are currently paying members for whom ABCT aims to provide advisory and advocacy services and initiate workshops and symposia. However, because the Secretariat is not yet equipped to provide this kind of assistance, capacity building is necessary on several levels to raise their own understanding of HIV/AIDS best practices and programming and to strengthen their ability to reach to the HIV/AIDS community to expand partnerships throughout Tanzania. Capacity building of ABCT would involve the hiring at least one full-time employee and several short-term consultants with HIV/AIDS programming experience. This would free up the Director of the Secretariat to dedicate more time to the overall mission and visibility of ABCT through strategic networking in both the public and private sector. An assessment of a clearly defined role for ABCT and identification of key interventions will do much to increase involvement of private sector businesses, and to enable a more comprehensive response to the HIV/AIDS epidemic in Tanzania. Key industries including transportation, agriculture, mining, and tourism will be targeted to realize far greater gains in reaching key target populations.

Thus far, ABCT has finalized the development of a generic work place policy, and with USG support in capacity building will expand initiatives in corporate responsibility and encourage businesses to reach out to the surrounding communities, which have tremendous potential for scale up throughout the prevention to care continuum. ABCT is also working with interested businesses on Zanzibar to develop a Zanzibar business coalition. The ABCT secretariat is in contact with other business coalitions in the region in order to learn from others' experiences.

The newly arrived US Ambassador to Tanzania has emphasized the involvement of the private sector as one of the principle issues in his diplomatic agenda. Strengthening the capacity of ABCT provides USG with a unique opportunity to leverage synergies between the advancement of the Emergency Plan goals, the agenda for the US Diplomatic Strategy, and Public-Private Partnership aspirations in Tanzania.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Information, Education and Communication	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	60	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	60	☐
Number of individuals trained in HIV-related policy development	250	☐
Number of individuals trained in HIV-related institutional capacity building		☑
Number of individuals trained in HIV-related stigma and discrimination reduction	1,000	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☑

Target Populations:

Community leaders

Private Sector

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	N/A
Prime Partner:	Deloitte Touche Tohmatsu
USG Agency:	U.S. Agency for International Development
Funding Source:	GAC (GHAI account)
Program Area:	Other/policy analysis and system strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	5256
Planned Funds:	
Activity Narrative:	This activity links to activities in Other/ Policy/ Systems Strengthening in Human Capacity Development through Capacity, NIMR, and AIHA Twinning Program.

The Rapid Funding Envelope (RFE) has proved to be a highly useful way to expedite resources to projects proposing innovative solutions to emergency problems. Deloitte and the RFE have a proven track record of sound program implementation and fiscal and programmatic accountability. In FY06, the USG will contribute $250,000 toward a special round of the RFE for innovative human capacity development initiatives, enabling worthy local organizations to rapidly roll out quick wins in recruitment, training, and retention of qualified health care workers.

Examples of possible RFE funding areas in recruitment and retention include the development and/or expansion of existing programs to place skilled health workers in high need areas through creative incentives; piloting of start-up or scale-up of supportive supervision within specific local organizations or agencies, such as a Zonal Training Centres; or an initiative to ensure that health care workers who have served a pre-determined length of time, eg two years, five years, etc. are able to work toward promotion through specifically aimed continuing education programs. Such a program might be geared toward Health Care Workers (HCWs) who work and/or are willing to work in remote or underserved areas.

Examples of possible funding areas for pre-service and continuing education programs might include the design and implementation of an emergency training plan for a cadre of critical shortage, such as Assistant Medical Officers, which would be short in duration without sacrificing quality. If emergency update training could be arranged, it would also be possible to re-engage retired officers and trained but unengaged HCWs to work in areas of critical shortage.

Lastly, the funds could be used for innovative life skills programs for unskilled older youth, including children orphaned by AIDS who have already been involved in caring for a parent. Such a life skills program could be a feeder for previously unskilled young people into the lower cadres of health workers, with the potential for career development.

The RFE will provide access to additional funds for innovative programs to address human capacity development needs from monies contributed by other donors that will be leveraged by this support. The grants will be awarded twice annually through a competitive process.

Emphasis Areas	% Of Effort
Human Resources	51 - 100
Infrastructure	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	6	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	6	☐
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building	12	☐
Number of individuals trained in HIV-related stigma and discrimination reduction		☑
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment		☒

Target Populations:

Host country government workers

Public health care workers

Private health care workers

Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas:

National

Table 3.3.15: Program Planning Overview

Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15

Total Planned Funding for Program Area:

B5

Program Area Context:

Ambassador Micheal Retzer manages the overall coordination of the Emergency Plan activities in Tanzania. On a daily basis, oversight is provided by the Deputy Chief of Mission who chairs the Interagency HIV/AIDS Coordinating Committee (IHCC). The IHCC, consists of Heads of Agency, as well as limited agency technical staff for coordination with lower level working committees. This team meets weekly to discuss implementation and policy issues requiring higher-level input. Under the IHCC is an HIV/AIDS Working Group (HAWG), which coordinates all technical input related to achieving the Emergency Plan goals.

A new addition to the team, expected to arrive early in calendar year 2006, is the PEPFAR Coordinator. The primary task of this individual will be to help manage critical communications and allocate tasks as appropriate to relevant departments/agencies regarding Emergency Plan planning and implementation An individual has been identified, and has accepted the position. Discussions are ongoing to resolve the few remaining logistical issues. The Team looks forward to having a Coordinator on board.

In addition, it is anticipated that a PEPFAR Outreach Coordinator, to be located in the Public Affairs Office, will soon be identified. The person in this position will undertake a range of public affairs activities in support of the Emergency Plan and fits in with the overall Public Diplomacy strategy of the Embassy. This person will ensure that the messages and activities associated with the Emergency Plan are disseminated within Tanzania, as well as reported to the Public Affairs Office of the Office of the Global AIDS Coordinator and the U.S. public.

Overall management and staffing under the Emergency Plan remains a challenge. The continued support necessary to implement activities coupled with the different modalities in which the U.S. Government Departments and Agencies operate, has necessitated growth across all sectors of the USG. While the composition of the teams may differ, the overall goal of providing the highest quality services with the greatest stewardship of taxpayer resources is expected. To this end, the new leadership across the Embassy, HHS/CDC, USAID, Peace Corps and Defense Attaché Office presents an opportunity to re-invigorate the team and further the development of high standards of professionalism and program excellence.

Across all five USG Departments and Agencies there are some increases expected in both technical and managerial staff. These increases have been reviewed internally and accepted as necessary for the level of management expected under this initiative. Significant expansion of the SI team and its capabilities at the CDC office will improve data collection and program monitoring both in support of MOH needs and USG Emergency Plan reporting. In addition, USAID will be hiring a staff member who will focus on the USG OVC portfolio, substantially augmenting the team's capacity to operate successful OVC programs. In addition to the direct support of staff, this section includes resources necessary to carry out ICASS functions and mission support and to ensure that overall implementation of the initiative is carried out in a smooth fashion. Depending on future levels of resources available to the USG Team in Tanzania, further staffing assistance may be required.

Table 3.3.15: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Peace Corps
USG Agency: Peace Corps
Funding Source: GAC (GHAI account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 3498
Planned Funds:
Activity Narrative:

The HIV/AIDS Program Officer - Recruited in FY 04
Provides technical assistance to Volunteers, organizes and facilitates ISTs, assists with PST training on HIV/AIDS for all three projects, attends Emergency Plan working group meetings, coordinates PC/T's monitoring and evaluation system, facilitates sharing of ideas learned and identifying new resources. He collaborates closely with the Health Education APCD. PC/T will ask for a salary increase for this Program Officer as he is currently underpaid, and could easily be recruited to work for other Emergency Plan partners if we do not pay him a more competitive wage. His current wage is not competitive for the work he is actually doing.

Emergency Plan Administrative Associate – New Position
To assist post in managing workshops, logistics, grants.
As PC/T has an integrated HIV/AIDS program where all of our Volunteers are engaged in some form of HIV/AIDS prevention work, post needs to enable them to conduct more prevention and now care activities by offering more workshops and VAST grants. Post believes this is the best route for PC/T to continue in FY 06, as it allows Emergency Plan funding to continue to build HIV/AIDS capacity in Tanzania.

Post will also be expanding in to the area of Care and Support particularly in the area of boosting immune systems of those infected and affected by HIV/AIDS through home gardening and permaculture demonstration activities. Nutrition is a focus area under palliative care and OVCs under the Emergency Plan. Post feels this an innovative way of expanding its efforts and this also segways nicely in to some of the agricultural activities our environment Volunteers are engaged with at present. Thus the number or workshops, seminars and VAST grants will also increase at post, creating the need to hire a sole person dedicated to managing grants and workshops.

Driver – Recruited in FY05
A driver was recruited during FY05 and continues to support Emergency Plan activities for all of PC/T's Volunteers who are all engaged in some form of HIV/AIDS prevention work.

OFFICE RENOVATION AND EQUIPMENT
The HIV/AIDS Program Officer currently sits in an office with two Program Assistants that support the core program. The office is crowded and does not provide a supportive work environment for him to concentrate on his work. With the hiring of an Emergency Plan Administrative Associate as well, post would like to renovate space for an Emergency Plan office that houses both the HIV/AIDS Program Officer and the Emergency Plan Administrative Associate. Within that space, post wants to incorporate a place for all of our HIV/AIDS resource materials for access by Volunteers. Currently post has no place to store these resources and Volunteers often do not know they are available because they are hidden in a closet. Post wants to renovate our current GSO office space to host this new Emergency Plan office with two staff and an HIV/AIDS resource center. Included with this renovation will be a need for additional equipment such as tables, chairs, bookshelves, computer and software, a laptop computer to support training and

off-site workshop activities, as well as a LCD projector to support Emergency Plan training and workshop field presentations.

As post just completed the Emergency Plan M&E Workshop with two center specialists, post sees a real need to capture more of the work Volunteers are doing in the field. Post wants to purchase a digital video camera to be able to film many of its HIV/AIDS field activities both for the purposes of training others through video and for increasing the visibility of Tanzania's Emergency Plan and HIV/AIDS activities in country. Post will be doing more with community theatre and HIV/AIDS and will want to capture these and other prevention activities on video for use in training more peer educators, teachers, and youth. PC/T also wants to produce short documentaries of Volunteers' HIV/AIDS prevention work to use for publicity and to show live examples of work they do in the field. The Emergency Plan computers should also have DVD capability to be able to play these videos for the purpose of training and increasing visibility of the program.

Table 3.3.15: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GAC (GHAI account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 3505
Planned Funds:
Activity Narrative: The US Department of Defense (DoD) will provide technical and managerial support to two primary programs: the Tanzanian Peoples Defense Forces (TPDF) and the Walter Reed HIV/AIDS Care Program in the Southern Highlands. Collectively between the two programs, more than six million Tanzanians will have access to HIV prevention, care, and treatment services. Covering active military and their dependents and fostering direct US-Tanzania military interactions, the TPDF is based in Dar es Salaam and covers eight military hospitals and over 30 camp sites nationwide including the National Service. PharmAccess, an NGO based out of the Netherlands, will provide direct management of the program with the DoD assisting with US and local technical support to this program primarily in the areas of treatment and laboratory development.

The Walter Reed HIV/AIDS Care Program is centered in the Mbeya Municipality at the Mbeya Referral Hospital, the primary location for surveillance and vaccine studies conducted by the United States Military HIV Research Program. The US DoD assisted with introduction of comprehensive HIV care and treatment services to this area in October 2004 under the Emergency Plan and through MOH support, thereby fulfilling a moral obligation to Tanzanians living in a previously underserved geographic region for treatment. It works closely with the Referral Hospital and Regional Medical Offices of Mbeya, Rukwa and Ruvuma in supporting regional development of treatment capacity as directed by the guidance of the National AIDS Care Programme of the MOH. Having rapidly grown to provide care and treatment in four districts within the Mbeya Region including five treatment facilities and over 10 community based groups in the Southern Highlands (supporting extension of clinical services), the Walter Reed HIV/AIDS Care Program is extending this program in FY06 to two neighboring regions within the Southern Highland zone to support a catchment area of greater than four million Tanzanians. By the end of FY06, the Walter Reed Program will support 10 hospitals in three regions.

Currently, seven (three Tanzanian/LES, three USPSC/Contractors and one USG Direct Hire) staff provide technical assistance to treatment, palliative care, OVC support and laboratory services. Five Tanzanian staff provide administrative support, including accounting and information technology services. The US Contract laboratory manager for the DoD under technical advisors/non-M&S is leveraged from research/operating expenses and is not included under Emergency Plan funds. One of the US Contractors and the three Tanzanian technical advisors specifically support clinical care and treatment and are supported under a line item submission in the treatment program area. The USG direct hire is located in Dar es Salaam and assists in managing the program with the director located in Mbeya and represents the DoD field effort and TPDF programs with the USG Team, other bilateral donors and GOT. All but four of the staff supporting the combined DoD efforts in Tanzania are in country nationals who work closely with our implementing partners. As much as possible, local staff is hired to fill needed administrative and technical positions. This not only provides partners with added resources but the expansion of the technical skills and expertise among the DoD local staff as part of program implementation adds to the development of the human capacity in addressing HIV/AIDS issues in Tanzania. There are no plans to expand this staff in FY06.

Administrative costs will support both the TPDF and Walter Reed HIV/AIDS Care Programs and include the provision of technical assistance required to implement and manage the Emergency Plan activities. DoD personnel, ICASS, local travel, management, and logistics support in country will be included in these costs.

Table 3.3.15: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GAC (GHAI account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 3514
Planned Funds:
Activity Narrative: USAID/Tanzania's management and staffing costs cover the HIV/AIDS Team and costs for financial and contractual staff. In FY05 the size of the team was expanded to include a stronger focus on OVCs and strategic information. Other additions included a second USDH who comes with strong HIV experience from neighboring Malawi. Based on concerns raised by the team, and with the approval of OGAC, the Mission is also in the process of recruiting a full time contracts officer. This will further augment the existing Mission staff (one LES, not covered through the Emergency Plan), and will provide a greater opportunity to expedite acquisition and assistance activities across the USAID program. Given that the Emergency Plan currently constitutes two-thirds of the Mission portfolio, an additional contracts officer who can focus primarily on PEPFAR activities will be very welcome.

Current Team Composition:

The team consists of the following: two (2) USDH (one is paid for centrally with GHAI funding), three (3) contractual staff (including one contracts officer who we are in the process of recruiting); seven (7) FSN staff, including two positions under current recruitment. Additionally, with FY06 resources we propose adding one additional FSN technical staff to support care and treatment activities.

While the overall size of the USAID team is relatively small, we believe we can optimize our management structure in order to cover the necessary program areas and provide appropriate oversight and support to our programs.

The continued requirement of the contracts officer and the newly identified staff member for care and treatment are the only additions to the management team within USAID. However, in order to round out support for the program, we will continue to rely on support from USAID/Washington as well as our other USG partners here in Tanzania who may have more frequent technical assistance visits.

To date we have been able to establish a well functioning team, not only within the USAID Mission but across the USG. Staff members from headquarters (regardless of Agency) routinely provide assistance across the USG portfolio. We believe this helps maximize and harmonize the efforts of the entire USG team.

In addition to the core staff support, the USAID ICASS costs are relatively modest at

Table 3.3.15: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: US Department of State
USG Agency: Department of State
Funding Source: GAC (GHAI account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 3516
Planned Funds:
Activity Narrative: The Management and Staffing costs under this submission cover two essential positions: the newly identified PEPFAR Coordinator and an EFM that will focus on Emergency Plan outreach through the Public Affairs Office.

Both positions have direct impact on Emergency Plan operations in Tanzania.

The PEPFAR Coordinator, a USDH, will assume day-to-day technical and managerial liaison functions within the USG and with key Government of Tanzania and other donor partners. This position will fall under the Office of the Ambassador and will report to the Deputy Chief of Mission serving as his "right hand" on all things Emergency Plan related. The primary task of this individual is to help manage critical communications and allocate tasks as appropriate to relevant departments/agencies regarding Emergency Plan planning and implementation. This position, which has been highly anticipated by the USG Team, will provide a level of coordination which heretofore had not been established within one position.

In addition to the above noted activities, specific duties will likely include:

(1) Advocate for reforms that will promote the effective implementation of the PEPFAR strategy.

(2) Apply knowledge and advanced expertise in HIV/AIDS and health policy and programs to ensure a broad approach that promotes health policy reforms and an effective HIV/AIDS strategy.

(3) Assess where development assistance can achieve sustainable impact and provide assistance to others, including the staffs of other international donors, to disseminate this knowledge.

(4) Maintain focus, intensity, determination, and optimism, even under the adverse circumstances of a challenging environment, and help others find opportunities to effect positive change.

The PEPFAR Outreach Coordinator is an EFM position, located in the Public Affairs Office, and will undertake a range of public affairs activities in support of the Emergency Plan. This position, fits in with the overall Public Diplomacy strategy of the Embassy to ensure that the messages and activities associated with the Emergency Plan are disseminated within Tanzania, as well as reported to the U.S. public.

In addition to the above noted activities, specific duties will likely include:

(1) Develop a media strategy identifying opportunities, such as signing ceremonies, facility openings, Ambassador visits/testing, etc., to highlight PEPFAR support for HIV/AIDS prevention, counseling, testing, and treatment activities in Tanzania. Attend all IHCC meetings and HAWG meetings as necessary for guidance in developing this strategy. Brief the IHCC as necessary. The strategy will be an integrated Team Tanzania product drawing on all mission elements including USAID, CDC, Peace Corps, and DOD.

(2) Provide support to PEPFAR program offices and implementing partner organizations to implement the media strategy by organizing activities (press releases, media interviews, media trips, etc.) to ensure that Tanzanians are aware of PEPFAR themes, priorities, and programs. Incorporate country statistics from the Country

Operating Plan (COP) and its required reporting into these activities.

(3) Monitor Office of the Global AIDS Coordinator (OGAC) outreach planning efforts to ensure that Embassy outreach activities support upcoming themes and events. Forward by e-mail OGAC press summaries and other relevant outreach materials to IHCC members.

(4) Create and periodically update "pocket briefs" for Embassy personnel, which provide information on the following aspects of PEPFAR in Tanzania: 1) HIV/AIDS facts; 2) PEPFAR policy priorities; and 3) PEPFAR accomplishments.

Table 3.3.15: Activities by Funding Mechanism

Mechanism: Base
Prime Partner: US Centers for Disease Control and Prevention
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Base (GAP account)
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 3521
Planned Funds:
Activity Narrative: During the next fiscal year, HHS/CDC will continue to collaborate closely with the Government of Tanzania, Ministry of Health and other key partners to further strengthen technical and program capacity for the President's Emergency Plan for AIDS Relief activities. This will include the establishment and expansion of quality-assured national systems in the areas of surveillance, PMTCT, laboratory services, blood safety and blood transfusion, ART, patient care and prevention programs. The CDC/HHS provides direct technical support for all of its HIV/AIDS programs through US- and Tanzanian-based organizations, which manage and implement in-country activities. These activities are funded through cooperative agreements and are performed at the field level in direct partnership and collaboration with Tanzanian governmental and non-governmental organizations. The non-governmental implementing partners have considerable experience in the field of HIV/AIDS and have established offices in Tanzania to carry out these activities. The technical assistance and support provided by the CDC/HHS through our cooperative agreements will ensure a long-term sustainable system for providing HIV/AIDS Care, Prevention and Treatment services to Tanzanians.

To effectively scale up Emergency Plan activities, HHS/CDC must continue to scale up its technical and administrative human resource capacity from 36 to 43 staff in FY06. Human resources funding is required for seven new staff that include (4) LES staff that includes (1) Information Technology Chief, (1) Budget, Management and Operations Chief, (1) Chief Laboratory Technologist, and (1) Executive Assistant. US-based contracting staff includes (1) Health Information Management Systems (HMIS) Officer, and (1) Strategic Information Coordinator and (1) Senior Laboratory Scientist.

Justification: New LES staff positions are being created at the senior management level to build long-term local capacity and sustainability in the administrative area. The two laboratory positions are needed to provide oversight and coordination of on-going efforts to expand and improve the quality and availability of laboratory capacity, in particular the development of a national network of quality-assured laboratories to support HIV programs. The three new contractors are needed to strengthen the strategic information team. This expertise is needed to strengthen both the monitoring capacity of the USG team and the National AIDS Control Program.

Staffing support continues in the next fiscal year for 36 current staff that include (4) USDH personnel that includes the Country Director, Deputy Country Director, Epidemiologist and Technical Public Health Advisor; (14) Program personnel that include (1) Senior Strategic Information Program Manager, (2) Monitoring and Evaluation Fellows, (1) Senior PMTCT Program Manager, (1) PMTCT Program Officer, (1) Care and Treatment Director, (1) Administrative Support Officer, (1) Senior Care Program Manager, (1) TB/HIV Program Officer, (1) Prevention and Cross-cutting Director, (1) Senior Laboratory Technologist, (1) HIV/AIDS Senior Program Manager, (1) Counseling and Testing Program Officer, (1) Youth and Other Program Officer, and a (1) Human Capacity Development Officer and (18) administrative personnel to support program staff that include (1) Senior Network Manager, (1) IT Specialist, (1) Computer Applications Developer, (1) Accountant, (1) Financial Planning Officer, (1) Finance Manager, (1) Motor Pool Supervisor, (5) Drivers, (1) Administrative Manager, (2) Administrative Assistants, (2) Full-time Secretary Receptionists and (1) Part-time Secretary Receptionist.

Quality Assurance and Supportive Supervision is provided as technical assistance through USG Direct Hire personnel. Commodity Procurements includes purchase of

computer consumables, printing, and medical equipment related to care and treatment and information technology requirements. Infrastructure includes security and related office administration expenses and ICASS costs. Development of Network includes development of Wide Area Network and HMIS systems at the Ministry of Health and Video Conferencing support at CDC to deliver distance-based training. Logistics includes field travel, staff overtime and vehicle maintenance and fuel.

Table 3.3.15: Activities by Funding Mechanism

Mechanism:	Country staffing and TA
Prime Partner:	US Centers for Disease Control and Prevention
USG Agency:	HHS/Centers for Disease Control & Prevention
Funding Source:	GAC (GHAI account)
Program Area:	Management and Staffing
Budget Code:	HVMS
Program Area Code:	15
Activity ID:	5353
Planned Funds:	
Activity Narrative:	This line item is to complete necessary financial support for management and staffing needs for the CDC Tanzania Office as described in the previous submission. This will fulfill necessary budget allocations not covered under the GAP funding award.

Table 5: Planned Data Collection

Is an AIDS Indicator Survey(AIS) planned for fiscal year 2006?	☐ Yes	☑ No
If yes, Will HIV testing be included?	☐ Yes	☐ No
When will preliminary data be available?		
Is an Demographic and Health Survey(DHS) planned for fiscal year 2006?	☐ Yes	☑ No
If yes, Will HIV testing be included?	☐ Yes	☐ No
When will preliminary data be available?		
Is a Health Facility Survey planned for fiscal year 2006?	☐ Yes	☑ No
When will preliminary data be available?		
Is an Anc Surveillance Study planned for fiscal year 2006?	☑ Yes	☐ No
If yes, approximately how many service delivery sites will it cover?	93	
When will preliminary data be available?	5/14/2006	
Is an analysis or updating of information about the health care workforce or the workforce requirements corresponding to EP goals for your country planned for fiscal year 2006?	☑ Yes	☐ No

Other significant data collection activities

Name:
Targeted Evaluation on Stigma Reduction

Brief description of the data collection activity:
Kimara Peers is currently implementing a pilot model community-based stigma reduction program, through a grant from the REACH project. Kimara's program is the first of its kind in Tanzania, and already being looked to as a model stigma reduction program. It is critical that this first of its kind model program be systematically evaluated to examine whether it has had the intended impact in both the short-term (immediate effect) and longer-term (sustained effect), as well as to capture and document lessons learned to allow for feasible replication and scale-up of stigma-reduction.
n
nInitial anecdotal evidence from the program indicates it is having significant impact. Kimara Peers have seen a significant increase in people coming forward for VCT since the stigma-reduction activities began, an increase in people living with HIV and AIDS (PLHA) joining group counseling sessions, and community demand for expansion of the stigma-reduction programming. However, without targeted program evaluation, it will be difficult to distinguish whether these increases are all or partly due to the stigma activities, rather than to other possible confounding factors, like the expectation of ARV availability or media campaigns. In addition to assessing whether these immediate apparent impacts are due fully or in part to the intervention, it is also important to examine whether there are lasting impacts, like whether behavior change is sustained once the intervention ends.
n
nWith FY05 funding, ICRW, MUCHS and Kimara Peers through FHI, will conduct the first phase of a targeted program evaluation of the ongoing Kimara Peers community stigma reduction program to assess short-term, immediate impact. In FY06, a second phase of evaluation will be conducted to examine the longer-term impact and whether the intervention has had lasting, sustainable effects.
n

Preliminary data available:

Name:
Tanzania Service Availability Mapping (SPA)

Brief description of the data collection activity:

The SAM tool which generates and maps information on the availability of specific health services in each district, and aims at providing a visual representation of health service gaps will continue to be supported in FY06. The information collected from the districts is linked to a GIS database containing the geographic coordinates of each health facility to produce maps showing the distribution of key health services across the districts. The long-term objective is to enable district and national planners to use service availability mapping as a key tool for public health decision-making. The information generated will help identify where health system's gaps need to be most addressed in order to reach individuals in need of HIV/AIDS services in the most equitable way possible. FY05 funds were used for preparations and the implementation of a full facility SAM that identified and mapped all HIV interventions in Mwanza region, to be followed by a representative sample SAM in the rest of the country. FY06 will be used to support a full SAM in an additional 5 districts. Assistance will include refinement of questionnaires and instruction manuals, training for fieldwork, supervising data collection, data processing and validation, data analysis, report writing and map production, and dissemination and data use workshopsPreliminary Report due dates: Mwanza full facility SAM – October 2005; national Representative sample SAM – January 06; 5 district full facility SAM - October 06
n

Preliminary data available:
January 01, 2006

Name:
Report Dessemination; Data Use- 2003/04 Tanzania HIV/AIDS Indicatory Survey (THIS)

Brief description of the data collection activity:
The THIS has been completed, with a final report released at a national seminar held in April 2005. This survey covered the full range of international HIV/AIDS indicators and including HIV testing. Survey results will be useful for planning, as well as monitoring and evaluating, health and HIV/AIDS programs. Activities for the coming year will cover further analysis and dissemination of the data. FY 06 Funds would be used to complete work on a study comparing the HIV prevalence levels from the survey with those generated from the antenatal sentinel surveillance system, to conduct 2 training of trainers workshops for civil society organizations using a HIV curriculum developed by Macro and Tanzanian counterparts and to print and disseminate more copies of the final report and the poster in Tanzania.

Preliminary data available:

Name:
Targeted Evaluation on Orphans

Brief description of the data collection activity:
This activity will be a part of a larger targeted evaluation effort being undertaken by USAID/Washington. The most vulnerable children's programming area lacks evidence on delivering comprehensive services to children to achieve outcomes in wellbeing. A targeted evaluation will be implemented to examine several models for designing, implementing, and tracking community-based approaches to strengthening nfamily, community, and government structures and systems to deliver
nessential services. The targeted evaluation aims to determine which models make a measurable difference in wellbeing and to what extent. USG/Tanzania would like to invest [redacted] in the larger targeted evaluation to be done in several countries. The objective is to include the Government of Tanzania's Most Vulnerable Child Committee model among the other models to be evaluated. Results should also inform standards of quality performance for each essential services (such as: education, psycho-social support, shelter, food, protection, health care, economic opportunity, and HIV prevention and care).
n

Preliminary data available:

Name:
HIV Drug Resistance Survey

Brief description of the data collection activity:
This will be carried-out alongside the 2005/06 ANC sentinel survey and limited to Dar es Salaam region. All participating ANC sites in Dar es Salaam will provide extra Dried Blood Spots (DBS) collected from women 24yrs or less, first pregnancy. The specimens will be shipped to CDC Atlanta for lab testing.

Preliminary data available:
May 14, 2006

Name:

Tanzania Service Provision Assessment TSPA

Brief description of the data collection activity:

TSPA is currently in the planning stages. It will address the monitoring and evaluation needs of HIV/AIDS and maternal and child health programs by evaluating the services provided at a sample of health facilities throughout Tanzania. The survey, addressing the emphasis area- facility survey, will cover government, non-government, and private health facilities. The data to be collected includes a listing of personnel working at each facility, an inventory of equipment, supplies, and medicines, observation of client-provider interactions, and possibly exit interviews with clients. There will also be an assessment of the facility's ability to provide such services as VCT, PMTCT, and anti-retroviral therapy. The target population for the survey will be adults, women and men, pregnant women, as well as children, including orphans and vulnerable children. The National Bureau of Statistics will conduct the survey. However, the Ministry of Health is playing a major role in design, implementation, and analysis. The importance of the survey to the country is evidenced by the fact that the entire local cost of implementation is being covered by the Government of Tanzania through its 'basket' of donor funds. FY06 funds will be used to complete the data analysis and report writing, to publish the final report (2,000 copies), the Key Findings report (4,000 copies) and the separate HIV/AIDS report (4,000 copies) and to disseminate the publications.

Preliminary data available:

August 14, 2006