3.1 Essential Services within the Disease Program

Provide a description of the current disease program in the country and the progress being made as well as the challenges to be met in providing essential prevention, treatment and/or care programs within this context.

The overall objective of HIV prevention in Tanzania is to reduce the rate of new infections. Strategies adopted include prevention programs such as the elimination of Mother to Child Transmission (eMTCT), HIV counseling and testing (HCT), blood transfusion safety, Sexually Transmitted Infections (STI) case management and medical male circumcision. Behavioral interventions include: condom promotion and use, Behavioral Change Communication (BCC), school based HIV prevention programs and peer education approaches. Below is a summary of the achievements and challenges in the delivery of HIV services which are coordinated by the National AIDS Control Program (NACP).

i. Elimination of Mother to Child Transmission of HIV (eMTCT)

eMTCT is one key element in the country's strategy to mitigate the impact of HIV and AIDS specifically to reduce new HIV infections as well as reduction in pediatric mortality. The government's commitment to eMTCT has been well reflected in the Health Sector Strategic Plan (HSSP-II) and the National Strategy for Growth and Reduction of Poverty (NSGRP). Two key entry points into eMTCT services are HIV testing and counseling for women of reproductive age and HIV screening at antenatal clinics (ANC) for all pregnant women. Identified HIV infected mother-infant pairs are linked to ARV prophylaxis or treatment provision during antenatal, intrapartum and postpartum service consultations. Indeed, eMTCT services have expanded rapidly in Tanzania. By end of 2011, about 93% (4,603/4,944) of all health facilities with RCH services in the country were providing eMTCT services[1]. However, about 72% (93,770/122,146) of projected HIV infected pregnant women accessed ARV therapy to reduce the risk of HIV transmission to their children; among them 16,335 (17.4%) were on long term ART treatment in 2011[1]. Compared to 2010, eMTCT achievement in 2011 marked an increase of 2% in coverage of prevention services to HIV infected pregnant women. In fact, in 2010, eMTCT coverage was 70% (87,343/116,204), whereas 13,444 were on long term ART treatment[2]. Furthermore, 2011 registered 56% (68507/122146) of all projected HIV exposed infants accessing ARV for HIV prevention as opposed to 57% (65,948/116,204) in 2010. HIV testing for partners of pregnant women has increased to 25% (353,523/1,398,184) in 2011 as compared to 21% (295,627/1,394,170) in 2010[1]. The program expects partner testing to increase to 35% in 2012 by increasing community sensitization through advocacy and popular HIV campaign messages on radio programs.

However, in spite of achievements, there are serious challenges facing eMTCT. Although Tanzania is close to 100% coverage in all health facilities, some HIV infected women and HIV exposed infants still do not access these services. About 30% of all HIV positive pregnant women in need of ARV therapy to reduce the risk of MTCT did not access eMTCT services at all in 2011; 44% of all children at risk of HIV infection from their mothers did not access ARV for eMTCT. This could partly be explained by the RCH service utilization pattern by pregnant women. Demographic and Health Survey (DHS) – 2010 data shows that 96% of women have had at-least one ANC visit while only 43% had at-least 4 ANC visits. This trend coincides with higher HIV testing that is done at first visit and very low ARV prophylaxis uptake for mothers and their infants later in the postpartum period. Inadequate community involvement especially male partners, is one key set back facing eMTCT efforts. It is not a common practice for spouses to escort their wives to ANC where eMTCT services are provided evidenced by only 25% male partner testing in 2011. Partly this is due to the fact that Tanzania is mainly a male dominant society, where most males are the bread earners and partner equality in reproductive and health matters still remains to be a challenge.

Every pregnant woman attending ANC is offered HIV testing and counseling as part of comprehensive ANC package. Those not infected are capacitated to stay HIV free through provision of continuous counseling during every clinic visit and condoms are offered to them. To prevent unintended pregnancies among HIV infected women, family planning (FP) is offered as part of the reproductive and child health package. Indeed, FP services have been integrated into HIV care and treatment centers and few youth centers. Community based distribution (CBD) of FP commodities is implemented and recently there has been efforts to integrate it with Home based Care (HBC) and reinvigorate community MNCH strategy. These strategies however still fall short of reaching youths that do not need to go to health facilities; CBD and Home Based Care (HBC) remain weak community strategies, available in few places, and receiving inadequate support. However, the following gaps have been identified in the implementation of prongs:

Table 1: Identified gaps in the implementation of eMTCT Prongs

Prong	Gaps
Prong 1: Primary Prevention of HIV among women of childbearing age	• 29% / 16% of married or cohabiting men and women, respectively, reported having extramarital sex • 8% of young women had sexual relationships with men 10 years older or more

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012

	• 8% of men aged 15-49 paid for sex in the past 12 months, of which 60% used a condom • Condom use during high risk sex is still low: 43% of women and 58% of men who reported having high risk sex in the past 12 months used a condom during the last act
Prong 2: Preventing unintended pregnancies among women living with HIV	• Only 28% contraceptive prevalence rate • 25% of unmet need of family planning • 24% of reproductive age women married or in union used any modern method of contraception • Majority of WLWHIV are young, while only 30% of service delivery points offer adolescent and youth friendly SRH/HIV services (UMATI 2009).
Prong 3: Preventing HIV transmission from woman living with HIV	• 30% of HIV + pregnant women were reported not to receive ARVs to prevent MTCT in 2010 • 43% of HIV exposed infants did not receive ARVs to prevent MTCT in 2010. • Low utilization (26%) of FP services among HIV+ women attending postnatal services
Prong 4: Providing appropriate treatment, care and support to mothers living with HIV and their children and families	• Lack of capacity and means to facilitate immunological assessment of pregnant WLHIV • Weak retention of pregnant WLHIV exposed into care and subsequent referral into CTC

ii. HIV Counseling and Testing (HTC)

HIV testing and counseling (HTC) is implemented through stand-alone Voluntary Counseling and Testing (VCT), integrated within the health system Provider Initiated Testing and Counseling (PITC), and eMTCT services. The testing algorithm for the country includes serial testing with DERTERMINE followed by UNIGOLD. For those who are HIV negative, algorithm demands for repeat test after three months. But the available information shows that 90% of those who take the first HIV test will return for re-testing after three months[3]. The achievements of the HTC program include the fact that by the end of December 2010, 2,134 sites were providing VCT services as opposed to 1,035 in 2009 while PITC was available in all hospitals and 50% of health centers. By end of 2010, the total number of new clients pre-test counseled and tested was 1,009,691 compared to 998,887 reported in 2009[4]. The challenges in the implementation of HTC services include low utilization of the VCT services especially in rural areas due to long distances; inadequate human resources; limited couple testing; and low disclosure of HIV test results to partners preventing efforts to make informed health decisions such as use of condoms. Programmatic gaps arising as a result of the above challenges include: 27% of men and 37% of women aged 15-49 were tested and received results leading to a gap of 73% for men and 63% for women that needs HTC services. PITC services had not been rolled out in 50% of health centers and in all dispensaries considering that health centers and dispensaries serve over 80% of the country's population.

iii. Medical Male Circumcision (MC)

Following the success of the three clinical trials undertaken in South Africa, Kenya and Uganda in reducing HIV acquisition among men by 50-60%, male circumcision was included as one of the key HIV prevention interventions to be rolled out in the country. The reported achievements include the following: successful piloting of male circumcision in Kagera, Iringa and Mbeya in 2009 and expansion of services to Shinyanga and Rukwa. The plan is to scale up circumcision services in 8 regions with low rates of male circumcision and high HIV prevalence. The National Strategy for Scaling Up Male Circumcision for HIV Prevention (201-2015) was finalized and the target is to circumcise 2,830,091 men by 2015. However, weaknesses have been highlighted and these include inadequate human and physical resources. The potential for behavioral misconceptions and false sense of security afforded by circumcision will however require intensive educational interventions.

iv. MARPS

The magnitude of MARPS in Tanzania remains principally unknown. However, the limited and scattered available evidence confirms their existence in the country and their major role as key drivers of the HIV epidemic. Increasing access to services and interventions for these groups will reduce the transmission of HIV infection not only among MARPs but also in the general population. The main weaknesses identified in this area of prevention strategy include: lack of standards, guidelines, or communications strategies for behavioral interventions targeting MARPs and limited data on the actual magnitude of the different categories of MARPS. Programmatic gaps identified include: countrywide MARPS magnitude and dynamics is still unknown; few available MARPS services; huge reported gap in terms of coverage of MARPS with workable interventions, and insufficient coverage and utilization of HIV treatment and prevention services by MARPS. A survey of MARP'S access to treatment and care has been included in this TFM as part of the monitoring and evaluation framework.

v. Care, Treatment and Support

The Government of Tanzania has been successful in improving the quality of life for PLHIV receiving HIV care, treatment and support services. This includes provision of ARVs and laboratory monitoring services for PLHIV and HIV testing services. There has been concerted efforts by the Government of Tanzania (GOT) to scale up care, treatment and support services in an attempt to achieve universal access to ART. ART services have been scaled up to 1,110 health facilities by December 2011 compared to 700 facilities in 2009[3]. With this increase, the country reported 244,148 patients on ART by September 2010[5]. In one year this number had increased by about 90,000 patients currently on ART so that by September 2011, about 333,33[6] PLHIV were on ART according to PEPFAR report, having considered 26% attrition rate.

Monitoring of Pre-ART and ART patients demands the following tests; CD4+, serum biochemistry, and hematology assessment at baseline and thereafter every 6 months. Occasionally viral load assessment is performed for PLHIV when resistance is suspected or for HIV exposed children. Currently 5 zonal laboratories perform viral load testing and DNA PCR.

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

All zonal, regional and district hospitals have the capacity to do CD4+ measurement. Primary health facilities which include health centres and dispensaries collect specimen and transport them to district and regional hospitals for essential laboratory tests. Point of care CD4+ equipments (PIMA) procured through phase one Global Fund Round 8 are currently being rolled out in selected primary health facilities with high patient load.

Challenges facing care and treatment services include the following: Human Resource for Health (HRH) due to retirements, resignations and low uptake of trained personnel from health sciences universities and colleges, inadequate infrastructure, and deficiencies in the current operational ART tracking system that generates reports on service use. The government is addressing HRH issues through task shifting, adjustment in appointment schedules by giving longer appointment dates for stable HIV patients, provision of ART through TB/HIV collaborative activities, increasing student capacity and numbers of health sciences universities. In addition, some of the retired heath workers have been re-engaged to boost staff numbers. The Patient Monitoring System has had indicators revised to harmonize with partner and international reporting obligations, while the electronic system has been updated to accommodate the effected changes and the training of all health care workers on the revisions has been completed. The strategic intent is to harmonize the reporting formats for the government system and the partners as well as international agencies.

vi. Condom promotion and distribution

Condom procurement and distribution is also an important component of the HIV prevention program. Reports showed that 72 million condoms were distributed in 2010. However, this is a reduction, compared to 150,000 million distributed and 82.7 million in 2007 and 2008 respectively. Challenges reported include limited number of condom outlets in terms of variety and the available condoms are mainly found in health facilities and in urban areas. Only 72 million condoms were distributed in 2010 against a need of 132,000 million resulting to a gap of 60 million condoms under the public distribution system.

3.2 Epidemiological Profile of Target Populations

a) Population Groups in Country

→ Specify the breakdown of the target population into relevant sub-populations (e.g., Females 0-4, Males 5-9, etc.) in the left-hand column. Add extra rows as necessary.

Population Groups	Estimated Number	Year of Estimate	Source of Data
Total target population (all ages and genders)	45,798,475	2012	Tanzania National Projections (vole XII) National Bureau of Statistics
Females (0-4)	3,982,695	2012	Tanzania National Projections (vole XII) National Bureau of Statistics
Males (0-4)	3,916,899	2012	Tanzania National Projections (vole XII) National Bureau of Statistics
Females (5-14)	5,892,477	2012	Tanzania National Projections (vol XII) National Bureau of Statistics
Males (5-14)	5,941,800	2012	Tanzania National Projections (vol XII) National Bureau of Statistics
Females (15-64)	12,009,226	2012	Tanzania National Projections (vol XII) National Bureau of Statistics
Males (15-64)	11,362,204	2012	Tanzania National Projections (vol XII) National Bureau of Statistics

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

b) HIV epidemiology of population(s) targeted in existing Global Fund grants				
Population Groups	Estimated Number	Estimated prevalence	Source of Data	Year of Estimate
Number of people living with HIV (HIV Adults + Children)	1,400,000	3.0%	UNAIDS/THMIS	2010
Number of adults living with H IV, 15+	1,300,000	5.7%	UNAIDS/THMIS	2010
Number of female adults living with HIV, 15+	760,000	6.6%	UNAIDS/THMIS	2010
Number of young people living with HIV, 15-24 years old	470,000	2.4%	THMIS	2008
Number of young people living with HIV, 15-24 years old, female	340,000	3.5%	UNAIDS/NBS	2008
Number of children living with HIV, 0-14 years old	160,000	0.8%	UNAIDS/NBS	2010
Number of pregnant women living with HIV	119,159	6.9%	HIV/AIDS/STI Surveillance July 2010	2008
Number of pregnant women needing eMTCT	119,159	N/A	HIV/AIDS/STI Surveillance Report 22; August 2011	2010
Other: Number of men aged > 25 years living with HIV	680,000	4.6%	UNAIDS/THMIS	2008
Number of men aged > 25 years living with HIV	680,000	4.6%	UNAIDS/THMIS	2008

SECTION 4: TFM REQUEST SUMMARY

4.1 Narrative Description of TFM Request

In this section:

1) Describe the essential prevention, treatment and/or care programs currently financed by the Global Fund in the country that are expected to be interrupted, which form your TFM request. In your response, please make reference to the goals and objectives as you present them in the performance framework.

2) Identify the risk of program interruption including a) an estimate of the size of these disruptions in terms of numbers denied essential services and b) a description of the potential impact of these disruptions on new HIV infections, quality of life and death.
3) If applicable, describe what reprogramming is being proposed in order to prevent disruption of essential services.
4) Outline which of the proposed TFM interventions would fall under the definition of Continuity of Services[1]

[1] The Global Fund's Continuity of Services policy provides up to two years of funding to continue courses of treatment (whether the treatment is for a limited duration or is lifelong) when a grant comes to an ed. Additional guidance is provided in the TFM guidelines

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

FOUR PAGES MAXIMUM

The Government of Tanzanian has identified areas for essential prevention, treatment and/or care programs that are expected to be disrupted should there be discontinuation if the flow of resources. These essential services include: ART services, HIV Testing services (including provider initiated testing and counselling (PITC) and voluntary counselling and testing (VCT)), and prevention of mother to child to child transmission (eMTCT).

The country's adoption of the 2010 WHO guidelines for ART initiation, along with sensitization and improved HIV services has resulted in an increased number of patients in the health system beyond the available resources which has strained the capacity of the health care system, and threatens to disrupt the effective and efficient delivery of health and HIV services and in turn, set back the efforts of the program to decrease HIV transmission as well as HIV associated morbidity and mortality.

The identified essential services are in line with the country´s proposal for Global fund Round 8, goal 1 which is to secure and sustain Tanzania's HIV and AIDS Prevention, Care Treatment and Support Services. **The numbering for the SDAs and activities that are in the Global Fund Round 8 has been retained in this document, in the log frame and performance framework. The log frame, performance framework, budget and this narrative have been consolidated and aligned.**

The preparation of the TFM occurred almost simultaneously with the application for the Tanzania Global Fund Phase II. This created a unique opportunity for reprogramming to be undertaken within the context of the Phase II application and to ensure that the following TFM conditions were met:

- The consolidation of both the Phase II and TFM requests in terms of eligibility, budgets, assumptions and unit costs, as well as target figures and counterpart resources which is also clearly elaborated in the budget attachments;
- The targets set for the TFM were a continuation of the Phase II process and fell within the specification of essential of services and there have been no scale up of activities nor dramatic increases of targets outside set criteria;
- The process allowed for the inclusion and explanation of counterpart funding and resources in order to provide for a reduced request for both the Phase II and the TFM;
- As part of Phase II, during the reprogramming exercise, a number of activities were either discontinued or decreased in scale and the funds were directed towards essential, high impact and cost effective activities which are: continued provision of ART, procurement and distribution of laboratory monitoring materials, procurement and distribution of HIV test kits, and treatment of opportunistic infections;
- A thorough and robust assessment of existing stocks of drugs and diagnostic commodities (as well as pipeline shipments) including buffer was undertaken using reliable and up to date information from the Medical Stores Department and the Supply Management Chain Systems and this process resulted in the reduction of a large amount of individual drugs and diagnostic commodities. This aspect has been fully explained in the budgets and in the breakdown of the funding requests for drugs and diagnostic commodities in this section.[7,8]
- Since a large amount of investment is being requested for drugs and diagnostic commodities, it has been found necessary to include robust monitoring and evaluation frameworks to ensure early forecasting and procurement; proper storage and distribution, proper usage and sustained stock in health facilities as well patient monitoring and records management.
- The TFM request has not included any new interventions nor have any of the planned activities involved any scale up or expansion but this proposal continues essential activities that are part of the Global Fund Round 8 Phase II.

Objective 1:To sustain care and treatment services to Health Facilities

SDA 1.1: Antiretroviral therapy and monitoring)
Activity 1.1.1 Quantify and procure ARVs for pediatrics and adults

Estimating the Targets for ART
By the end of 2010 the country reported 258,069 PLHIV on ART[9], this coverage is equivalent to 49% of the all 610,000 PLHIV requiring ART in Tanzania according to **WHO** estimates which took into account the 2010 WHO ART initiation guidelines[9]. This is the most recent data in terms of total numbers of PLHIV requiring treatment and it clearly shows that even in 2012, Tanzania is requesting less than the total number of PLHIV who require treatment but only those whose care, treatment and support would be disrupted (see Table 2).

The Government of Tanzania (GoT) adopted 2010 WHO guidelines for earlier initiation of ART based on the invaluable scientific gains in HIV related mortality and morbidity. However, in setting the target for the need for ART, the Government of Tanzania (GOT) in collaboration with CDC/PEPFAR Tanzania and other stakeholders estimated the need for ART based on the natural increase of PLHIV in the care and treatment facilities throughout the country. It is estimated that there shall be an increase of about 10,100 patients each month, with at an attrition rate of 26% for the first year[7]. This increase is equivalent to a net increase of 80,000 new PLHIV requiring ART per year[10]. Taking into account the baseline of 333,333 PLHIV of ART by September 2011, it is projected that by 2012 and 2013 we shall have 400,000 and 488,889 PLHIV respectively requiring ART. These figures were calculated to the month of June each year (start date for this application), an additional nine months of clients, equivalent to three quarters of the net 80,000 patients on ART which is equal to an addition of 60,000 to the baseline of 333,333. Below is table 2 which shows the targets according to June start dates and the projections to the month of September as per Government of Tanzania and CDC calculations. The TFM proposal has been set for the June start date due to a number of reasons, the most important being the very low levels of commodities currently in the country and some of the most important drugs are due to run out within the next few months or less.

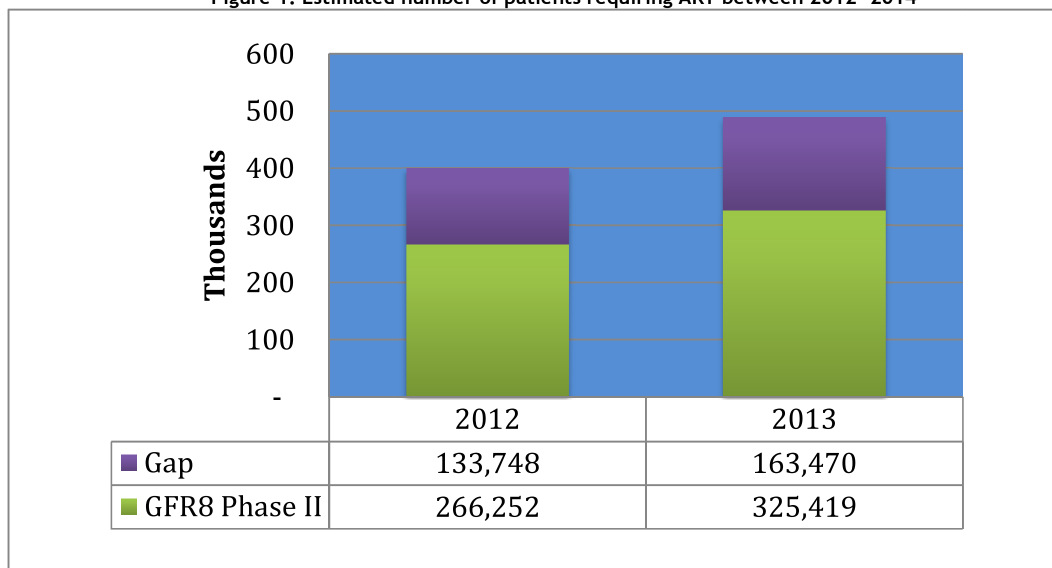
[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

Table 2: Estimated numbers of patients on ART and Pre-ART 2012-2013

Patient Category	June 2012	June 2013	June 2014
June Start date			
# on ART by June of the respective year (TFM estimation)	400,000	488,889	577,778
Pre-ART by June of the respective year	488,889	597,531	706,173
Proportions of paediatrics on ART as of June of the respective year	8%	8%	8%
Total Pre and ART as of June of the respective year	**888,889**	**1,086,420**	**1,283,951**
September Start date			
# on ART by September of the respective year (GOT/PEPFAR)	422,222	511,111	600,000

The key activity in the Global Fund Round 8 phase II objective is to provide ART to 400,000 and 488,889 by June 2012 and June 2013 respectively. Implementation of this activity in GF-R08-II in Tanzania coincides with the publication of the country's National Guidelines for the Management of HIV and AIDS 4th Edition which stipulates earlier ART initiation at ≤ 350cells/ml or WHO stage 3 and 4. This translates into treating all patients with TB/HIV co-infection, pregnant mothers with CD4≤350/μl and all children with HIV infection below 24 months of age. The guidelines further stipulate the use of the more effective and safer regimen (Tenofovir based) as well as phasing out Stavudine.

Figure 1: Estimated number of patients requiring ART between 2012 -2014



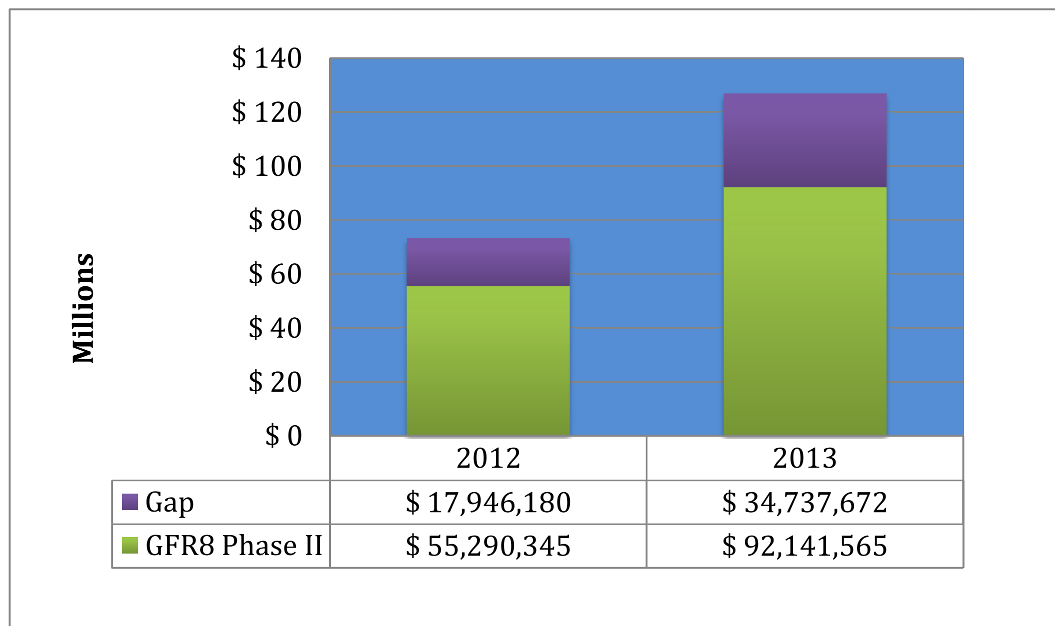
Estimating size of disruption in ART

The government, with the support from the Global Fund has been the main provider of ARV for adults, adolescents, children, and the eMTCT program in the country. Procurement of second line ARV is supported by the President's Emergency Plan for AIDS Relief (PEPFAR). During the implementation of Global Fund Round 8 Phase II, the country will have US$55,290,345 and US$92,141,565 for procurement of ARVs for 2012 and 2013 respectively. The Ministry of Health and Social Welfare in collaboration with other partners has estimated the average cost of ARV per patient per year for 2012 and 2013 to be US$156 and US$158 respectively[11]. Given these funds and considering the stock status currently available and in

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2] Ministry of Health and social welfare, PMTCT annual report 2012

the pipeline, the GoT is able to provide ARVs for only 266,252 and 325,419 PLHIV eligible for ART in 2012 and 2013 respectively. This is equivalent to sustaining 67% of ART needs for two years, for the period June 2012-June 2014. Figure 1 and 2 show the gaps in numbers and cost for ART in 2012 -2013. . **Therefore, the country shall face a disruption of about 33% in terms of ART needs (see figure 1).**

Figure 2: Estimated cost for ARV procurement, transportation and distribution US$



Effects of disruption of ART services

Consequently, if the country is unable to secure additional funds about 133,748 and 163,470 PLHIV eligible for treatment will not be able to be treated with ARV in 2012 and 2013 respectively as indicated in figure 1. This effect does not only cause disruption of service, but also will create fear, misunderstanding and lack of trust by patients and the general population with regards to the HIV care and treatment services. The unavailability of ARV will ultimately translate into increased viral load in untreated PLHIV, making them more infectious, susceptible to opportunistic infections, increasing morbidity and creating a greater burden to the country's health system. It has been well documented that eligible PLHIV denied of ARV are at a greater risk of mortality due to HIV.

The lack of ARVs will also affect eMTCT activities and hence slow down the government's efforts and commitments to virtual elimination of new infections among children and to ensure survival of HIV infected mothers**. When all these factors are taken together, it means that the unavailability of ARVs will drastically and dramatically increase the incidence of new infections as diminished treatment and adherence to drug intake will increase the ability of PLHIV to pass on infections as treatment for prevention will be at risk**. The new HIV infections will be an increased burden on the health care system, on family and community networks, and will consequently lead to an increase in the numbers of orphans and vulnerable children. Loss of skilled labour and bread winners will lead to deepening socio-economic difficulties including poverty and delayed attainment of the country's development efforts as stipulated in the National Strategy for Growth and Reduction of Poverty (NSGRP) and Millennium Development Goals (MDGs).

In-order to improve access of care and treatment for MARPS, Tanzania conducted a biological and behavioral survey among Female Sex Workers (FWS). The results from the survey revealed high prevalence of HIV (31.4% versus 5.7%) in the general population. However, MARPS are not accessing HIV treatment services widely. The disparities in HIV prevalence and access to care between MARPS and general population necessitated targeted interventions for the group, mainly done by PSI and T-Marc. However, the situation in Intravenous drug users (IDUs) and men who have sex with men (MSMs) is not yet studied. Determinants of access to care and treatment are necessary to conduct to optimize opportunities for directed treatment interventions for MARPS which will eventually reduce HIV infections. This request has included funding request to sustain M&E systems that will increase uptake and identification of MARPS in HIV care and treatments clinics.

Objective 2: To sustain testing and counselling capacity across the country to respond to demand as well as identify HIV+ individuals who require services

SDA 2.2: Counselling and Testing: Test Kit Procurement
Activity 2.2.1 Quantify and Procure HIV test kits for all HIV testing

HIV Testing and Counselling (HTC) services are critical to the implementation of Tanzania's Health Sector HIV Strategic Plan – II (HSSP-II). HTC is an entry point into HIV care, support, and treatment services. It plays a key role in HIV prevention

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012

through knowledge of HIV status and thus appropriate measures through behavioural change, safer sexual practice and linkage to HIV care and treatment services. HTC is an opportunity for health promotion for prevention of associated disease and integration of services like sexual and Reproductive health components such as Family Planning and like sexually transmitted diseases (STI). In Tanzania, HTC consolidates different strategies to maximise access to HIV testing and linkage to care. These strategies include, Provider Initiated Testing and Counselling provided by Health Care Providers in health facilities (PITC) including testing at antenatal clinics and other reproductive and child service clinic and Home Based Counselling and Testing (HBCT).

The numbers of VCT sites both facility-based and stand alone in public and private have increased from 521 in 2004 to 2,137 by June 2010. By December 2011, thirteen (13) million people were already counselled and tested for HIV through different services. During the year 2012 and 2013, the country targets to reach 6,895,474 and 6,952,203 clients with HIV testing services respectively (table 3) below.

Table 3: The distribution of clients accessing HIV testing services in 2012 and 2013

Implementation year	2012	2013	2014
Number of people tested (VCT) (#)	1,200,000	1,200,000	1,200,000
Number of people tested (PITC,eMTCT,MC) (#)	5,695,474	5,652,208	5,752,203
Total number targeted for HIV testing **(#)**	6,895,474	6,852,208	6,952,203
GFR08 PHASE-II funds ($)	9,545,688	12,399,579	0
Numbers of patients to be covered by TFM (#)	4,406,058	5,806,111	-

According to the national HTC guidelines, serial testing is done using DETERMINE followed while UNIGOLD is used for confirmatory tests. Estimates and reports show that about 10% of those who take the first test will require the confirmatory test with UNIGOLD. Table 3 below provides the distribution of numbers of patients requiring HIV testing by DETERMINE and UNIGOLD in 2012 to 2014.

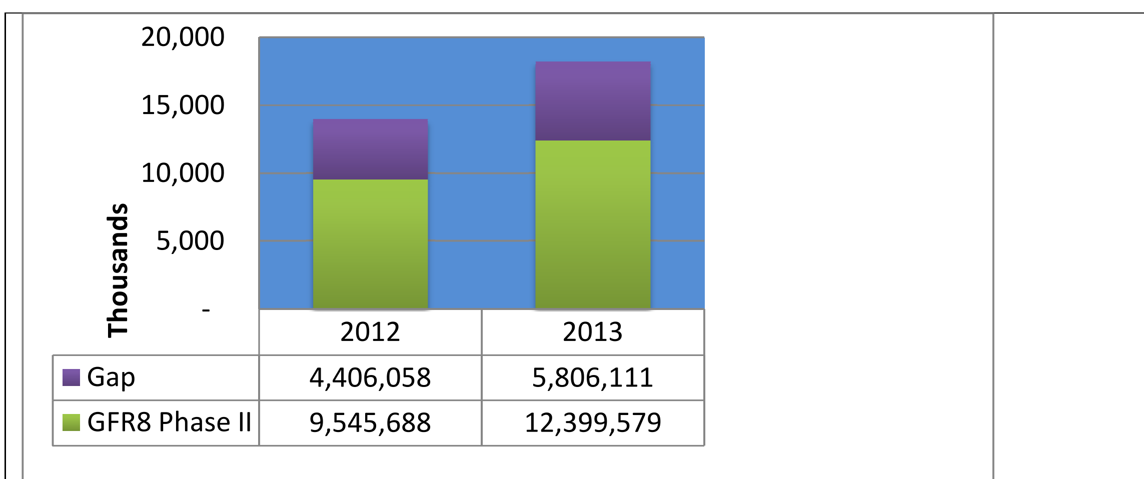
Table 4: Number of patients to be tested by type of test and by year.

YEAR	**DETERMINE** **(# first HIV test according to HTC algorithm)**	**UNIGOLD** **(# taking confirmatory test (10% of all who test positive with the Determine)**
2012	**6,895,474**	**689,547**
2013	**6,852,208**	**685,221**
2014	**6,952,203**	**695,220**

Figure 3 below shows the gaps for clients that will require HIV testing. The Global Fund Phase II accommodates 66% of total gap for each of the two years.

Figure 3: Estimated number of clients that will require HIV testing

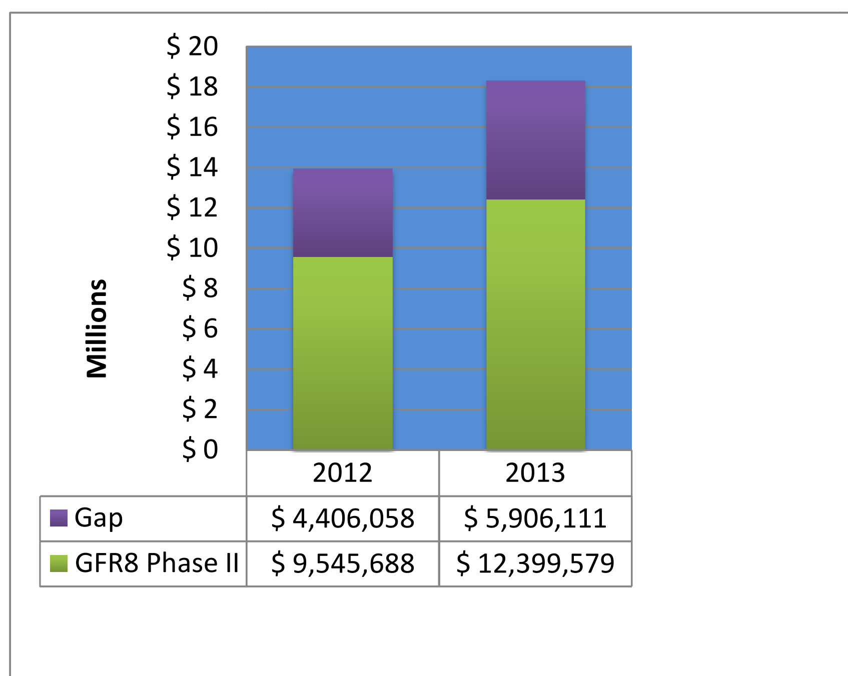
[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.



In order to ensure quality HTC services, the program requires continuous supply of HIV test kits according to the national HIV testing algorithm. In Tanzania, long distance and poor infrastructure are among factors leading to poor access to health services especially in rural areas. Statistics show that only 55% of pregnant women deliver in health facilities, and 90% of pregnant women access ANC at least once. Routine medical-dental check-up is a rare phenomenon. Ultimately, lack of HTC services will lead to patients to not being captured within the health system and will thus lead to anticipated uncontrolled HIV transmission, morbidity and mortality. Therefore it cannot be overemphasized that a regular supply of HIV testing facilities is a pre-requisite to avoiding missed opportunities for HIV testing and providing essential linkage to care and treatment for a sustainable HIV prevention program.

The Government of Tanzania with the support of the Global Fund is the provider of HIV testing kits. About 13,951,746 and 18,305,690 USD is required for the procurement of HIV test kits in 2012 and 2013 respectively (figure 4). However, with the available resources, the government will be unable to meet the HIV testing demands for 4,406,058 and 5,806,111 during 2012 and 2013 respectively. Should the government lack these funds, these numbers of people will be denied of HIV testing services. The GOT is seeking for these funds so that the achievements that have been made will not be eroded, and that treatment service delivery may not be interrupted and that Tanzania will continue to contribute to the global efforts to respond to HIV and its associated effects. Figure 4 elaborates the funding gap for HTC services.

Figure 4: Estimated HIV test kits cost in USD



Reprogramming
The country is currently implementing the Global Fund Round 8 Phase II. Reprogramming has been done to secure funds for identified essential services. This has resulted in securing a total of US$ 8,805,016 as detailed in the log frame. The details are in 4.3.

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2] Ministry of Health and social welfare, PMTCT annual

Transitional Funding Mechanism

The activities we proposed in the TFM interventions do not fall under Continuity of service CoS since we have an on-going Global Fund Round 8 Phase II. However, these services are part of essential services and in case of disruption will halt the effort to create an HIV free generation.

SUMMARY of the request

In summary, we are requesting for a total of **USD 66,469,743(Sixty six million four hundred and sixty nine thousand seven hundred and forty three United States dollars)** to avoid **disruption of about one** third of ART provision and HTC services for 2012 and 2013 respectively with a start date of June 2012. Reprogramming has been done to secure about **US$8,805,016** which was reallocated to essential services.

4.2 TFM Request in the Context of a Consolidated Application

Skip if there are no existing grants that will be ongoing as of the start date of the TFM funding

a) Logframe for TFM request

Prepare a logframe in Microsoft Excel form in the template provided [Attachment D].

The logframe should provide an overview of the goal(s), objectives, service delivery areas (SDAs) and key activities in this TFM request, including the key indicators. Indicate the SDAs and key activities of existing grants to be included in this TFM request and note if they will be continued without change or decreased in scale. Wherever applicable provide the number of people supported by the current grant and the number of people who will continue to be supported through TFM. Also describe all SDAs and key activities. SDAs and key activities from existing grants that will be discontinued will be captured in table 4.2(b).

Develop a numbering system for organizing the goal(s) and linking the objectives, SDAs, and activities. Each goal, objective, SDA and activity should have a unique identifying number. This numbering system should be carried throughout the rest of the TFM request and should match the narrative description and the detailed budget and work plan.

This logframe should be used to present how you have reprogramed existing funds to cover gaps in essential prevention, treatment and/or care programs.

Logframe (attachment D) has been attached.

b) Discontinued Activities

In the table below, list the SDAs and key activities of existing Global Fund grants which would be discontinued with approval of this consolidated TFM request in order to cover the most essential prevention treatment and care services. This table is only for SDAs and activities that have been dropped. Those which have been modified should go in the log frame.

→ For this question only: applicants are requested to use the same numbering of SDAs and activities as in the previously approved grant(s).

Discontinued SDAs and activities	Existing grants	Reason for Discontinuation
1. [SDA 1.1: Anti-retroviral Therapy and Monitoring]	[TNZ-809-G13-H]	
1.1 [Activity: 1.1.3 Train HCWs from health centers and dispensaries; 500 Facilities]	[TNZ-809-G13-H]	No funds were allocated in this activity due to prioritization to more essential services
1.2 [1.1.5 Conduct Refresher training of 50 ToTs on new guidelines]	[TNZ-809-G13-H]	Training will be restricted to replacement no refresher training will be conducted. Funds that were allocated for this activity in GFR 8 Phase II been reprogrammed to procure HIV commodities. ARV's, HIV test kits and Reagents
2. [SDA 1.2: Care for the Chronically ill]	[TNZ-809-G13-H]	
2.1 [Activity 1.2.1: Quantify and procure Home-based care kits]	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II been

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

		reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
2.2 [Activity 1.2.4: Quantify and procure nutritional supplements (RUTF) for malnourished children and PLHA]	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
3. SDA 2.1: Counseling and Testing: PITC	[TNZ-809-G13-H]	
3.1 [Conduct workshop to develop PITC messaging for the general population and HCWs	[TNZ-809-G13-H]	There were no funds that were allocated for this activity in GFR 8 Phase II
3.2 [Develop and Print IEC/BCC materials to support roll out of PITC]	[TNZ-809-G13-H]	There were no funds that were allocated for this activity in GFR 8 Phase II
3.3 Incorporate PITC in regular IEC messaging via electronic mass media channels	[TNZ-809-G13-H]	There were no funds that were allocated for this activity in GFR 8 Phase II
3.4 Develop IEC/BCC guidelines for community level PITC outreach and messaging	[TNZ-809-G13-H]	There were no funds that were allocated for this activity in GFR 8 Phase II
3.5 Support districts to conduct community level PITC outreach and messaging	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
4.SDA 3.1 eMTCT	[TNZ-809-G13-H]	
4.1 [Activity: Provide refresher training for 100 Master Trainers every 2 years]	[TNZ-809-G13-H]	There were no funds that were allocated for this activity in GFR 8 Phase II
5.SDA 3.2: STI Management	[TNZ-809-G13-H]	
5.1 Refresher training of 100 STI/RTI ToTs on new training packages	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
5.2 Train 1000 new HCWs on STI/RTI management	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
5.3 Training 1,440 HCWs on Adolescent Sexual Reproductive Health (480 health care workers per year)	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

5.4 Refresher training of 1,200 health service providers using the new training packages by 2010	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
5.5 Train 900 HCWs in syphilis screening using Focused Antenatal Care	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)
5.6 Quantify and procure STI drugs and Consumables	[TNZ-809-G13-H]	Funds that were allocated for this activity in GFR 8 Phase II have been reprogrammed to procure HIV commodities(ARV's, HIV test kits and Reagents)

4.3 Ability to finance through reprogramming of existing Global Fund grants

Justify why the planned interventions described in 4.1 and 4.2 cannot be fully or partly addressed through reprogramming of existing Global Fund grants.

The reprogramming exercise was completed by a team of key stakeholders and decision makers and funds were re-allocated from non-essential to essential programs. However, it was found that in spite of the reprogramming exercise, which was quite thorough and scrupulous, gaps in essential services remained. Essentially the reprogramming has occurred in two stages – as part of the request for the Global Fund Round 8 Phase II and at the proposal development stage for the TFM request. The details of the reprogramming exercise is as follows:

(a) To realign resources from low impact, non-essential and less effective programs such as home based care, behavioral change communication, management of sexually transmitted infections and selected trainings to anti-retroviral treatment (ART) for both adults and children, treatment of opportunistic infections, prevention of mother to child transmissions (PMTCT), and laboratory supplies and support. The reprogramming exercise was conducted as part of the Global Fund Round 8 Phase II renewal process and the following amounts were made available for use in the essential and high impact program activities:

Table 5: Ministry of Health and Social welfare (MOHSW) reprogramming and gained funds

Goal(1)	**Goal 1: Secure and Sustain Tanzania's HIV/AIDS Prevention, Care Treatment and Support Services**		
Objective 1	Objective 1: To sustain care and treatment services to Primary Health Facilities		
SDA 1.1	**SDA 1.1: Anti-retroviral Therapy and Monitoring**		US$
Activity 1.1.4	Refresher Training for 1600 HCWs previously trained on care and treatment of PLHIV	Decreased in scale. This activity overlapped in both phases of the GFR8 grant. In phase two, a total of 2400HCW's were to be trained. However, only 1600 HCWs will be trained. In this case, the 800 HCW's will not be trained as originally planned. Therefore, the gained funds will be reprogrammed for HIV commodities procurement (ARVs, test kits and reagents). The country will incur training of dropout.	319,040
Activity 1.2.2	Orientation of 306 HCWs on RUTF use in three years	Decreased in scale. This activity overlapped in both phases of the GFR8 grant. In phase two, a total of 612 HCW's were to be trained. However, only 306 HCWs will be trained. The country will meet cost of trainings for the dropped 306 HCW'S. The gained funds from the dropped HCW'S will be reprogrammed for HIV commodities procurement (ARVs, test kits and reagents).	171,882

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

			126,252
Activity 1.2.3	Supportive supervision (per quarter) on nutritional supplements use	Decreased in scale from 9 quarters supportive supervision to 4 quarters in year three of GFR8 phase II, the gained funds from 5 supervision that were to be conducted in year 4&5 of phase II , will be reprogrammed for the procurement of ARV, HIV test kits & reagents.	
SDA 2.1	SDA 2.1: Counselling and Testing: PITC		
Activity 2.1.1	Train 418 HCWs on Basic PITC	Decreased in scale. This activity overlapped in both phases of the GFR8 grant. In phase two, a total of 812 HCW's were expected to be trained. However, only 418 HCWs will be trained. The country will meet cost of trainings for the dropped 418 HCW'S. The gained funds from the dropped HCW'S will be reprogrammed for HIV commodities procurement (ARVs, test kits and reagents).	176,291
SDA 3.1	**SDA 3.1 PMTCT**		
Activity 3.1.1	Train 780 HCWs on PMTCT to reach 100% coverage of facilities providing Reproductive and Child Health Services	Decreased in scale, this activity was for phase one (GFR8) and will continue in phase two. In phase two a total of 1,350 HCW's were expected to be trained, however, only 720 HCW's will be trained. The gained funds will be reprogrammed to compliment the procurement of HIV commodities (ARVs, Test kits and Reagents).	697,509
Activity 3.1.2	Provide refresher training for 100 Master Trainers every 2 years	Decreased in scale, this activity was for phase one (GFR8) and will not continue in phase two. The fund allocated for this activity in phase two, will be reprogrammed for TFM essential activities (procurements of HIV commodities)	47,462
SDA 3.2	**SDA 3.2: STI Management**		
Activity 3.2.3	Training 1,440 HCWs on Adolescent Sexual Reproductive Health (480 health care workers per year)	Decreased in scale, this activity was for phase one (GFR8) and was to continue in phase two. Instead these funds were reprogrammed for procurement of for ARV, HIV test kits & reagents.	369,702
Objective 4	**Objective 4: Ensure continuous quality services are delivered**		
SDA 4.1	**SDA 4.1 Service Delivery**		
Activity 4.1.1	Conduct cascade of supportive supervision from national level via regional and district levels to facilities	Decreased in scale, this activity was for phase one (GFR8) and will continue in phase two. It was expected that a total of 2,737,160USD could have been used for supportive supervision in Phase II. However, only 909,327 will be spent for this activity. The remaining funds 1,827,833 have been reprogrammed for procurement of HIV essential commodities (ARV's, Test Kits and Reagents).	1.827,833
Activity 4.1.2	National level mentorship (4 Mentors & 21 drivers in 21 regions for 12 days every Quarter for 3 years)	Decreased in scale, this activity was for phase one (GFR8) and will continue in phase two. It was expected that a total 970,689 USD could have been used for supportive supervision in Phase Two. However, only 748,739 will be spent for this activity. The remaining funds 221,950USD have been reprogrammed for procurement of HIV essential commodities (ARV's, Test Kits and Reagents).	221,950
		Overhead	10,000
	Total		**3,786,039**

The reprogramming for TACAIDS was as follows:

Table 6: Tanzania AIDS Commission for AIDS (TACAIDS) reprogramming

Goal(2)	**Goal 2: Strengthening Coordination and implementation capacity of**		

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

	key stakeholders		
Objective 1	Strengthen National level Stakeholders and Coordination Mechanism		
SDA 1.1	**SDA 1.1: Strengthening Government**		US$
Activity 1.1.1	Undertake study to assess reasons for not reporting and compliance by MDAs, Private sector on TOMSHA	This activity was planned to be undertaken in year 3 of GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	8,020
Activity 1.1.2	Undertake study to assess the implementation of workplace HIV and AIDS interventions in both public and private institutions	This activity was planned to be undertaken in year 3 of GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	21,888
Activity 1.1.3	Conduct training on TOSHA and M&E package to 100 umbrella organizations in six zones (TOMSHA managers)	This activity was planned to be undertaken in year 3 of GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	174,897
Activity 1.1.4	Print and distribute 3000 TOMSHA primary source documents and 3000TOMSHA forms for HIV and AIDS implementers annually	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	142,942
SDA 1.6	SDA 1.6 Support National level Multi-sectoral Coordination		
Activity 1.6.1	Conduct mapping exercise to identify stakeholders dealing with advocacy and communication issues in HIV and AIDS to facilitate coordination	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	21,000
Activity 1.6.2	Develop planning and budget guidelines	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	94,500
Activity 1.6.3	Conduct 2 weeks training on programme Management course to 15 staff (5 staff annually)	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	156,971

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2] Ministry of Health and social welfare, PMTCT annual report 2012.

Activity 1.6.4	Conduct 2 weeks training on Financial Management to 3 staff annually	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	94,182	
Activity 1.6.5	Conduct 3 weeks course on M&E to 3 staff annually	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	116,862	
1.6.6	Conduct capacity building workshop to 20 staff on resource mobilization skills	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	33,108	
Activity 1.6.7	Develop quality assurance plan	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	31,500	
Activity 1.6.8	Conduct annual multi-sectoral HIV and AIDS Scientific conference	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	814,147	
Activity 1.6.9	Conduct consultative meeting with small groups of stakeholders	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	11,118	
Activity 1.6.10	Undertake evaluation study to assess the progress of HIV and AIDS interventions in High Learning Institutions	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	16,138	
Activity 1.6.11	Conduct survey to identify existing guidelines and tools for mapping of HIV and AIDS Stakeholders and services	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	17,500	
Activity 1.6.12	To harmonize and disseminate the identified mapping guidelines and tools for CSOs and DPs	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	246,719	

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

	Activity 1.6.13	To carry out quarterly supportive coordination visits/meetings to LGAs to ensure proper application of the guidelines	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	7,644	
	Activity 1.6.14	To facilitate annual CSO, PS, IS, FBO, MDAs, RS, CHACs/DACCs forums for information sharing and documentation of best practices on HIV and AIDS implementation	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	177,335	
	Activity 1.6.15	Study visit to countries that have the best deployed HIV and AIDS ICT system application	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	42,353	
	Activity 1.6.16	Conduct advocacy forum with CEOs of public and private sectors to mobilize resources for HIV and AIDS	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped, instead efforts are done to encourage CEOs to contribute to the implementation of this activity. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	114,138	
	1.6.17	To document 20 best practices for information sharing	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	63,000	
	Activity 1.6.18	To facilitate staff orientation and the implementation of e-government for TACAIDS	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	91,918	
	Activity 1.6.19	To develop and implement HIV and AIDS information business continuity and data disaster recovery plan	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	176,515	
	Activity 1.6.20	To conduct annual refresher training on use of TOMSHA database system for reporting to 133 LGAs and 21 Regions	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	984153	
	Activity 1.6.21	To orient 133 LGAs, MDAs and other implementers on effective auditing and reporting of HIV and AIDS resources	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	243,796	

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

Activity 1.6.22	Sharing of auditing and risk management process among TACAIDS staff	This activity was planned to be undertaken in GF R8 phase II. Now it will seek funding from other sources in fiscal year 2012/2013. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents	126,997
Activity 1.6.23	To conduct 1 feedback meeting with CEOs and directors from MDAs, LGAs and NSAs	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	177,388
Activity 1.6.24	To conduct annual coordination meeting for regional and international programs implementers targeting Key Population and mobile population who are MARPS	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	163,985
Activity 1.6.25	To facilitate annual and semi-annual Regional Programs Steering Committee meetings	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	178,076
Activity 1.6.26	Conduct regional programs stakeholders' meeting for review of HIV and AIDS strategic plans implementation for harmonization with National HIV and AIDS Multi-sectoral Strategic Framework and other sectoral strategic documents	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	203,144
Activity 1.6.27	Conduct review meeting for regional researches (SADC, EAC, EALP and GLIA) and identify the contribution of their findings to the HIV and AIDS national response through evidence based planning	This activity was planned to be undertaken in GF R8 phase II. Now it has been dropped until funds from other sources are available. The gained funds from not implementing this activity in GF R8 phase II is reprogrammed for the procurement of ARV, HIV test kits & reagents.	267,044
	Total		**5,018,977**

Therefore the total amount that has been reprogrammed is **US$ 8,805,016** (Eight million, eight hundred and five thousands and sixteen United States dollars. This amount is a total of the funds reprogrammed by the MoHSW and TACAIDS as shown above.

(b) However, in spite of channeling funds to the essential services through reprogramming and in many cases leaving the low impact interventions with zero resources, there were still serious gaps in resources for the essential services such as ART and PMTCT for the following reasons the country's adaptation of the 2010 WHO guidelines. The country faces an increase in the absolute numbers of eligible patients. **It must be stressed that some of these patients are already enrolled in care and treatment facilities but were initially non eligible for ART initiation prior to the 2010 WHO earlier initiation of ART. With the recent changes, the country is forced to continue to provide them with ART.**

4.4 Other Sources of Funding

Describe efforts made to find other funding sources to meet the potential gap in essential prevention, treatment and/or care programs currently financed by the Global Fund in the country. These sources may be from a) domestic resources or b) other donors.

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

Apart from the Global Fund and PEPFAR, Tanzania does not have other counterpart funds to meet the shortfalls in essential services delivery that have been Identified. PERFAR contribute to HIV care and treatment services through its procurement of all second line ARV drugs, ART for pediatric patients and condoms. However this funding is committed until September 2013. It is hoped that Tanzania will continue to benefit from this funding beyond its termination, especially at this time when there are increasing numbers of patients on ARV and decreased international funding. In fact the flow of funds into the country has skewed down dramatically with many donors completely cutting off their support partly due to global financial difficulties. It is not expected that this situation will improve in the short term and therefore Tanzania is putting in place measures to counteract this by steadily increasing the amount set aside for health and HIV and AIDS from the treasury and by establishing the Tanzania AIDS Control Trust Fund (TATF). However, the TATF is anticipated to begin operating in earnest in a couple of year's time as by that time it is planned that the legal and logistical impediments would have been resolved.

Significant changes in external funding have already occurred in the last few years due to the Global financial crisis and ending of commitments. UNITAID had been providing $2.5 MM annually for Drugs and diagnostics for HIV and AIDS, including $1.3 million for ARVs. However, this support came to an end in 2010. JICA had been particularly active in supporting the procurement of HIV test kits, RPR test kits for syphilis screening, and drugs for STI treatment. This support came to an end in 2011. On the other hand, many of the partners that provide annual commitments have found it difficult to provide adequate information on their commitments for the next few years. PEPFAR funding has also significantly reduced from US$359 million in 2009 to US$338 million for the period 2011 to 2013. The figures for 2014 and 2015 are estimates based on the historical projections as provided by PEPAFR for the period 2012 to 2013 and they are estimated at a flat figure of US$338 million per annum.

Buffer and Existing Stock
Normally the buffer stock applied is 25% of the total requirements. The rationale for the 25% buffer stock applied takes into consideration the lead time, reorder level by facilities – turn-around time between placing an order and receiving the medicines in a facility and Medical Stores Department, and the lead time between placing an order and arrival of medicines in country.

The buffer stock applied differs from commodity to commodity this is due to the budget constrain .However, the Government have put measures to strengthen the Supply Chain to avert stock outs that may be caused by insufficient buffer stock, hence it is expected to order commodities in time. The current situation is that there are no buffer stocks in place and many of the commodities are at very low levels.

The assumption**s** used to calculate the requirements of ARVs, were based on number of patien**ts per regimen. Since the country has ado**pted WHO Recommendations using Tenofovir based regimens, Phasing out stavudine based regimens, **treating WHO HIV stage three** and four as well as patients with CD 4+ count ≤ 350 cells/µl, the country has been experiencing a net increase of about 80,000 patients per year. That means about 10,100 new patients starting ART each month at an attrition rate of about 26% (Ref Care and Treatment Report 2 and PEPFAR report).

A proper and systematic assessment of existing stocks of drugs and diagnostic commodities (as well as pipeline shipments) including buffer was undertaken using reliable and up to date information from the Medical Stores Department and the Supply Management Chain Systems and this process resulted in the reduction of a large amount of individual drugs and diagnostic commodities. Table 7 below provides a list of some of the essential drugs that formed part of the assessment of stocks and it will be noticed that the situation is dire as many of these drugs will ran out soon, unless resources are found. Table 7 also shows that those drugs that will be available during the first twelve months of the TFM have been taken into account and this has reduced the overall TFM request considerably.

Table 7: Stock Status of Key Commodities as at 8th February, 2012

Product / Dosage Form	Estimated Consumption as of June 2012	Stock on Hand 8th February, 2012	Shipped Quantity	Quantity on Order	Month of Available Stock	Beginning Balance as of June 2012	Balance Requested from GF for 2012
Lamivudine-Zidovudine	105,879	294,567.0	172,786.0		4.4	-	12
Tenofovir DF-Lamivudine-Efavirenz	51,732	85,485.0			1.7	-	12
Efavirenz	110,363	456,315.0	137,269.0		5.4	0.4	12
Zidovudine-Lamivudine-Nevirapine	105,967	699,453.0			6.6	1.6	11
Lamivudine	19,589	138,141.0			7.1	2.1	9
Lamivudine-Stavudine-Nevirapine	62,079	453,535.0			7.3	2.3	9
Zidovudine	43,826	183,560.0	150,000.0		7.6	2.6	9

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

Stavudine	6,898	94,960.0			13.8	8.8	3
Nevirapine	20,693	423,883.0			20.5	15.5	0
Lamivudine-Stavudine-Nevirapine	4,160	12,319.0			3.0	-	0
Nevirapine	21,600	13,531.0			0.6	-	0
Lamivudine-stavudine	416	1,480.0			3.6	-	0
Efavirenz	10,144	10,992.0			1.1	-	0
Tenofovir disoproxil fumarate	12,692	2,722.0		10,080.0	1.0	-	0
Lamivudine-Stavudine-Nevirapine	5,696	7,521.0	16,000.0	15,642.0	6.9	1.9	0
Zidovudine-Lamivudine	4,461	36,852.0			8.3	3.3	0
Tenofovir disoproxil fumarate-Emtricitabine	12,485	64,858.0		66,931.0	10.6	5.6	0
Zidovudine-Lamivudine-Nevirapine	17,280	166,622.0	11,262.0	21,458.0	11.5	6.5	0
Efavirenz-Emtricitabine-Tenofovir disoproxil fumarate	13,795	112,824.0	131,280.0	153,642.0	28.8	23.8	0

Note: The commodities in yellow are procured using funds from PEPFAR. The requested balance from GF TFM is about 33% of the total requirement.

SECTION 5: MONITORING AND EVALUATION

5.1 Performance Framework

All applicants must complete a performance framework (Attachment A) which reflects the targeted outcomes of all of the interventions proposed in section 4.1 and 4.2. Ensure that the indicators in the performance framework are linked to those developed in 4.1 and 4.2 b). For detailed guidance on how to complete the performance framework, refer to the guidelines and instructions in the attachment.

[1] Ministry of Health and social welfare, PMTCT annual report 2011. [2]Ministry of Health and social welfare, PMTCT annual report 2012.

<table>
<tr><td colspan="6">5.2 (a) Impact and Outcome Measurement</td></tr>
<tr><td colspan="6">Describe all planned future surveys, surveillance activities and routine data collection in country that are being used (or will be used) to measure impact and outcome indicators relevant to this proposal. Add rows and change the "Years of Implementation" as needed. Given that the scope of activities funded under the TFM is limited, applicants are strongly encouraged to seek alternate sources of funding (domestic and non-Global Fund) for surveys, surveillance and other data collection that are not routine.</td></tr>
<tr><td rowspan="2">Impact/Outcome Indicators relevant to the proposal</td><td rowspan="2">Year of last data collection</td><td rowspan="2">Method of Data Collection/ Data Source</td><td rowspan="2">Funding</td><td colspan="2">Years of Implementation</td></tr>
<tr><td>Year 1</td><td>Year 2</td></tr>
<tr><td rowspan="3">Tanzania HIV Malaria Indicator Survey</td><td rowspan="3">2008</td><td rowspan="3">Source 1
(large scale surveys, demographic surveillance, vital registration systems, other)</td><td>Total cost</td><td></td><td></td></tr>
<tr><td>Secured funding amount and funding source</td><td></td><td></td></tr>
<tr><td>TFM funding request for routine data collection Source 1</td><td></td><td></td></tr>
<tr><td rowspan="3">ANC sentinel Surveillance</td><td rowspan="3">2011</td><td rowspan="3">Source 2
(large scale surveys, demographic surveillance, vital registration systems, other)</td><td>Total cost</td><td>600,000</td><td>700,000</td></tr>
<tr><td>Secured funding amount and funding source</td><td>600,000</td><td>700,000</td></tr>
<tr><td>TFM funding request for routine data collection Source 2</td><td>0</td><td>0</td></tr>
<tr><td rowspan="3">MARPS Behavioral Biological Surveys</td><td rowspan="3">2010 (female sex workers only)
Fund request is for MSM, IDU, BBS</td><td rowspan="3">Source 3
(large scale surveys, demographic surveillance, vital registration systems, other)</td><td>Total cost</td><td>900,000</td><td>0</td></tr>
<tr><td>Secured funding amount and funding source</td><td>0</td><td>0</td></tr>
<tr><td>TFM funding request for routine data collection Source 3</td><td>900,000</td><td>0</td></tr>
<tr><td rowspan="3">eMTCT</td><td rowspan="3">-</td><td rowspan="3">Source 4
(Plans to identify and establish sentinel sites for eMTCT transmission rate-impact monitoring)</td><td>Total cost</td><td>1,000,000</td><td>0</td></tr>
<tr><td>Secured funding amount and funding source</td><td>200,000</td><td>0</td></tr>
<tr><td>TFM funding request for routine data collection Source 3</td><td>800,000</td><td>0</td></tr>
</table>

5.2 (b) Program Evaluations (preparing for the Global Fund Periodic Review)

Please describe the arrangements that will be put in place to conduct the program and impact evaluation, including whether an existing national review will be used or whether an ad hoc evaluation will be conducted. In your response, please describe:

(a) what methodology will be used;
(b) the roles and responsibilities of the key stakeholders who will be involved; and
(c) Planned timelines for data collection.

Transitional Funding Mechanism

TWO PAGE MAXIMUM

The Government of Tanzania uses various systems to collect information for monitoring outcomes and impacts of HIV interventions. Systems in use include: Behavioural and Biological surveillance among specific populations, such as ANC surveillance, MARPs studies, drug resistance monitoring; Population-based and facility surveys, such as the Tanzania HIV Indicator Survey (THIS), Service Provision Assessment (SPA), Health and Demographic Surveillance Survey (HDSS);Recording and reporting systems, including Health Management Information System (HMIS),Inventory Medical Products Information Systems (ERP- EPICOR 9); For M&E of non-health HIV and AIDS interventions, and multi-sectoral data as captured in the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA).As the Global Fund is a performance and evidence based grant Tanzania ensures that the Performance Framework used per grant is capable of capturing all the key information to monitor progress. However, some information that is necessary to review the performance of the Global Fund Grant may not be available and thus this necessitates Global Fund Periodic Review. The framework for evaluation will involve contracting the task to a renowned institution with the capacity to do the review. Global Fund Periodic Review will be done biannually during the implementation of Global Fund Round eight phase 2 and TFM phase. The matrix below narrates what will be done:

TASKS	RESPONSIBILITY	TIMELINE
1. Identify priority areas for Global Fund Periodic Review	GF coordinators, TNCM, LFA and PRs	June -July 2012
2. Technical Assistance to Develop documents for requesting letters of intent and call for full proposals for Global Fund Periodic Reviews	GF secretariat- TACAIDS	August- September 2012
3. Develop Global Fund Periodic Review criteria and identify potential reviewers	GF secretariat- TACAIDS and TNCM	October- November 2012
4. Develop schedule of reviews by recipient levels and service delivery area	GF secretariat- TACAIDS and contractor	December 2012- January 2013 June- July 2013 December 2013- January 2014 June - July 2014 December 2014
5. Develop Action Plans to address gaps observed in specific GF Periodic Reviews	Contractor, GF secretariat and PRs, SRs	January 2013- July 2014
6. MARPS sero-survey including treatment, care and support for high risk groups	GF secretariat- TACAIDS and MOHSW	January 2013-June 2013
7. Pharmacy module to monitor usage of ARVs	GF secretariat- TACAIDS	June 2012 to June 2014
8. Coordinate Continuous Infant HIV Infection and Survival Surveillance	GF secretariat- TACAIDS	June 2012 to June 2014

Issues to be assessed in the Global Fund Periodic Review will include: MSD - Supply Chain Management, Storage and Distribution, Forecasting and Quantification, Inventory Control and Stock Management; NACP - Functioning of Recording and reporting systems (electronic and paper based) for HIV Care, Home based Care, STI and HIV Testing and Counseling services, Linkage between coverage(facility) and consumption (pharmacy) data. eMTCT: Progress made in setting functional M&E systems for eMTCT and EID (surveillance, M&E) to provide transmission rates and survival trends OTHER SRs: NIMR, TFNC, TFDA, and TACAIDS. The GF periodic reviews will involve Field Assessments and Desk Reviews of existing reports.

The justification for MARPs sero-survey is that Tanzania has managed to conduct a biological behavioural survey among Female Sex Workers, results from the survey revealed high prevalence of HIV (31.4 %) versus 5.7% in the general population. The results have necessitated targeted interventions for the group, mainly done by PSI and T-Marc. However, the situation in IDUs and MSMs is not yet studied, being bridging populations for HIV and other STI it is crucial to assess the disease burden and formulate better target intervention in care and treatment for the key

populations. This is particularly significant as both the Global Fund Phase II and the TFM will invest enormous resources in drugs and equipment meant for f the treatment of PLHIV and it is therefore necessary that MARPS are mainstreamed in these critical and essential interventions. Funds for these activities have been budgeted for in the TFM proposal.

It is important that the usage of ARVs is closely monitored and the information obtained is used for corrective action and for better patient treatment, care and support. A pharmacy module which is already available will be used for this purpose. Activities will include essential training of various health care stakeholders, the procurement of computers and accessories as well as the oversight of the implementation of the module. Funds for these activities have been budgeted for in the TFM proposal.

The coordination of Continuous Infant HIV Infection and Survival Surveillance will ensure the training of a core team of technical persons from various organizations on Early Infant HIV infection and survival survey methods; and the training of 60 research assistants on Early Infant HIV infection and survival survey methods. Data and sample processing, analysis and report analysis for Infant HIV infection and Survival will also form part of the key activities. The monitoring of infant infection and survival will ensure that treatment and care practices are improved according to the evidence that will be made available from the surveillance reports. Funds for these activities have been budgeted for in the TFM proposal.

In addition, as part of the reporting on Condition Precedent 5 which is on the capacity gaps and weaknesses of the Medical Stores Department and treatment and care facilities as identified in assessments by the Global Fund Office of the Inspector General, the Local Funding Agent and the government of Tanzania and development partners (the "Action Plan"). The Action Plan shall detail the timeline for implementing key recommendations including strengthening of the supply chain management, storage and distribution, forecasting and quantification, inventory control and stock management, updating and monitoring of adherence to procedures. Attending to all the issues raised in Condition Precedent %5 will ultimately lead to improved monitoring and evaluation of the commodities that are planned to be procured in Global Fund Round * Phase II and in the TFM. It should be noted that all the following strategies and actions are outside the TFM framework as they are funded by the donors and funds from Global Fund Round 9 which was a Health Systems Strengthening proposal.

The issue is strengthening of the supply chain management. The objective is to Improve the supply chain management. The strategies proposed are as follows:

- Monitoring of ARV pipeline is conducted quarterly by NACP, SCMS and MSD
- 16 Zonal Supply Chain Monitoring Advisors (SCMA) are overseeing ARV supply chain and other HIV commodities.
- Additional 10 SCMA have been hired for laboratory commodities to work with Medical Stores Department (MSD) and health facilities providing HIV care and treatment services.
- The SCMA (26) mentioned above have been tasked to provide technical assistance including on job training to HCWs managing HIV commodities and medicines.
- Supply Chain subcommittee meeting are held on quarterly basis to address all HIV commodities stocks and amend the demands and distribution.
- To ensure continuity in HIV commodity management, building the capacity of the health management team to manage HIV commodities in the regions is a priority; mentoring tool.
- 16 Zonal Supply Chain Monitoring Advisors (SCMA) are overseeing ARV supply chain and other HIV commodities.
- Additional 10 SCMA have been hired for laboratory commodities to work with Medical Stores Department (MSD) and health facilities providing HIV care and treatment services.
- The SCMA (26) mentioned above have been tasked to provide technical assistance including on job training to HCWs managing HIV commodities and medicines.
- Supply Chain subcommittee meeting are held on quarterly basis to address all HIV commodities stocks and amend the demands and distribution.
- To ensure continuity in HIV commodity management, building the capacity of the health management team to manage HIV commodities in the regions is a priority; mentoring tool kit on logistic management was developed and training to the health teams conducted in all 21 regions.
- Medical Stores Department (MSD) Tanzania is currently in process of installing the new ERP Computer Software System with the support of USAID (SCMS) to enhance and Adequate Management Information System (MIS) for PSM to replace the ORION Computer System which failed to comprehend MSD business growth. The system business' to be" processes have already been defined, Conference Room Pilot 1 has been conducted and the new ERP will be operational from April/May 2012.
- Conference Room Pilot 2 is planned for February 2012. The new ERP EPICOR 9 is equipped with a 'Warehouse' module.

On the issue of storage and distribution, the objective is to expand the storage and distribution of the HIV commodities in supply chain system. The proposed strategies is as follows:

- MOHSW with support from PEPFAR and Global Fund Round 4 have strengthened storage capacity for MSD by building additional 14,000 squares meters storage capacity.
- With Global Fund Round 9 HSS Grant, 24,000 sq meters storage capacity will be increased. The increase in space available for storage at these warehouses will ease the implementation of Good Storage Practices hence reducing wastages-FEFO
- MOHSW in collaboration with PEPFAR implementing partners (MDH, EGPAF and ICAP, AIDS Relief) together with district councils have refurbished some existing storage facilities to facilitate implementation of good storage practices and improve storage space for HIV commodities and other pharmaceuticals.
- Storage capacity is also being improved through joint development of warehouse capacity using funds from the Principle recipient (MSD) and PEPFAR.

- Warehouse at Moshi ,Tabora, Mtwara, Mwanza and Iringa have been expanded.
- MSD is also undertaking the Warehouse in Box (WIB) project as a way forward in addressing the storage capacity extension for both MSD Central and MSD Zones. The Project is carried in two Phases.
- The WIB Project Phase I earmarked for Dar es Salaam, Dodoma and Mbeya started in August, 2011 and the expected completion date August, 2012.
- WIB Project Phase II earmarked for Dar es Salaam, Tanga, Tabora, Mbeya and Dodoma is expected to start in March, 2012 and is expected to completed by 31st December.

On the issue of forecasting and quantification, the objective is to enhance forecasting and quantification of HIV commodities. The proposed strategies are as follows:

- MOHSW with support from PEPFAR and Global Fund Round 4 have strengthened storage capacity for MSD by building additional 14,000 squares meters storage capacity.
- With Global Fund Round 9 HSS Grant, 24,000 sq meters storage capacity will be increased. The increase in space available for storage at these warehouses will ease the implementation of Good Storage Practices hence reducing wastages-FEFO
- MOHSW in collaboration with PEPFAR implementing partners (MDH, EGPAF and ICAP, AIDS Relief) together with district councils have refurbished some existing storage facilities to facilitate implementation of good storage practices and improve storage space for HIV commodities and other pharmaceuticals.
- Storage capacity is also being improved through joint development of warehouse capacity using funds from the Principle recipient (MSD) and PEPFAR.
- Warehouses at Moshi ,Tabora, Mtwara Mwanza and Iringa have been expanded.

SECTION 6: PHARMACEUTICAL AND OTHER HEALTH PRODUCTS

If this TFM request seeks funding for any pharmaceutical and/or health products please fill out sections 6.1-6.3

6.1 Management of Pharmaceutical and Health Product Activities

(a) Identify the organizations that will be responsible for the management of each of the following key functions in relation to this TFM request and describe their past management experience.

Function	Name of the organization(s) responsible for this function	Short description of management experience
Procurement policies, and systems	PPRA/MSD	PPRA is a government authority responsible for regulations of all procurements practices in the country. The authority established in 2001 has 10 years' experience with professionals responsible for ensuring procurement practices align with government policies. MSD was established in 2003 by act of parliament. Has conducted procurement of all pharmaceuticals circulating in the country. Global Fund procurements has accounted for 30% of all procurements done by MSD. Procurement procedures are outlined in the Public Procurement Act (PPA) No 21 of 2004 and specify advertisement of tenders and the handling of proposals, including acceptance, evaluation and tender awards through the tender board. The PPA empowers procuring entity with overall responsibility of procurement of drugs and medical supplies in the Health Sector. The act also ensures that there `is fairness and transparency in all tenders. Securing competitive bidding and the lowest possible total cost of ownership is the key issue that is taken into consideration when tendering. This includes ensuring flexibility in contracts and minimizing risks of loss and expiry.
Procurement planning	MTB/MSD/MOHSW	This procurement plan is focusing on the procurement of pharmaceuticals, non-pharmaceuticals, equipment and other non-health products. Methods of procurement to be used are specified in the Government Procurement Act No. 21 of 2004. For both sources of funds the applicable tendering method will be International Competitive Bidding. Whereas, the Global Fund quality assurance policy requires to procure products which are (i) Prequalified by WHO Prequalification Programme or authorized for use by a Stringent Drug Regulatory Authority (SRA) (ii) Recommended for use by an Expert Review Panel, as described in the Global Fund Quality Assurance Policy Guidelines, this is different to the funds from Tanzania Government budget whereby the Government of Tanzania intends to promote local Pharmaceutical industries and hence registration by NDRA (TFDA) is enough to prequalify the product. Therefore procurement using GF money and or other development partners is handled separately from GOT Funds. In order to alleviate challenges in stock holding space and minimizing procurement lead time, MSD had started implementing Framework Contracts of at least 24 months from July 2009. In the course of implementing this procedure, Call Off Orders have been implemented in respect of individual programme

		requirements.
Forecasting	MOHSW/MSD	Forecasting for antiretroviral drugs as well as laboratory supplies is normally done through the coordination of Ministry of Health and Social Welfare together with partner organizations-Supply Chain Management systems and in collaboration with Medical Stores Department. Forecasting is done every two years and review conducted every six months. The exercise involves NACP, SCMS, and MSD. The forecasting procedure uses consumption data from facilities providing care and treatment services. Other data sources are obtained from NACP HIV Care and treatment enrollment reports as well as ISSUES data from Medical Stores Department. Information on expected shipment to be delivered from GOT-GF support and SCMS are also used on forecasting. Number of patients on different regiments is also taken as a basis for forecasting of patients to be initiated on different regimens as well. The 'Quantimed' tool is then used to quantify the requirements.
Product selection	MOHSW	Ministry of Health and Social Welfare reviews the National Essential list of medicines every two three years. National Guideline for Management of HIV AIDS was first developed in 2003 and every three years, revision of the guideline has been done. The last revision was conducted in 2011 and new guideline is printed and will be distributed in 2012 among all care and treatment clinics. Selection of products to be procured follows the guidance of the updated national guidelines in the country. A team of staff from MOHSW and national hospital, referral hospitals work together to ensure correct selection of the products as per the national needs.
Coordination of the supply chain	TACAIDS/MOHSW/MSD/HF	Role of TACAIDS on PSM will be to provide oversight and ensure multi-sectoral coordination as well as secretariat on TNCM. The coordination of TACAIDS which is under Prime minister's office is to ensure timely availability of funds for procurement of HIV commodities as well as timely reporting of progress of implementation of Global Fund Projects. The role of Medical Stores Department as an entity of MoHSW is to ensure availability of medicines and medical supplies in all health facilities in a timely manner. MSD and MOHSW work in collaboration to ensure that procurement of these commodities are done in planned time. TFDA as a regulatory authority has the role of ensuring quality, efficacious and safety of medicines circulating in the country are of acceptable standards. TFDA conducts post marketing surveillance of medicines circulating in the country. All MSD procured drugs under GF are subject to quality check by TFDA. Health facilities that provide Care and Treatment services receive medicines and supplies for treatment of PLHA and keep records of usage through dispensing registers and prepare on quarterly basis Report and Request forms for submission to MSD. Under Pharmaceuticals and Supplies Unit of (MoHSW) the follow up of all sites stocks of medicines will be done on quarterly basis.

Management Information Systems	MSD/MOHSW	Medical Stores Department (MSD), Tanzania is currently in process of installing the new ERP Computer Software System with the support of USAID (SCMS) to enhance and Adequate Management Information System (MIS) for PSM to replace the ORION Computer System which failed to comprehend MSD business growth. The system business' to be" processes have already been defined, Conference Room Pilot 1 and 2 has been conducted and the new ERP will be operational from April/May 2012. The new ERP EPICOR 9 is equipped with a 'Warehouse' module. The expected effort of the new system is to increase data integrity and timely decision by MSD. Installation of the Pharmacy module intending to capture the ARVs used with number of people being served at the care and treatment clinics. The pharmacy module will be linked with CTC2 database so as to be able to capture consumption of medicines (ARVs) with people being served in the CTC.
Inventory management (including storage arrangements)	MSD	The New ERP system at MSD has accommodated the required features for batch tracking. The current ERP design has included the warehouse module of which batch tracking is a compulsory requirement. Standardization of all warehouse locations is in the process the new ERP development, Perpetual inventory count is done by stock verifiers on monthly basis, and partners SCMS are working hand in hand with MSD to assist in strengthening the capacity of MSD staff through on job training. Throughout the supply chain system-Inventory monitored through a replenishment system of 3 month as minimum level for health facilities and maximum stock levels is 6months; at zonal MSD minimum levels of 9 months and maximum levels of 12 months. This is being reinforced in every level. Tools for management of ARVs and other related commodities are used. Ledgers and bin cards for inventory management at the pharmacy stores are available
Distribution	MSD	MSD capacity of hauling goods from central to facilities is comprises of 21 heavy duty trucks, 19 Light vehicles and 11 hard top land cruisers. The entire fleet has the capacity of carrying approximately 500 metric tonnes at one time. The full responsibility of checking the items shipped and received lies with the personnel responsible for the vertical programmes, this being at both the shipping (central) unit and the receiving (zonal) unit. This includes also monitoring of the stock levels and overall checking of stocks distributed. The MSD ten zones are evenly distributed throughout the country to service an average of two regions per zone thus covering all 126 districts. Six zones are reachable by road within 24 hours whereby the remaining two zones can be reached by airfreight within a working day. . This has been made possible through GF support in strengthening the MSD transport fleet during Round 3, 4 and 6 projects where we acquired 8 Land cruiser vehicles and seven 3- tonne light trucks in total.
Quality control	TFDA/MSD	Tanzania has a fully functioning National Drug Regulatory Authority (NDRA) called Tanzania Food and Drugs Authority (TFDA). TFDA is an executive agency under the Ministry of Health and Social Welfare established by Act of Parliament; the Tanzania Food, Drugs and Cosmetics Act No.1, 2003.

		According to the Act, all pharmaceutical products to be used in the country (both imported and locally produced) should be registered by TFDA to assure their quality, safety and efficacy. In view of this, products to be procured through the Global Fund will be those prequalified by WHO Prequalification Programme or authorized for use by a Stringent Drug Regulatory Authority (SRA) (ii) Recommended for use by an Expert Review Panel, as described in the Global Fund Quality Assurance Policy Guidelines. There is a functioning quality control laboratory under the TFDA which is responsible for testing products being applied for registration and those picked up during post marketing surveillance of registered products circulating on the market. This ensures that all batches imported into the country and those produced locally meet appropriate standards of quality, safety and efficacy.
Ensuring rational use and patient safety	MOHSW	Rational drug use is an integral part of Tanzania National Drug Policy to ensure that medicines are prescribed, dispensed and used rationally including the availability of alternative methods of treatment. There are several strategies to encourage adherence to treatment. They include: Patient and/or partner education which aims to enhance compliance/ adherence to treatment Used of fixed dose combination. Training of healthcare team (clinicians, pharmacists, nurses, laboratory technicians and counselors). At the care and treatment clinics, there are registers for the recording of the patients who are being prescribed and dispensed different antiretroviral drugs. These registers keep records of consumptions of these regimens and then these data are used to form basis of consumption reports.

(b) Describe how the TFM request uses country systems for pharmaceutical and health products management (PHPM) in compliance with national policies and regulations and the Global Fund policies on PHPM.
Identify any programmatic gaps with the existing supply chain and the proposed strategies to address these gaps.

GE MAXIMUM

The Transitional Funding Mechanism uses country systems for pharmaceuticals and health products management (PHPM) in compliance with national Policies and regulations as well as Global Fund Policies on PHPM, including internationally accepted guidelines such as those stipulated by WHO.

The number of patients by medicine (or by regimen) by year for both Global Fund Round 8 Phase 2 and the TFM based on the 2009 WHO Guidelines are as follows:

Table 8: Expected number of patients by medicine (or by regimen)

First Line Adults	2012	2013	2014
AZT/3TC + EFV	**103,465**	**139,431**	**175,413**
AZT/3TC / NVP	**86,221**	**121,440**	**132,889**
d4T(30) +3TC+ EFV	**6,898**	**4,498**	**2,658**
d4T(30)/3TC/NVP	**62,079**	**13,493**	**7,973**
TDF/FTC/EFV	**13,795**	**13,493**	**37,209**

First Line Paediatrics	2012	2013	201
AZT / 3TC + EFV	**4,448**	**5,749**	**9**
AZT / 3TC / NVP	**17,280**	**24,640**	**32**
d4T / 3TC + EFV	**416**	**352**	
d4T(12)/3TC(60)/ NVP(100) Junior	**5,696**	**4,498**	**2**
d4T(6)/3TC(30)/ NVP(50) Baby	**4,160**	**3,872**	**2**

TDF + 3TC + NVP	10,346	26,987	26,578
TDF / 3TC + EFV	51,732	103,449	127,573
TDF/FTC + NVP	10,346	26,987	21,262

Second Line Adults	2012	2013	2014
TDF/FTC/+LPV/r	**2,000**	**2,609**	**3,083**
AZT/3TC+LPV/r	**1,380**	**1,799**	**2,126**
TDF/FTC/+ATVr	**138**	**180**	**213**
AZT/3TC+ATV/r	**1,035**	**1,349**	**1,595**
TDF+3TC+ATV/r	**966**	**1,259**	**1,488**
TDF+3TC+LPV/r	**1,380**	**1,799**	**2,126**

Second Line Paediatrics	2012	2013	2014
ABC + ddI + LPV/r	**314**	**383**	**453**
AZT + 3TC+ LPV/r	**6**	**8**	**9**

The prices used are ones that are internationally competitive. The Supply Chain Management System's (SCMS) prices were used for ARVs while the Medical Stores Department's (MSD) prices were used in other HIV Commodities including Opportunistic Infection Medicines (OIs), HIV Rapid Test Kits and HIV Laboratory Commodities.

Calculations were made based on the assumptions of the different number of patients currently on different regimens as well as those expected to be on different regimens as per the changes in WHO guidelines and the consensus reached by partners during the quantification of ARVs needs in the country. The assumptions used to calculate the requirements of ARVs were based on number of patients per regimens. Since the country has adapted WHO Recommendations which stipulate earlier ART initiation at CD4+ ≤ 350cells/ml or WHO stage 3 and 4. This translates to treating all patients with TB/HIV co-infection; all children below 24 months of age, and HIV infected pregnant women with CD4+ ≤ 350cells/ml. The other contributing factor is the adoption of more effective regimens (tenofovir based) and the phasing out drugs with more side effects (Stavudine). As a result a net increase of 80,000 patients per year or about 10,100 new patients per month has been experienced – taking into account an attrition rate of 26%. The attrition rate includes loss to follow up, mortality and transfers that occur outside the normal procedures.

The products identified to be procured under TFM will be procured using the same procurement procedures and Medical Stores Department will be the procurement agency. International Competitive prices will be applied. Methods of procurement to be used are specified in the Government Procurement Act No. 21 of 2004. For both sources of funds the applicable tendering method will be International Competitive Bidding. Whereas, the Global Fund quality assurance policy requires the procurement of products which are (i). Prequalified by WHO Prequalification Program or authorized for use by a Stringent Drug Regulatory Authority (SRA) (ii) Recommended for use by an Expert Review Panel, as described in the Global Fund Quality Assurance Policy Guidelines. Products to be procured will be those registered with TFDA and those that are in line with national guidelines of treatment. The products will also be the one prequalified by WHO and also complying with Global Fund Policies or authorized for use by a Stringent Drug Regulatory Authority (SRA) (ii) Recommended for use by an Expert Review Panel, as described in the Global Fund Quality Assurance Policy Guidelines. Programmatic gaps with existing Supply Chain and proposed strategies:

Logistic Challenge	Proposed Strategy
Procurement taking longer times	Framework contracts
Collection of consumption data	Introduction of pharmacy module SDP Database
Storage and distribution	Build/renovate warehouses

Describe the systems to be used to ensure rational use and patient safety
To ensure rational use of these medicines and patient safety, products procured will be those which have been prequalified by WHO and are TFDA registered, the medicines will also be those that are in line with the national guidelines. For ease of administration, preference will be for fixed dose combination so that adherence is ensured among patients using these medicines. For new products and medicines, training on rational use of these medicines and products will be conducted. Post marketing surveillance by TFDA is ensured so as assure safety of products circulating in the country. Patients and health worker issues and factors will be considered so as to address adherence among patients using these products. Safety will be ensured by working with TFDA and MSD Quality Assurance Department.

6.2 Pharmaceutical and Health Products Required for continuation of essential prevention and treatment services Complete the Pharmaceutical and Health Products List (Attachment B) and list all of the products that are requested to be funded through the TFM request.
ONE PAGE MAXIMUM Attachment B has been completed and is part of the documentation to be sent to the Global Fund with this TFM proposal.

6.3 Multi-drug Resistant Tuberculosis	
Is the provision of treatment of multi-drug resistant tuberculosis included in this TB or HIV/TB TFM request?	Yes *→ include USD 50,000 per year over the full TFM request term to contribute to the costs of Green Light Committee Secretariat support services*
	No *→ do not include the Green Light Committee costs*

SECTION 7: FUNDING REQUEST

7.1 Financial Gap Analysis and Counterpart Financing Calculation **Instructions for completion of the financial gap analysis and counterpart financing table** *→ For guidance on how to complete the financial gap analysis and counterpart financing table refer to Section 7.1 of the guidelines and the detailed instructions included in the Excel template. The financial gap analysis and counterpart financing table is available as a separate tab in the Global Fund budget template (Attachment E). For those that do not use the Global Fund budget template, it is available in the separate Excel file along with the mandatory summary budget tables (Attachment F). Applicants only need to complete Attachment E or Attachment F, but not both.* **CCM and Sub-CCM applicants** must prepare and submit the financial gap analysis and counterpart financing table in Microsoft Excel format. They must also complete sections 7.2 to 7.4. **Non-CCM applicants and multi-country applicants** are not required to complete the financial gap analysis or the counterpart financing table nor Sections 7.2 to 7.4.	
(a) Has the financial gap analysis and counterpart financing table been submitted in Microsoft Excel format?	xYes No

(b) To better contextualize and assess financial data provided in the TFM request, applicants are required to:

1. Provide an overview of the composition of government contribution to the national program; Please specify the levels of government (central, regional, local) that incur spending on the disease programs and the major agencies through which government funds are spent. Elaborate on the availability of earmarked budget line-items to capture government disease spending and the extent to which these budget line-items capture total government spending on the disease program.
2. Indicate whether amounts forecast from each source for the years 2013 to 2014 are an estimation or commitment

1. In Tanzania, HIV and AIDS accounts for 10% of the national budget (PER 2010). Tanzania requires about 1 trillion shillings per year for the National Response, however receives only half of this (550billion shillings). Tanzania's HIV and AIDS programmes are still dependent on donors (97%) just like it is in many other African countries. About ninety one percent (91%) of all foreign funding comes from two donors (GFATM 20% and PEPFAR 71%). About nine percent (9%) come from 8 other multi- and bilateral donors. The Health sector receives 59%, TACAIDS 23% and other MDAs 18% of the total funding for HIV and AIDS. The MoHSW is externally financed to a tune of 90% and TACAIDS at 84%.

Civil Society Organizations (CSOs) also receive large proportion of their funding from foreign donors mainly PEPFAR and Global Fund. A large portion of funding goes to international CSOs which sub- grants to national NGOs. Direct funding to CSOs by Foundations and development Agencies accounts for more than 70% of the HIV and AIDS resources coming to Tanzania. Private sector such as the Clinton Foundation and Bill Gates and Melinda accounts for (4%) of spending for the HIV and AIDS response. Private sectors in Tanzania contributes through Work Place Programmes for their own staff, it is hoped that when the Tanzania AIDS Control AIDS Trust Fund is established, mechanisms will be put forward for them to contribute to the national response to HIV and AIDS. The GFATM has disbursed about 61% of its funding to HIV and AIDS. The World Bank is the second largest multilateral donor to finance HIV and AIDS response in developing countries and is one of the eight co-sponsors of UNAIDS.

Since 2008 some Development Partners (DPs) have phased out their support to HIV and AIDS. Funding for HIV and AIDS had been increasing since 2002 and reached to a peak at about 600 billion in 2008/09 and 2010 and then started to decline and the trend is expected to continue in the coming years. The negative impact of the global financial crisis on AIDS programmes is a serious concern for most of the African countries, and the worst affected programmes are those on prevention.

The NMSF Grant was established in 2009 to support the implementation of multi-Sectoral non-medical response to HIV and AIDS in Tanzania mainland. It allocates resources to Local Government Authorities, Regional Secretariat for supportive supervision and PMORALG and TACAIDS for coordination. The NMSF grant follows Government of Tanznaia (GoT) financial regulations and procedures. Allocation of funds to the LGAs is governed by the formula that looks at population size (70%), number of poor residents (10%), district medical vehicle route (10%) and the council's estimated HIV prevalence (10%).

7 (b) 2. The amounts quoted for the period 2013 and 2013 are explained as follows:

For the government budget the figures projections based on actual government disbursements as enunciated in the national development plans and the national budgets. The Government of Tanzania has recently completed the preparation of the Five Year Development Plan for implementation of the National Development Vision 2025. The plan has identified four pillars for considerations, these are: sustaining macroeconomic stability and maintaining the success achieved in providing social services; using the available resources as catalyst for economic growth; exploit Tanzania's geographical advantages; and increase the use of Information and Communications Technology (ICT).

The Tanzania development agenda takes into consideration the Tanzania Development Vision 2025, the National Strategy for Growth and Reduction of Poverty –NSGRP/MKUKUTA II, the Millennium Development Goals (MDGs); the CCM Election Manifesto of 2005; Joint Assistance Strategy for Tanzania (JAST); and National Debt Strategy.
The MKUKUTA II focuses on the following important areas of:

- Infrastructure, especially rural roads, railways, ports, airports, electricity, information and communication infrastructure and transportation of fuel and gas;
- Agricultural sector including livestock and fisheries development;
- Industry sector with the aim to develop factories that will use locally available resources;
- Public Private Partnership by expanding and strengthening private sector participation and contribution in the areas of infrastructure, food production, trade as well as provision of social welfare services such as health, transportation, education and financial services.

In spite of various measures made in the national budgets to increase revenue collection, the government budget continued to depend on assistance from development partners, to the tune of 17% of the budget in 2010/11 down from 28% in 2007/08. Cognizance of the need self-reliance at the national level both in attitude and in resources, the Government has decided to take strong measures to improve domestic revenue collection which includes measures aimed at broadening the tax base, increasing efficiency in revenue collection and Identification of new tax payers. In addition, expenditures will be controlled so that by the year 2015, the percentage of aid dependence does not exceed 10% of the budget. The government intends to protect and uphold achievements in education, water and health sectors.

The Government will continue to strengthen domestic revenue collections by deploying policy and administrative measures on both tax and non-tax revenues as well as widen revenue bases to cover large portion of unharnessed revenue potentials. The measures that will be considered to increase revenue collection include the following:

- Strengthening knowledge and skills of tax audit capacity on business books of records and accounts; improve tax

administration on block management system, enterprise wide risk management and tax evasion; and continue with the efforts of widening tax base by formalization of the informal sector to be in the taxation system;

- Reviewing and harmonise various tax laws, which have provisions of exemptions, with a view to minimise such exemptions. Currently tax exemptions stand at 2.5% of the GDP and the target is to reach at least 1% of GDP;
- Continue strengthening systems of revenue collection by ensuring that all payments are made through banks;
- Enhancing extensive use of ICT in tax administration with particular attention on communication, financial management, forensic audits as well as maintenance of statistics for further analysis;
- Ensuring effective use and control of the Electronic Fiscal Devices – EFDs and provide taxpayers' education to the business community
- Continue monitoring closely the TRA's Third Five Year Corporate Plan by ensuring that it is in the right track of collecting more revenues;
- Improving systems of collection and administration of non-tax revenues by reviewing system of issuing receipt, licensing and improve retention schemes' rates by the Government Ministries, Department and Agencies;
- To review property tax collection systems in cities, municipalities, towns councils, district councils and small town councils with a view to improve administration and revenue collection by using updated valuation of the properties; including reviewing other revenue sources and collection systems in the local authorities;
- Sustaining macroeconomic stability and improving business environment for the private sector growth and thus contributing to the Government revenue;
- Improving infrastructure for ports, railways and roads to stimulate business and subsequently enhance revenue collection; and
- Strengthening supervision, monitoring and control of all transit goods through our ports to neighbouring countries, particularly petroleum products, so that dumping of such products does not occur to deplete domestic revenue.

The sectoral allocation to Health in 2011/2012 was pegged at Tshs 1209.1 billion compared to Tshs 1,205.9 billion in 2010/2011. This represents an increase of 0.3% and is about 11.4% of the total budget.

For the donors and other counterparts, the figures used are estimates based on the historical trend and on indications received from local offices. However, these figures are subject to change as many of the decisions on funding depend on a host of factors including the policies of donor countries such as the United States of America and large corporations. However, the other largest donor apart from the Global Funds is PEPFAR and the figures shown are actual The figures for PEPFAR are a reduction from US$359 million in 2009 to US$338 million for period 2011 to 2013. The figures for 2014 and 2015 are estimates based on the historical projections as provided by PEPAFR for the period 2012 to 2013.

The figures that have been used are also based on funds that are made available by partners such as DANIDA and SIDA to the basket funding that is administered by the Ministry of Finance. The funds in the basket funding are mainly for use in the regions and by local government administration as counterpart funds in support of the National Multi-Sectoral Framework (NMSF) for HIV and AIDS. PEPFAR figures are based on committed and pledged support and the funds are mainly used for the procurement of second line ARVs and pediatric ARVs. Tanzania has no loans and debt that were swapped for development.

7.2 Estimation of Current and Anticipated Domestic and External Funding

→ Corresponds to LINES B and C in the financial gap analysis and counterpart financing table.

Describe how contributions from various sources of funds were estimated, including reference to:

(a) methodology for estimating current and anticipated funding;
(b) Composition of reported government spending (part or all of government spending; programmatic costs alone or includes apportioned health system costs; recurrent costs alone or includes capital costs);
(c) Whether amounts contributed by each source for the current and previous years pertain to budget, disbursement, expenditure or an estimate of spending;
(d) Whether amounts forecast from each source for the future years pertain to estimation or commitment.

a) The annual amounts were developed by costing National Multi-sectoral Strategic framework (NMSF) based on the available strategies. Activities developed were cost-valued in a detailed excel sheet that had embedded formulae where there were following items: target, description input, assumptions, number of input, unit cost, number of days, frequency and total cost. The costing took into account the implementers at the national, regional, district and at the community/village levels.

For each strategy, all the activities were cost-valued for the five years. The priority from each strategy was identified. The annual cost was established based on the identified activities to accomplish the strategy.

At the end of costing for each strategy, there was the operational two year action plan of which activities to be under two years plans were based on the priorities from stakeholders' suggestion .In brief, the costing was done for every activity for each strategy.

Annual amounts were Budgeted in a way that ensures that government, non-government and community needs were included to ensure full implementation of country's HIV program strategies.

The country develops MTEF every three years which reflects the priority areas of the National Strategy for Growth and Reduction of Poverty (NSGRP) and projects financial needs accordingly. Among the priority areas in the MTEF health and HIV and AIDS are included. On the basis of this and the Universal Access Targeting the demand for HIV and AIDS programmes was projected. This includes the need for all programmes implemented by the different stakeholders.

b) The composition of the government spending consists of both recurrent (particularly salaries and wages) and capital expenditure in the form of buildings, equipment and vehicles. Most of the funds are for the support of regions and local government administration and for the operations of TACAIDS (for the coordination of the multi-sectoral response and for capacity building). As part of the support for the implementation of the National Multi-Sectoral Strategic Framework (NMSF), the government provides resources for prevention and impact mitigation activities such as provision of services for orphans and other vulnerable children at district levels. In addition, government Ministries, Departments and Agencies (MDAs) are required to put aside 5% of their recurrent expenditure for HIV and AIDS activities and these are administered according to the priorities of the Medium Term Expenditure Review (MTEF).

c) The amounts contributed by each source for the period 2010-2011are actual based on expenditures while the figures 2012 to 2015 are based on estimates (for the government) and pledges for donors.

d) The amounts forecast from each source for the future years pertain to estimations and not commitments. However, it can be argued that for the government and for the large donors such as PEPFAR, these amounts are in essence a commitment as these amounts have been agreed as part of the national budgetary framework and as part of the development agreement between Tanzania and USAID.

U.S. Government financial contributions have been discussed in partnership with the Government of Tanzania in light of the Tanzanian government priorities and national plans, other donor contributions, and the U.S. Government's core competencies and added value[2]. The two Governments intend to revisit investment decisions on an annual basis to respond to new priorities, emerging data, and lessons learned, as well as to ensure sustained focus on country leadership and capacity building. The current funding trajectory for the Partnership Framework is based on this understanding.

7.3 Compliance with the Counterpart Financing Requirements

Describe whether the counterpart financing requirements listed below have been met. If not, provide justifications which include actions planned during implementation to reach compliance.

(a) Minimum threshold for counterpart financing
→ Percentage in Line M of the financial gap analysis and counterpart financing table must be greater than or equal to the minimum threshold that applies to the applicant's income level (refer to the Global Eligibility List for 2012 Funding Channels) Fund

(b) Increasing government contribution to national disease program over the TFM request term
→ Figures in Line B of the financial gap analysis and counterpart financing table must increase over time

(c) Increasing government contribution to the overall health sector over the TFM request term
→ Figures in Line I of the financial gap analysis and counterpart financing table must increase over time

(a) The minimum threshold has been calculated at 30% per cent and is in line with Tanzania's classification as a low income country.

(b) The government's contribution to the national disease program over the TFM request term as follows:

- The national allocation to health will be increased by etc and correspondingly the amount allocated to HIV and AIDS from these amounts will increase almost by the same percentage margins
- Plans are underway to set up a Tanzania AIDS Control Trust Fund,

(c) The government intends to increase the contribution to the health sector over the TFM request term by gradually increasing the allocation to health from the national treasury until the Abuja declaration of 15% allocation to the health sector is reached. Currently the government contributes about 11% to health and this is a slight increase from last year's budget.

7.4 Financial Gap and Counterpart Financing Data Sources

(a) Describe the sources used to complete the financial gap analysis and counterpart financing table;
(b) Provide an assessment of the completeness and reliability of financial data reported; and highlight any assumptions and caveats associated with the figures.

[2] The Government of the United Republic of Tanzania and the Government of the United States of America March 27, 2009, DRAFT: Partnership Framework Implementation Plan - A Five-year Cooperative Plan in Support of the Tanzanian National Response to HIV and AIDS, 2009-2013, Dar es Salaam, Tanzania

(c) Provide details of how the country plans to improve data quality consistent with the guidelines for reporting of program financial data to technical partners; and

(d) If applicable, state if the TFM request includes a request for Global Fund support for an expenditure tracking study and/or measures to strengthen financial data collection and reporting data during the first reporting period

Applicants may request up to USD 50,000 for an expenditure tracking study in the first implementation period. This must be included in the detailed budget.

(a) The sources used to complete the financial gap analysis and counterpart financing table include government documents such as the national budget, the Mid-term Expenditure Framework (MTEF) and the Public Expenditure Review (PER).

(b) The data provided is complete in the sense that Tanzania plans to improve data quality consistent with guidelines for reporting of program data to technical partners. The domestic financing is prioritized on the basis of the burden of the diseases and its effects to influencing the achievement of the NSGRP and the Millennium Goal targets. The government has developed and implemented an integrated financial management system. The implementation of this system has been done by installing an electronic accounting system (EPICOR) and Planning and Reporting Program (Plan REP):

- Provides for recording of expenditures based on budgeted items. It also simplifies the generation of financial reports;
- Plan REP ensures implementation according to the strategic national plans and detects any deviations from the plans.

(c) The country plans to consolidate its financial audit and financial data to technical partners by improving the technical skills and knowledge of its finance, technical and program personnel and by improving general oversight of funds and expenditure. To ensure public resources are utilized efficiently, several structures have been put in place. For example, all Ministries, Departments and agencies (MDAs) have internal audit units; there is the National Audit Office which conducts external audits to most public accounts. There also are Parliamentary committees; the Public Accounts Committee, Local Authorities Accounting Committee and the Parasitical Organizations Accounts Committee. These are a combination oversight and watchdog structures that serve to monitor mismanagement of funds and hence ensure transparent and proper utilization of funds by the government and its institutions EPICOR is capable of and has improved enforcement of compliance to spending according to budgeted amounts.

(d) The request to the TFM does not include a request for an expenditure tracking study. However, plans are underway to undertake such a study in the next couple of years. This will also supplement the NASA which is expected to be completed in 2012.

7.5 Detailed Budget and Work Plan

Instructions for completion of the detailed budget and work plan:

→ For guidance on the level of detail and required budget and work plan format (or for a template) refer to the Section 7.5 of the guidelines.

(a) Submit a detailed budget and work plan in Microsoft Excel format. Applicants are strongly encouraged to use the Global Fund budget template or the WHO budget tool. **However, note that TFM requests are only for up to two years of funding.** Applicants may use their own template; however the format in which the budget and work plan is presented must conform to those presented in the TFM request guidelines.

(b) Ensure that the detailed budget and work plan is consistent with the numbering system developed in the logframe and the performance framework.

(c) Do not include a request for CCM or Sub-CCM funding in this TFM request. Requests for funding are available through a separate application. The application is available at: http://www.theglobalfund.org/en/ccm/

(d) Funding duration is up to 2 years

7.6 Summary and Incremental Request Tables

Instructions for completion of the summary budgets:

→ For instructions on how to prepare the summary budgets (or for a template) refer to Section 7.6 of the guidelines.

As a tab in the Global Fund summary budget (Attachment E) or as Attachment F if not submitting the Global Fund summary budget:

(a) Prepare a summary table by objective and service delivery area.

(b) Prepare a summary table by cost category.

(c) Prepare a summary table by PR (where more than one PR is being proposed).

(d) Prepare a summary table which calculates the incremental (new) funding request. This is not necessary if there are no existing grants that will be ongoing as of the start date of the TFM funding

→ The totals of all of these tables should match exactly, and correspond with the totals in the detailed budget and work plan.

7.7 Compliance with Focus of TFM request Requirement

Describe whether the focus of TFM request requirements for the specific funding pool chosen have been met as listed below.

For the General Funding Pool:

a) LMICs must demonstrate that at least 50 percent of the TFM request incremental budget focuses on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context; and

b) UMICs must demonstrate that 100 percent of the TFM request incremental budget focuses on these populations and/or interventions.

For the Targeted Funding Pool, and regardless of the country's income level, applicants must demonstrate that 100% of the TFM request focuses on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context.

The funding request is for essential and high impact interventions targeted at services that would result in loss of gains made, fracturing of partnerships and synergies, loss of life years as well as deaths if they are disrupted. The incremental budget has taken into account only the essential and high impact programs, that serve populations at great risk should there be a disruption in the provision of treatment, testing and laboratory services. The TFM budget has been arrived at after considering all the resources available and reprogramming these resources towards these essential life support activities that assure value for money. In fact the numbers of people that require continuity of services in terms of treatment and laboratory services are in dire need of these services and for them it is literally a matter of “life and death”.

As stated in 3.1 and 4.1 above, the Government of Tanzania has identified areas for essential prevention, treatment and/or care programs that are expected to be disrupted should there be a discontinuity in the resource flow particularly from the Global Fund. The intention is to maintain the momentum and not to lose the gains that have been made in the past two decades in responding to HIV and AIDS as Tanzania has been successful in improving the quality of life for PLHIV through the provision of care, treatment and support services. These essential and high impact service include the provision of ART services (including eMTCT), HIV voluntary counseling and testing (VCT) services (including provider initiated testing and counseling (PITC)); and laboratory monitoring of HIV patients on care and or treatment. The identified essential services are in line with the country´s proposal for Global fund Round 8, Goal 1 which was intended to secure and sustain Tanzania's HIV and AIDS Prevention, Care Treatment and Support Services.

SECTION 8: MANAGEMENT STRATEGIES

8.1 Principal Recipient(s)

Describe the technical, managerial and financial capacities of each confirmed or nominated Principal Recipient (PR). All PRs that will be implementing the programs over the lifetime of this TFM request should be included here, whether or not this TFM request is requesting new funds for those PRs.

In the description for each PR: (a) indicate if there are any anticipated limitations to strong performance; (b) refer to any existing assessments of the PR(s); (c) if any existing PR(s) is being re-nominated, explain why; and (d) if a new PR is being nominated, explain why the new PR is a suitable choice e) How multiple PRs will coordinate with each other

→ Copy and paste tables below for each nominated Principal Recipient.

PR 1 Name	Ministry of Finance and Economic Affairs	**Sector**	Public/Government
Mailing address	P.o Box 9111, Dar es Salaam Tanzania		
Telephone	+25522 2111174-6		
Fax	+25522 2110326		
E-mail address	ps@mf.go.tz		

Does this PR currently manage Global Fund grants in this disease area?	◉ Yes ○ No

The Government of Tanzania (GoT) agrees to the principles of harmonized assistance and alignment of aid modalities as set in the Tanzania Assistance Strategy (TAS), Independent Monitoring Group (IMG), the Joint Assistance Strategy (JAS), the 2003 Rome Declaration and the 2005 Paris Declaration on Aid Harmonization. Accordingly, it is the policy of the GoT to channel all bi-lateral and multi-lateral donor funds through the Ministry of Finance and Economic Affairs (MoFEA) in order to ensure that they are recorded and tracked within the national budget and public expenditure reviews. The MoFEA is therefore the only legal entity in Tanzania which has the authority to receive funds on behalf of the public sector. Being the Paymaster General for the public sector in Tanzania, MoFEA is responsible for the national budget and fiscal policy. It also has the overall responsibility of monitoring the enforcement of financial regulations in the country.

Through the many years of handling public funds and management of donor funds, MoFEA has acquired substantial experience and built technical, managerial and financial capacities for managing large budgets. The MoFEA has a sophisticated infrastructure for financial management. It has well established and advanced information technology system and uses an Integrated Financial Management System that allows full financial control and transparency in government finances. Quarterly budget execution reports and allocations are also published in the press for the purpose of increasing dissemination coverage, transparency and promoting public accountability. Channelling funds through the MoFEA system, therefore, permits public scrutiny and improved ownership of Global Fund grants.

Three segments of MoFEA are involved in managing Global Fund resources: the External Donor Unit, the Budget Office, and the Auditor General. The MoFEA has extensive experience in managing and disbursing grants. Indeed, MoFEA has served as the PR for the public sector in all previous Global Fund grants except Round 1. To ensure consistent, transparent and effective performance, Global Fund grants are now operationalised in Tanzania's Medium Term Expenditure Framework (MTEF). Payment is through Exchequer System, while the monitoring of the grant follows government procedures in adherence with the Global Fund Operational Manual towards the planned outputs and outcomes. The MoFEA has nominated a senior officer to deal with Global Fund grants. This senior officer serves as the focal point for all public sector sub-recipients and is responsible for tracking disbursement of the funds. In addition, the MoFEA provides important support to its sub-recipients, including, but not limited, to:

a) Providing support to the sub-recipients in obtaining tax and duty exemptions from the Tanzania Revenue Authority.
b) Covering any exchange rate losses from foreign exchange fluctuations.
c) Supporting the auditing costs from the Government Auditor General.

The management letters have the following issues which are all in various stages of being attended to by the PR:

Table 8: Response to Management Letters

Issue	Recommendations	Time line	Status
We have noted that the following indicators partially achieved their targets: 1. Number of STI cases treated (38% of achievement) 2. Number of people who received testing and counseling services for HIV and AIDS received their results (57% of achievement) 3. Numbers and percent of civil society organizations that received TOMSHA supportive supervision in the past 6 months (36% of achievement Four indicators targets were not reached: 1. Number of malnourished individuals provided with ready to use therapeutic food (0 vs a target of 15,633 0% of achievement); 2. Number of adults and children with HIV infection receiving care and support outside health facilities (3,399 vs a target of 224,910, 2% of achievement); 3. Number of health and demographic sentinels surveillance sites strengthened (0% of achievement);	We recommend that the PR continues all efforts to improve the performance of grant and closely catch up on activities which are partially/poorly performing We wish to remind the PR the importance of ensuring that results are reported accurately as per the performance framework (cumulative over the program period and not over the program life)	On-going	Noted. PR agrees with the recommendations. Targets reporting will improve in the future report. As measures to curb the situation, the STI programme is planning to do the following: 1. Harmonize the two data recording and reporting tools so as to have one data collecting and reporting tool for STI programme. 2. Conduct refresher and on-the-job training to the service providers on the harmonized data collecting and reporting tool. Efforts have been made with HTC implementing partners to ensure that all HTC providers are oriented to the tool which is basically translated in Swahili language for prompt and accurate data. The first RUTF consignment has been delivered and distribution is underway.

4. Number of supported operational research and special studies conducted and coordinated (0% of achievement). We note that the PR in some cases reported results cumulatively over the program period instead of cumulatively annually as agreed in the performance framework.			HBC recording and reporting tools are being rolled out and currently 17 out of 21 regions have been covered. We expect better results in the next PUDR. We expect better results in the next PUDR.
We note that grant funds amounting to TZS 182,950,000 equivalent to $123,168 were transferred to various sub treasuries to enable HIV Coordinators to coordinate various HIV AIDS matters for TACAIDS. However the recipients did not acknowledge receipt of those funds. As such it cannot be verified that funds were indeed sent and received by the intended recipients	We strong recommend that the PR ensures that all recipient of grant funds formally acknowledge receipt so as to ensure transparency and facilitate audits and LFA verifications	Continuous	All Sub treasuries have already submitted their acknowledgement receipts and all the acknowledgements receipts have been submitted to LFA.
We note that staff were given cash advances to carry our various activities but they didn't account for expenditures after completion of those activities. It was noted that cash amounting to TZS 180,654,700 equivalents to $121,622 (NACP USD 15,953 and TACAIDS USD 105,669) was advanced to staff but not accounted for with third party supporting documents.	We strongly suggest that when staff receives cash advances to carry out various activities as budgeted, it should be correctly accounted for by supporting documents as evidence of expenditure.	On-going	All the TACAIDS & NACP outstanding retirements have already been submitted to LFA.
We note that an unspent cash balance of TZS 1,510,000 had not been put in the bank by the PR as at February 2011.	The PR should make every effort to avoid the risk of keeping large cash in hand and endeavors to put all unspent cash in the bank	On-going	The issue has been addressed and verified by LFA.
We note that some conditions precedent in the grant agreement have not been fully addressed by the PR.	It is strongly recommended that the PR makes all effort to full address all condition precedents and special conditions in order to avoid withholding of grant funds in the future	On-going	The CP's have been addressed and submitted to LFA for verification.

Therefore the PR is up to date on its submissions to the Global Fund and the LFA and the current grading is B1.

8.2 Sub-recipients

List identified sub-recipients and describe:

- the number of sub-recipients identified;
- the work to be undertaken by each sub-recipient;
- past implementation experience of each sub-recipient;
- any challenges that could affect performance of each sub-recipient as well as a strategy to address these potential challenges; and
- how they will coordinate with PRs and each other

Almost all the pre-identified sub recipients have varied experience according to their comparative advantage, their size and type constituency, their geographical reach and coverage, and their capacity and ability to deliver services. The major challenge for many of them will be their ability to recruit and retain high calibre personnel that have the managerial and technical competence to administer the various programs. They will also experience challenges in meeting their administrative and operational costs. However, measures have been taken to ensure sustainability by reprogramming resources and reducing on non-efficient and low impact programmes and activities.

Public sector sub-recipients

Ministry of Health and Social Welfare (MoHSW)
MoHSW has been involved with all GF grants, initially as PR and subsequently as SR. It has built capacity in handling GF grants and implementing GF activities in HIV and AIDS, TB and Malaria. The major challenges that MoHSW has encountered in the implementation of activities under GF support are largely related to weaknesses in the Procurement Management Unit (MoHSW-PMU), leading to delayed procurement of goods and services. To address this challenge a specific activity for strengthening MoHSW PMU was undertaken and the MoHSW will continue to coordinate HIV prevention activities related to eMTCT; male circumcision; and condom and family planning commodities specifically for 50% of women living with HIV.

The MOHSW will coordinate and work the CSO group which implement CBD initiative. The integration of antenatal (eMTCT, infection treatment vaccination and pregnancy care up to delivery), delivery (intrapartum care- delivery, help baby breath and eMTCT,), postnatal (growth monitoring, family planning, prevention of non-vaccinated diseases, vaccination and nutrition).

Tanzania Commission for AIDS (TACAIDS)
TACAIDS is responsible for coordinating the implementation and monitoring of the national multi-sectoral HIV and AIDS Strategic Framework and has been a Lead SR in the previous rounds. It also plays the significant role being the Secretariat to the TNCM. TACAIDS has accumulated a wealth of experience in coordinating multi-sectoral partners involved in implementing GF funded HIV and AIDS-related activities. TACAIDS is thus well-informed of the various challenges that affect Global Fund grants. No major challenges are anticipated in the implementation of TACAIDS' own activities. In this proposal, TACAIDS will work with The Principal recipient, to orient all the lead sub-recipients in the operationalization of the Global Fund Round 8 Phase II and the Transitional Funding Mechanism (TFM).

Transitional Funding Mechanism

DOCUMENT CHECKLIST

Section Reference	Mandatory Attachments	File Name
4.3(a)	Logframe (Attachment D) (Not necessary if there are no existing grants for the disease in the country which will be ongoing by the start date of this request)	
5.1	Performance Framework (Attachment A)	
6.2	Pharmaceutical and Health Products List (Attachment B)	
7.1	Financial Gap Analysis Table	
7.5	Detailed Budget and Work Plan	
7.6(a)	Summary Budget by Service Delivery Area (SDA)	
7.6(b)	Summary Budget by Cost Category	
7.6(c)	Summary Budget by Principal Recipient (PR)	
7.6(d)	Calculation of incremental funding request (Not necessary if there are no existing grants for the disease in the country which will be ongoing by the start date of this request)	