PROGRAM SCORECARD

Tanzania

HIV/AIDS

September 2013

1. SUMMARY OF RECOMMENDATION

Grant number	**PR name**	**Performance Rating & Recommendation Category**	**Recommended Incremental Amount** *(renewals only)*	**Interim Funding Amount** *(if applicable)*	**% of Adjusted TRP clarified amount** *(or % of total Interim Funding)*	**% saving**	**Within Investment Range?**
TNZ-405-G06-H	PSI	A2 Go	US$ 28,294,178.06		98%		
TNZ-809-G13-H	MOF	B1 Go	-	US$ 51,000,000			
Total Adjusted TRP clarified Amount (by PR) *[renewals only]*			US$ 28,294,178.06				
Total Recommended Incremental Amount (all PRs)			**US$ 79,294,178.06**				
Total Interim NFM Amount Available				US$ 51,000,000			

Background

This program scorecard refers to two grants: the interim funding application for year five of the existing Round 8 HIV/AID grant with the Ministry of Finance of the United Republic of Tanzania as the Principal Recipient, and the Rolling Continuation Channel (RCC) Phase 2 renewal (years 9-11) of Round 4 HIV grant with the Population Services International (PSI) as the Principal Recipient. The R8 HIV grant was extended into Phase 2 in December 2012 with an incremental funding of US$ 308,414,419 and the total grant value of US$ 411,069,946 million over a five year period (2010-2015). The goal and objectives of the grant are fully in line with the National HIV and AIDS Strategic Framework and the epidemiological context in the country. It focuses on securing and sustaining HIV/AIDS prevention, care, treatment and support services and on strengthening the coordination and implementation capacity of key stakeholders in the HIV and AIDS response. The Round 4 HIV grant focus mainly on increasing the correct and consistent condom use by improving access to high-quality, affordable male and female condoms through social marketing, and increasing the adoption of safer sexual behaviors and the reduction of risk taking behavior among target risk groups (MARPS). The CCM has requested US$ 51 million of interim funding for Round 8 HIV grant and an incremental amount of US$28,354,143 for Round 4 HIV grant, totaling US$79,354,143.

2: EPIDEMIOLOGICAL CONTEXT AND PROGRAM PERFORMANCE

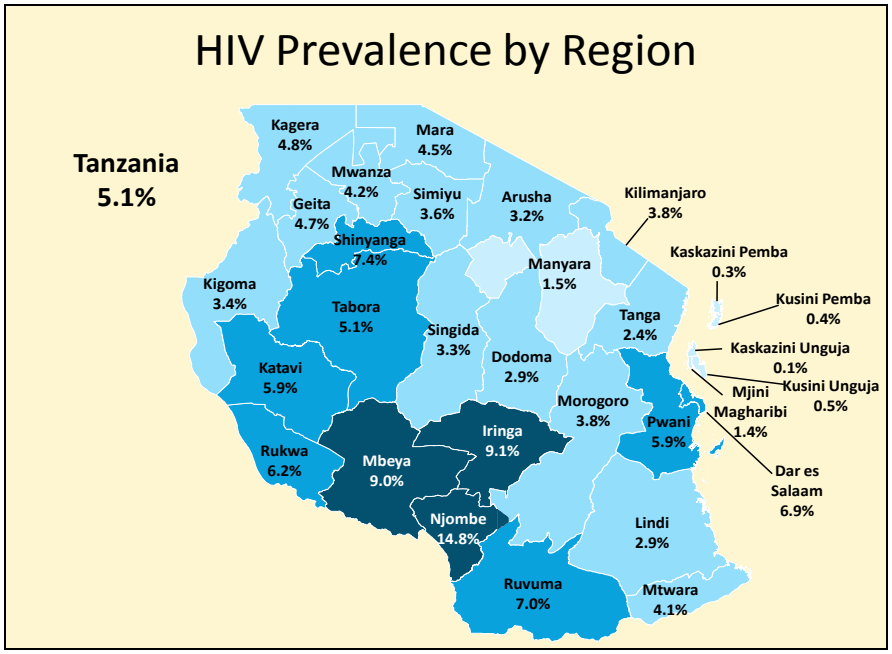
2.1: Epidemiological Situation and Country Context

In this section, please provide an overview of the epidemiological context. Describe key partners and their role in supporting the program implementation. Also, briefly summarize the key elements from country dialogue as relevant for the portfolio.

Tanzania is currently experiencing a mixed and geographically heterogeneous HIV epidemic with characteristics of both generalized epidemic among the general population and concentrated epidemic among specific key population groups (NMSF III 2013-2017). As of 2011, an estimated 1.6 million people in Tanzania are living with HIV, among them about 1.3 million are people aged 15 year and older (UNAIDS, 2012).

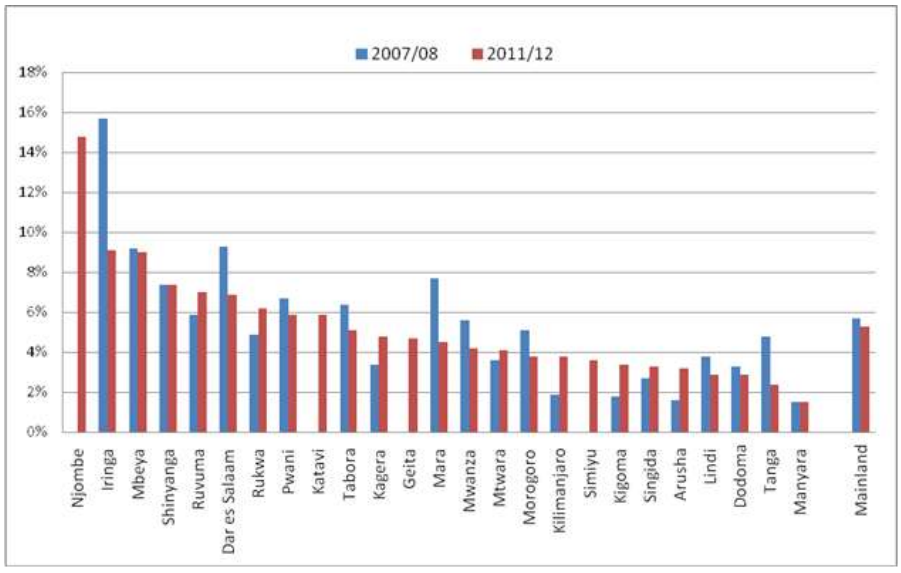
During the past decade (2003-2013), the HIV prevalence in the general population has decreased from 7.0% in 2003/04 to 5.1% in 2011/12. However, the last two recent HIV and malaria indicator surveys (THMIS 2007/08 and 1011/12) indicate stabilized HIV prevalence with a marked differential between regions and with no significant decline over the two periods. Although the HIV prevalence in Mainland Tanzania has declined during the period 2003/4- 2011/2 from 7.0% to 5.3% among all adults aged 15-49 and among men in the same age group from 6.3% to 3.9%, there has not been a statistically significant decrease among women. Women bear the brunt of the epidemic as those aged 20-24 were almost three times (4.4%) more likely to be HIV seropositive than men (1.7%). The prevalence among women varied by age from 1.3% in those aged 15-19 years to 10.2% in those aged 45-49 years. Among men the prevalence ranged between 0.8% among those aged 15-19 to 7.1% among those aged 35-39 years (THMIS 2011/2012).

Regional variation throughout Mainland Tanzania ranges from a low of 1.5% in Manyara to a high of 14.8% in Njombe.



Between the 2008/12 and 2011/12 THMIS surveys, there are 8 regions that witnessed an increase in prevalence levels and these include Ruvuma, Rukwa, Kagera, Mtwara, Kilimanjaro, Kigoma, Singida and Arusha. The exact cause for this increase is not clear, i.e. whether it is related to ineffective or inadequate programming or an actual rise in HIV infection within the regions or both.

Figure 5: HIV prevalence (%) by region between 2008 and 2012

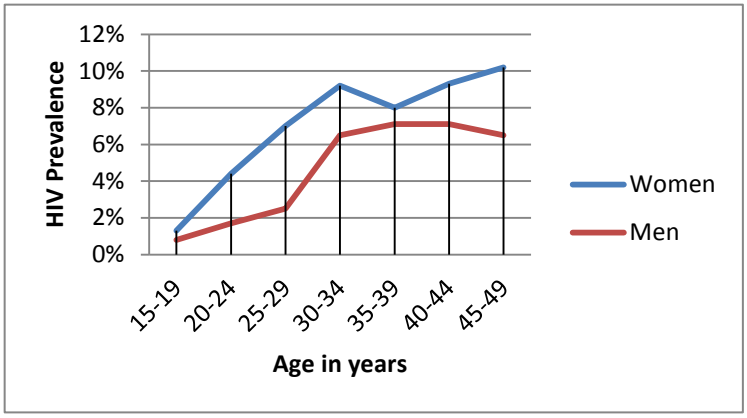


Source: THMIS 2007/08 and THMIS 2011/ 2012

Six regions in the Southern Highland Zone (Njombe, Iringa, Mbeya, Ruvuma, Rukwa and Katavi), two regions in the Coastal zone (Pwani and Dar es Salaam) and one in the Lake zone (Shinyanga) have HIV prevalence rates above the national average. These variations call for a strategic focus to control and bring down new HIV infections in the regions with high prevalence and to understand

and address the factors behind rising trends in prevalence in the regions.

Figure 2: HIV prevalence (%) by age and sex (Source: THMIS 2011/12)



Both HIV incidence and prevalence have stabilized in Tanzania. The incidence of HIV infection in the age group 15-49 years peaked at 1.34% in 1992, declined rapidly to 0.64% in 2000 and thereafter steadily declined to 0.32% in 2012. Similarly, the HIV prevalence peaked at 8.4% in 1996, then declined to 5.7% in 2008, and continued to decline to 5.3% by 2012. In contrast, studies conducted by various institutions and individuals indicate that the HIV prevalence among key population groups is markedly higher than in the general population, with prevalence ranging from 31.4% among female sex workers (FSWs), 42% for men who have sex with men (MSM) and 51% among people who inject drugs (PWID) (TACAIDS, 2012).

HIV Mortality Data

Tanzania has been implementing Sample Vital Registration (SAVVY) in 13 districts and conducting Demographic Surveillance Surveys (DSS) in two regions. Data from 13 SAVVY districts released in June 2013 indicates that HIV was the leading cause of death in the 15-54 year age group. The overall percentage of deaths from HIV disease was 12%, while Mbozi and Iringa Urban districts had almost double the mean percentage of deaths due to HIV and Mtwara Urban, Kahama, Sumbawanga and Musoma Rural had higher than an average share of HIV deaths. No particularly close correlation between the percentage of deaths attributable to HIV disease and Pulmonary TB was noted. For instance, Rungwa had the lowest percentage of deaths due to HIV disease (2.5%) but had above-average percentage of deaths attributable to TB (5.1%).

Human Rights/Policy Consideration

MARPs are key drivers of the epidemic, however, accurate estimates of their population size in the country have not yet been established. Programming for key populations is relatively new in Tanzania and a recently circulated draft of the National Guidelines for Key Populations in Mainland Tanzania (2013-2017) has as its main goal a cost-effective delivery of a comprehensive package of quality health services to all key populations in order to significantly minimise the transmission of new HIV infections and to reduce HIV-related mortality, stigma and discrimination.

Population Services International, whose main focus is reaching out to key populations, has been supporting the National AIDS Control Program (NACP) in the development of national guidelines for HIV prevention interventions among key populations and adopting the new WHO/UNAIDS guidelines on the HIV prevention and treatment for sex workers. This PR is contributing towards improving and building capacity for surveillance of key populations through the implementation

of a 7 region Integrated Biological and Behavioural Surveillance (IBBS) with sex workers which will provide baseline data on HIV and STI prevalence, factors that place sex workers at risk of HIV infection and the population size estimation. Currently an IBBS study is being conducted and the results would give more data on impact/outcome indicators. The IBBS is implemented in collaboration with NACP.

The recently released Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (draft: 2013 – 2017) is a broad National Strategic Plan, designed to guide the country's response as a whole to human rights considerations. It calls for scaling up of the comprehensive multi-sectoral response in prevention, care, treatment, and impact mitigation, in a way that is responsive to issues of gender.

In addition, in responding to concerns regarding the lack of information and program gaps for MARPs and in particular in MARPS accessing treatment, the Round 8 HIV grant has an allocation of US$ 660,563 which will be released, subject to the delivery of a plan detailing the activities related to MARPs' improved access to prevention, care, and treatment services, including PMTCT. Once the MARPs plan is finalised and the activities have commenced, the PR is expected to include a narrative update on the implementation of the MARPs related activities in each progress update and disbursement request to the Global Fund.

Partnership Environment

A strong in-country partnership among various stakeholders/development partners that has contributed to the effective scale up of the HIV, malaria and TB response over the last three years. The Tanzania National Coordinating Mechanism (TNCM) provides an excellent forum to enhance partnership arrangements. Active collaboration between the Government of Tanzania, PEPFAR and the Global Fund is the backbone of the HIV program scale-up. PEPFAR has thus far provided US$ 1.9 billion to Tanzania and remains the principal donor to the HIV program, with annual contributions of US$ 350 million on average. The three partners work in a highly symbiotic relationship where Government of Tanzania provides infrastructure, people, systems and policy environment, the Global Fund finances health commodities procurement, training, HR, coordination support and health systems strengthening components while PEPFAR finances certain health commodities (such as second line and paediatric ARVs) and emergency stocks while continuously strengthening service provision and providing long-term technical assistance (patient monitoring system, PMS, M&E, training, HR support, HSS, etc.). PEPFAR implementing partners operate in seven regions of Tanzania with the highest HIV prevalence, whereas the Government of Tanzania and the Global Fund both have national coverage. The Global Fund grant funded activities (both HIV and HSS) are all inter-related and complementary to the government policies and strategic plans as well as PEPFAR goals. Indeed, the success - or failure - of each of the three partners has a direct bearing on the others and the HIV program in general.

The development partners group for AIDS (DPG-AIDS) is instrumental in strengthening the Tanzania AIDS Commission's (TACAIDS) coordination role, organizing patner effective engagement in HIV/AIDS architecture, expanding partnerships including resource mobilization, promoting based policy and decision making for the AIDS response and gauging performance and effectiveness. Both DPG-AIDS and DPG-health are represented on the TNCM.

2.2: Program Performance and Impact

This section describes the impact that Global Fund support is having in the country, including investments from government and other partners. CTs should present a full picture of progress toward impact and coverage. This section should also summarize programmatic and financial performance, with details on relevant operational and capacity issues.

Impact, Outcome and Coverage

Tanzania has made significant strides in the HIV response. The SPECTRUM estimates of 2012 show that Tanzania has achieved ART coverage of 69% among population aged 15 years and above, and 25% among <15 and 77% coverage for PMTCT services, coverage for TB screening among PLHIV is 88%.

The estimated number of PLHIV in Tanzania is 1.6 million while new infections were estimated at 86,000 by Dec 2012 (UNAIDS 2013). Country data also shows that the cumulative number of HIV positive patients enrolled in HIV care and treatment has increased significantly over the years. Since 2011, the country has managed to report on a number of active clients who are currently on treatment. In December 2011, 206,304 clients who were reported to be currently on treatment while, by December 2012, the number was 432,338, more than double than in the preceding year (NACP Program Data).

The number of women and men who have ever been tested and received their results showed an increase from 37% and 27% (2008) to 62% and 47% (2012) respectively (THMIS 2011/12). Still, more than a half of the male population and about 40% of women do not yet know their HIV status.

PMTCT coverage is quasi universal, with 93% of health units offering PMTCT services. Around 70% of HIV+ women and 57% of exposed children were reported to have received ARV prophylaxis (MOHSW Bottleneck Analysis Report 2012). Less than 30% children have had access to Early Infant Diagnosis (EID). According to available DNA-PCR laboratory data from one third of children tested in 2012, 8.78% of all children tested were positive.

HIV Prevalence among Key Population Groups

Key population groups have recorded a high prevalence of HIV in the country. Approximately 40% of 25,000 PWID are HIV infected, while about 13.6% of MSM are reported to be injecting drugs; of these, 77.5% are paid for sex according to the MoHSW surveillance report of April 2010. Data on MSM and transgender people are limited yet various studies show their existence[1]. MSM in Tanzania are stigmatized, criminalized and hidden, and the contribution of MSM to the HIV epidemic in Tanzania has not been officially reported. However, preliminary results from a recent study in Dar es Salaam report HIV prevalence among MSM at 42%. Prevalence among female sex workers is 31.4%.

[1] Matasha et al, 1998; Haberland, 2001; Lockhart, 2002; Ikamba and Ouedraogo, 2003; Moen, 2011; Nyoni and Ross, 2012; Mmbaga et al, 2012; Ross et al, 2013

Condom Use

The THMIS and TDHS show relatively steady growth in comprehensive knowledge among men of how to prevent the sexual transmission of HIV/AIDS, rising from 43.9% to 50.1% over eight years, though for women this has been more variable, fluctuating between 40% and 50% over the same period. During the same period, young people have improved their knowledge of sources of condoms with over 92% of young men in urban areas and over 82% in rural areas knowing a source of condoms.

There have been marked improvements in condom use among unmarried youth and among those engaged in high risk sex over the years. Condom use for unmarried urban youth has risen from around 60% to 70% since 2003 and for rural youth from around 35% to over 50% during the same period. For those engaged in high risk sex, male use of condoms has grown from 49.7% to 56.8%, while women have shown an even larger increase, moving from 38% to 54.6% since 2003.

The biggest area of concern, however, is the reported decline in condom use among men who pay for sex. This has fallen from an average of around 58% to around 52.9% since 2003. In urban areas, the reported use rate of around 65.9% among those who pay for sex is consistent with data from a survey among urban sex workers in Dar es Salaam. Condom use at last paid sex is highest (at 67.3%) among men 30-39 years old, and this age group also has amongst the highest HIV prevalence.

Male circumcision

Nearly three-quarters (72%) of Tanzania men aged 15-49 reported having been circumcised. Circumcision is more common in urban than rural areas (94% vs. 64%). More than half of the regions on Mainland Tanzania show levels of male circumcision of 50% or more.

R8 HIV Grant Performance (PR: Ministry of Finance)

This grant is in its fourth year of implementation following Phase 2 renewal in September 2012. The latest progress report received concerns the implementation of HIV program activities during the period January-June 2013. Compared to the previous reporting period (July-December 2012), the program has made remarkable improvements with regards to both the actual performance of selected indicators and the quality of data submitted. The overall grant rating is strong B1. Eight out of eleven output indicators are Top 10 with the average performance of 84%.

The following indicators performed well: adults and children receiving ART (94% of target); screening of HIV patients for TB (120% against the set target, or 94% for all patients on ART); HIV patients that were found to have TB and were initiated on DOTs (107%); testing and counseling for HIV (99%) and pregnant women tested for HIV and who knew their results were reported (120%). The improvement in performance for this period was attributed to the availability of HIV test kits, previously out of stock due to shift between SD Bioline and Determine, and the improved collaboration between the HIV and TB programs to screen and initiate on DOTs the HIV patients found with TB.

The indicators with performance challenges were: children born to HIV positive mothers who were started on Co-trimoxasole and one training indicator where training was not conducted due to late submission and approval of the grant training plan. Although the indicator on HIV+ mothers who received ART to reduce risk of transmission to their babies performed well at 80%, only half of the children born to HIV+ mothers received Co-trimoxazole (49%). This is in line with

reported high attendance during antenatal and low delivery rates in facilities and subsequent low post natal attendance.

There was notable increase in the submission of reports from health facilities providing care and treatment (>100% from <80% previously) which in part explains the improvements in program performance.

Financial Performance

The grant amount for five years is US$ 411,069,946 with the first commitment of US$ 193,136,016 comprising of the first three years of the grant (Phase 1 plus Year 3 of the grant in Phase 2). US$ 187,653,778 has been disbursed to date, representing 97% of the first commitment. Cumulative expenditure by end-June 2013 was US$ 178,668,483 vs. a cumulative budget of US$ 198,921,441 (88% burn rate). About 90% of the grant funds are for the procurement of health products. To a large extent, expenditures reported in the EFR was adequately supported by the cashbooks, expenditure reports and other supporting documents. However, there have been instances of expenditures not adequately supported which are being followed up. Overall, the expenditure rate is in line with the B1 rating. The audit for the financial year ending 30 June 2012 has an unqualified opinion. Several weaknesses and SR oversight issues were highlighted by the Controller and Auditor General which are being followed up.

Program Management

The Ministry of Finance had traditionally been a pass-through PR, with TACAIDS taking the role of the PR, who is also the lead Sub-Recipient of the grant. The Ministry of Finance's PR role was minimal with regards to grant management as well as sub-recipient oversight. This situation was sub-optimal in a number of ways: reporting was late and incomplete leading to delayed and often emergency disbursements to prevent stock-outs. The turnaround happened in late 2012 when the leadership of the Ministry of Finance agreed to both formally and functionally resume the PR role. The two leading sub-recipients - TACAIDS and MoHSW - realigned their support to the PR and the US funded Grant Management Solutions team commenced a comprehensive capacity building program through technical assistance provision. The PR team was reorganised to deliver with an organogram similar to the Global Fund country team, with the key technical positions (finance, M&E and PSM) now having incumbents in place either through reassignment within departments or SR secondments, and the senior management working more closely with the Global Fund. The operational budget was approved and spread across three grants (HIV, malaria and HSS). The improvement in grant management has thus far resulted in more comprehensive and timely reporting, in addition to active follow up on management issues on the part of the PR. This positive trend is also reflective of the improved grant performance and for the first time an "A" grant rating seems realistically within reach with the next reporting period.

With regards to the M&E aspect of the grant, quality of the data has also improved with few issues that still remain to be addressed: health facilities data reporting in terms of completeness and timeliness, better data aggregation from facility to central level and training of staff in M&E, to mention the few. The nationwide roll-out of the revised HMIS tools and DHIS electronic platform is expected by December 2013. Prior to that, increased demand by various data users had rendered the old HMIS inadequate, causing creation of multiple sub-systems to serve the vertical program reporting needs. The Global Fund is investing in the improvement of the HMIS under the HSS grant where it is planned to have the DHIS as the recommended platform for all health data generated from health facilities. The existing electronic systems will interface with the DHIS.

Pharmaceutical and Health Product Management (PHPM) constitutes over 89% of the budget

and is an absolute major portion of the grant. Overall, the PR has complied with the approved PSM plan while historically failing to fully utilize the budget for health products due to delays in meeting and addressing PHPM specific Conditions Precedent which had resulted in delayed disbursements.

R4 HIV-RCC Grant Performance (PR: PSI)

Round 4 grant started in July 2005 and is in its eight year of implementation following RCC Phase 1 renewal in June 2011. The latest progress report received is for the period June-December 2012. Cumulative rating for this grant is A2 (upgraded from quantitative B1 rating). The average performance of the Top 10 indicators is 88% and of all indicators is 85%. The two main indicators: number of male and female condoms sold through private outlets achieved 92% and 85% of their intended targets respectively. To put it in perspective, until December 2012 this grant sold 476,757,152 male condoms and 2,749,979 female condoms since inception. At the same time, 512 MSM and 3,371 CSW were reached with HIV prevention activities in hot spots or otherwise.

Financial Performance

The total signed grant amount is US$ 34,935,601. US$ 2,373,516 was the budget for Phase 1, US$ 15,612,283 for Phase 2 and US$ 16,949,802 for RCC Phase 1. To date, US$ 31,899,726 has been disbursed, representing 91% of the grant amount. Under the grant's RCC Phase 1 the cumulative budget was US$ 9,344,970 and the actual cumulative expenditure US$ 3,474,958 (37% burn rate). The grant focuses mainly on the procurement of male and female condoms and their social marketing. An annual disbursement for the grant was released end-July 2013 in the amount of US$ 7,468,008 of which US$ 5,919,005 was for condom procurement and US$ 1,549,003 for supporting activities.

Program Management

PSI is a strong PR with wide experience in socially marketed condoms and outreach to MAPRs. Thanks to good program management, for the period ending December 2012 the overall grant rating was upgraded to A2 from the quantitative indicator rating of B1. PSI is working closely with the Government and other national stakeholders regarding HIV program response and, importantly, it helps enhance the government efforts to provide condoms to outlets, by including 21 million condoms per year for the public sector. However, there still remains inadequate access and effective interventions for MARPs and the PSI will need to strive to expand its interventions nationwide, so that key populations outside of Dar es Salaam can also have access to the effective interventions provided. Also, there is a risk that female condoms and water based lubricants procured under the grant are not accessible to all who would need them. Therefore the innovative strategies should be deployed so that the grant can sustain the achievements made so far.

CROSS-CUTTING ISSUES

Linkages between Round 9 HSS grant and HIV, TB and Malaria Interventions

In May 2013, the Global Fund approved a Phase 2 extension of the Round 9 HSS grant with an incremental funding amount of US$ 37,600,405. While this stand-alone HSS grant objective is to achieve broader system-wide effects, the country was additionally tasked to present, together with the first upcoming interim funding application, clear linkages between the Global Fund investments in HSS in Tanzania and the improved performance and achieving the impact on the

three diseases.

The HSS grant funding is allocated for the following interventions: 1) increasing the production of skilled health workers; 2) supporting the recruitment and retention of health workers; 3) strengthening national HMIS for planning and monitoring; 4) improving procurement and supply chain management systems; and 5) strengthening management and leadership skills at all levels of the healthcare system. The grant focuses on improving health service through wider outreach in ***70 remote and underserved rural districts***, many of which are among the ones with the highest prevalence of HIV, TB and malaria according to THMIS 2011/2012 and TB Prevalence Survey 2012/13.

The 2011/2012 THMIS results revealed that eight regions witnessed an increase in HIV prevalence levels: ***Ruvuma***, ***Rukwa***, Kagera, ***Mtwara***, Kilimanjaro, ***Kigoma***, Singida and Arusha. Highest HIV prevalence was found in ***Mbeya***, ***Iringa*** and Njombe, followed by ***Katawi***, Tabora, ***Shinyanga*** and ***Pwani***. Malaria prevalence was highest in ***Geita***, ***Kigoma***, Mara, Mwanza, ***Ruwuma***, ***Mtwara***, Morogoro and ***Pwani*** regions. TB prevalence is higher in rural compared to urban populations, men compared to women, older compared to younger participants and in participants with lower compared to higher socio-economic position. The expansion of health training institutions for increased production of human resources for health is happening in Pwani, Rukwa, Mtwara, Dodoma and Tanga. The HSS programme supports renovation of training facilities in referral hospitals all over the country, also in regions with the high disease prevalence. The construction of staff houses with the goal of improving health worker deployment and rention rates focuses on Rukwa, Katavi, Mtwara, Ruvuma, Pwani, Mbeya, Shinyanga, Geita, Iringa and in additional 12 Regions with low health workers density. It should be noted that prioritization of regions for the construction of staff houses under the HSS grant was not informed by the disease prevalence. Rather, it was based on those hard to reach areas where no health workers were reported to be available in health facilities due to scarcity of staff accommodation, resulting in people walking long distances to access basic health care. These hard to reach areas normally offer generalized rather than specialised health services which means that the unavailability of health workers equals no services for, HIV, TB, malaria and other OPD services. Additionally, because they are hard to reach, a good number of them fall under the high disease burden regions.

M&E Systems Strengthening

Specific gaps in Tanzania's M&E system for health were identified that affected performance of the HIV and other program indicators. Whereas non-routine systems (surveys) are well scheduled and regularly implemented, the challenges remain with a view to establishing the routine systems that provide outcome data.

To respond to the M&E identified gaps and to improve reporting, key stakeholders in the health sector developed the Monitoring and Evaluation Strengthening Initiative (M&E SI), which is a five year M&E systems strengthening program (2010-2015). The initiative aims to enhance collection, reporting and the analysis of data for evidence based decision-making. It is implemented by a consortium of partners which include MoHSW, Prime Minister's Office Regional and Local Government (PMO-RALG), the Netherlands Embassy, Government of Norway, US Government, the Global Fund and a number of technical support partners including Ifakara Health Institute, University of Dar es Salaam, University of Oslo; Research Triangle Institute; the CDC Foundation (m-health project) and the Clinton Health Accesses Initiative (CHAI) Tanzania.

The M&E SI focuses on the integration of vertical programs into the HMIS and the utilization of the DHIS platform for reporting on all program data in the country. Some elements of vertical program data, including the malaria and HIV, have been incorporated into the revised HMIS and

its DHIS platform. In response to the Global Fund recommendations, the M&E SI is working towards the integration of other vertical programs, including TB, into the establishment of the data warehouse. Guided by the M&E SI priorities, the MoHSW is implementing a major revision of its HMIS tools and DHIS Version 2. By end-2012, a total of 9,473 service providers from five HMIS roll-out regions were trained in the new HMIS forms and templates. Currently the HMIS trainings are ongoing in the remaining 15 regions of Mainland Tanzania. Around 24,000 service providers were trained by mid-2013, and plans are to train additional 16,000 service providers before the end of 2013. Recently, the HMIS Unit has successfully included 10 tracer medicines into the routine HMIS of Tanzania Mainland and the DHIS2 can now produce monthly tracer drug information. Notable improvement is therefore expected in the near future regarding timeliness, accurateness, completeness and quality of reporting of all Global Fund supported indicators that are reported through HMIS.

Procurement and Supply Management

The Medical Stores Department (MSD), with the support of the Global Fund and USAID is undertaking the construction of 18 warehouses-in-a box (prefabricated storage units) around the country. The expansion of MSD storage capacity in warehouses has enabled more streamlined warehousing and stock management. With Global Fund and other partner support, MSD senior staff have been trained in modern ways of supply chain management, and other staff in areas of forecasting and product storage targeting reductions of expiring medicines and customer care. Middle management and senior level staff have been trained in performance management and leadership skills with the special emphasis on procurement and quality management systems. This, together with transfer of procurement duties to VPP, has ensured that no treatment disruptions due to lack of ARV supplies have been recorded over the last year.

In addition, the Medical Stores Department through the Global Fund support has refurbished its transport fleet to ensure regular delivery of medical supplies at the facility level in the entire country planned to start from July this year. Through the Public Private Partnership project with Coca Cola and other partners, MSD has been able to record up to 70% savings on distribution costs from the efficiencies gained from route planning and optimization. These gains will be further consolidated with the procurement of 25 delivery trucks to be included in the TB interim funding application in order to deliver health products to hard-to-reach areas of the country. This fleet renewal request, apart from supporting Phase 3 of the Coca Cola project, will benefit the roll out of PMTCT Option B+ to the country's >5000 health facilities. Stock management training has been provided for District and Regional health staff to build their capacity in pharmaceutical and health products management.

Currently, the Global Fund together with partners is in the process of preparing a joint action plan to strengthen the supply chain in Mainland Tanzania. This action plan will ensure that future PSM system strengthening funding requests are based on evidence-based, high impact interventions agreed with all in-country partners thus ensuring the complementarity between various partner support. While significant gains are already recorded from the current investments in PSM system strengthening, more time is required to record PSM system-wide improvements.

The current on-going investments in the health systems strengthening may need some time to be translated into measurable improvement in the HIV, TB and malaria programs performance.

Financial Performance at Program Level

PR Type	No. of SSFs / Grants	Cumulative Signed Budget to cut-off date (Grant Agreement)	Cumulative Adjusted Budget to cut-off date (EFR)	Disbursed to cut-off date (Finance)	Expenditures to cut-off date (EFR)
	1				
PSI	1	9,344,965.70	9,344,965.70	8,720,542	3,474,959.08
Grand Total	**2**	**9,344,965.70**	**9,344,965.70**	**8,720,542**	**3,474,959.08**

Disbursed vs. Adjusted Budget at cut-off date	**93%**
Expenditure vs. Adjusted Budget at cut-off date	**37%**
Current Implementation period % time elapsed	**92%**

PR Type	No. of SSFs / Grants	Cumulative Signed Budget to cut-off date (Grant Agreement)	Cumulative Adjusted Budget to cut-off date (EFR)	Disbursed to cut-off date (Finance)	Expenditures to cut-off date (EFR)
GOV	1	209,228,941.26	209,228,941.26	187,653,778.03	137,709,178.04
Grand Total	**2**	209,228,941.26	209,228,941.26	187,653,778.03	137,709,178.04

Disbursed vs. Adjusted Budget at cut-off date	**90%**
Expenditure vs. Adjusted Budget at cut-off date	**66%**
Current Implementation period % time elapsed	**45%**

3: INVESTING FOR IMPACT

3.1: Investment Request

This section should describe the strategic focus of the requested funding, including scope and scale. In your narrative, please describe the extent to which the request reflects input provided to the applicant by the CT during country dialogue.

The investment request concerns additional interim funding of US$ 51 million for the existing Round 8 HIV grant with current committed amount of US$ 308,414,419 and Phase 2 renewal of RCC Round 4 HIV grant with incremental request of US$28,354,143. The two requests are aligned with the relevant disease specific Health Sector HIV Strategic Plan (2008-2012) and the draft Third Tanzania National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017).

Investment in Treatment Scale-up (PR: MoF)

The ARV treatment component is planned to significantly increase in scale and scope in accordance with the country's decision to adopt PMTCT option B+ and to use simplified ARV regimens (TDF300/3TC300/EFV600) as first line ART and for PMTCT Option B+. Comprehensive PMTCT services are expected to cover 4,914 out of 5,972 (97%) of health facilities that provide RCH services countrywide, which is more than four-fold increase from 1,100 sites providing ART in Dec-2012.

The Tanzania National AIDS Control Program in 2012 formulated an elimination of mother-to-child transmission of HIV/AIDS (eMTCT) strategy which in line with the Health Sector Strategic Plan III 2009- 2015 and the Health Sector HIV and AIDS Strategic Plan II 2008-2012. In line with the country's request, current Round 8 HIV budget has been revised to reflect the strategic goal of the eMTCT strategy to eliminate new HIV paediatric infections and keep mothers alive through improved maternal, new born and child health and survival programs by 2015.

The corresponding outcome results are expected: 90% of HIV positive pregnant women put on and retained on ART by the year 2017 from 77% in 2012; all children living with HIV are put on ART and 90% are retained by the year 2017 (from 81% in 2011) and 85% of all adults are put on and retained on appropriate ART regimen by the year 2017 (from 76% in 2012) respectively. The associated targets in terms of people on ART for each outcome results are: 118,291 children put on ART by the end of 2017 from 32,772 in March 2013 and 1,068,799 adults and adolescents on ART by the end of 2017 from the current 457,182 (March 2013). These targets are essential for the country to reach the desirable national programmatic tipping point (i.e. increasing number of PLHIV receiving ARVs while reducing number of new HIV infections).

ARV Funding Gap

The expansion and scale up of HIV treatment services translates to increased number of patients on treatment and hence increased demand for ARVs. According to the quantification review done during the amendment of the current Round 8 HIV grant budget to reflect the eMTCT strategy, the total requirement for pharmaceuticals for the period of July 2013–June 2015 is US$ 235,757,553.65 whereas the committed funds for ARVs for the same period was US$ 161,453,595.58 from the available sources. This leaves a funding gap amounting to US$ 74,303,958.07. The gap is a result of adopted changes in the first line ARV regimens including phase out of the less expensive Stavudine30/Lamivudine150/Nevirapine200 tabs and the introduction of Tenofovir300/ Lamivudine300/Efavirenz600 tabs as the preferred first line regimen for ART and PMTCT Option B+. The changes have lead to significant increase in projected proportion of patients expected to be placed on the regimen resulting in the increased requirements for the regimen which is more expensive compared to the one previously used.

The CCM is requesting to use the interim funding of US$ 51 million to partly cover the gap in order

to achieve the treatment targets. The additional funds will reduce the funding gap to US$ 23,303,958.07 (31.4% of the gap) which could be covered from alternative sources.

Resource Analysis for HIV commodities for 2013-2014 Period

Category of Commodities	Source of Fund	Total financial requirements for Jul2013-Jun2014	Percentage contribution by Source of Fund	Total financial requirements for Jul2014 - Jun2015	Percentage contribution by Source of Fund
ARV	GF/GOT	$ 82,363,081.61	77%	$ 129,033,442.45	100%
	PEPFAR	$ 24,361,029.59	23%	0	
Test Kits	GF	$ 9,358,784.11	100%	$ 9,485,831.13	100%
Lab reagents		$ 22,267,023.90	100%	$ 25,601,041.10	100%
OIs	GF	$ 656,141	41%	0	
	PEPFAR	$ 963,768	59%	0	
TOTAL		$139,969,828.21		$ 164,120,314.68	

Committed funds and Gaps				
Committed funds for ARVs	GF/GOT	US$ 61,487,556.54	72%	US$ 54,729,484.38
	PEPFAR	US$ 24,361,029.59	28%	
Funding gap for ARVs				US$ 74,303,958.07
Committed funds for Test Kits & Lab reagents	GF/GOT	US$ 31,122,490.12	100%	US$ 34,670,927.50
	PEPFAR			
Funding Gap for Test Kits & Lab reagents		US$ 503,317.94		US$ 415,944.71

The Tanzania HIV/AIDS program has been identified as eligible for Global Fund Standard Application in 2014 under the NFM full roll-out. The CCM will be encouraged in that application to review their current strategies in light of new evidence. It is expected that Tanzania will work on the HIV/AIDS concept note/standard application in 2014.

Investment in Prevention through Condom Distribution and MARPs (PR: PSI)

The focus of this program is on social marketing of male and female condoms. The request for Phase 2 renewals aligns with the relevant disease specific Health Sector HIV Strategic Plan and with the draft Third Tanzania National Multi-Sectoral Strategic Framework for HIV and AIDS

(2013 – 2017).

Phase 2 of the HIV-RCC grant will continue to build on the successes to date, with a particular focus on key populations including FSW and MSM while maintaining the efforts to scale up the procurement, distribution and social marketing of male and female condoms. 355,023,175 of male condoms and 1,910,082 female condoms are targeted to be sold by the end of HIV-RCC Phase 2. In addition, 15,132 FSW and 9,079 MSM are targeted to be reached by HIV prevention activities by the same period.

Through a partnership with the India Learning Network, the PR in this last phase will strengthen programming with key populations by supporting the development of national guidelines and scaling up best practices.

The Global Fund investment can be broken down as follows:

- Procurement and distribution of male and female condoms using social marketing (70.47%)
- Branded communications promoting consistent and correct condom use (17.61%)
- BCC using outreach with female sex workers (11.91%).

3.2: Programmatic Gap Table

Table: **Summary of Programmatic Performance and Targets- Treatment & Care and PMTCT**

	ART		TB/HIV			PMTCT
	Adults	**Children**	**TB screening among HIV patients**	**TB patients with known HIV status**	**HIV-positive TB patients on ART**	HIV+ve pregnant women receiving ART to prevent mother-to-child transmission
Estimated population in need (by 2015)	1,600,000*		533,333*****			67,998*****
I. Country target *(from NSPs where these exist)*- # & % coverage	1,068,799 (95%)	118,291 (80%)	100%	100	100%	100%
II. Current coverage (# & %, latest results)	69% (457,182)	32,772	431,260 (94%)	83.9%***	54%****	70-77%
A. Country target planned to be covered by domestic and other sources- # & % coverage	US$** 42% (54,729,484 .38)					
B. Country target already covered by other existing GF grants- # & % coverage	US$** 42% (54,729,484 .38)					
III. Expected annual gap (I- ΣA+B) # & % of country need	US$** (58%) 74,303,958. 07					
IV. To be covered by GF (phase 2/ Indicative funding request)- # & % coverage						
Year 1 (2013)						
Year 2 (2014)						
Year 3 (2015)						

**The NMSF states 1.6 million as the people (adults and children) living with HIV but does not state what fraction of these are in need of ART*
*** These figures do not indicate a split between children and adults*
**** This indicates TB patients who are tested for HIV and provided with results*
*****: This data may be under-reported because of reporting between HIV and TB programmes*
******: These are numbers from the PF but not reflected in the NMSF.*
The numbers on ART are obtained from the CCM request but which are not in the NMSF although targets in % are from the NSP. NSP targets are all %, numbers to be determined when M & E Plan for the NMSF is developed.

3.3: Funding Gap Analysis and Counterpart financing

**This table should be modified according to the information available*

Funding Source	Next Implementation Period (USD Million)				
	2013-14	2014-15	2015-16	Total	% Share
Overall Needs Costing	**742**	**779**	**818**	**2,339**	**100%**
Government Resources	54	54	54	162	7%
Private Sector	5	5	5	14	1%
Total Domestic Resources	**59**	**59**	**59**	**176**	**8%**
PEPFAR	255	255	255	765	
DANIDA	6	11	11	28	
CIDA	11	11	11	33	
Joint UN Program	7	7	7	20	
Total External (non GF)	**279**	**284**	**284**	**846**	**36%**
TNZ - 809 - G12 - H	**1.6**	**0.6**		**2**	
TNZ - 809 - G13 - H	**124**	**94**		**218**	
Total Global Fund (Existing)	**126**	**95**		**220**	**9%**
Total Resources Available	**458**	**432**	**338**	**1,228**	**53%**
Unmet Need Gap	**284**	**347**	**480**	**1,111**	**47%**
CCM Funding Request (Total)	11	61	9	81	3%
RCC Phase-2 Request	11	10	9	30	1%
Interim Funding Request		51		51	2%

Please summarize financial needs, current and planned sources of funding from all domestic and external sources and the financial gap for this disease. Please include details regarding the funding landscape and relevant information on counterpart financing.

Funding Need and Gap

The Third National Multi-sectoral Strategic Framework (NMSF) on HIV/AIDS for 2013-17 is under development and its costing is not yet finalized. The funding need for the next phase is derived from an updated costing of the existing NMSF by TACAIDS.[2]

As per CCM projections, government will contribute about 7% of the funding required for the next phase (12 % of currently available funding). The CCM projections are based on the assumption that actual government HIV spending in fiscal year 2009/10 (the latest year for which total government spending data is available) will at the minimum be maintained in dollar terms. Over 75% of government HIV spending in 2009/10 was on human resource, infrastructure, and overhead costs of outpatient and inpatient HIV services in public hospitals. Direct programmatic support for the implementation of the NMSF, is mainly for prevention and impact mitigation activities such as OVC services and HIV mainstreaming in government Ministries, Departments and Agencies (MDAs). A clear picture of government contribution to the funding need is not presently available

[2] Tanzania Commission for AIDS. July 2012. *Public Expenditure Review, 2011 HIV/AIDS Tanzania Mainland.* Dar es Salaam, Tanzania and Health Systems 20/20 project

as: (1) it is not known if non-programmatic costs of HIV service delivery in public hospitals is captured in the funding need; and (2) known commitments related to MDA mainstreaming and counterpart contribution to RCC grant; potential outcomes of recent sustainability initiatives and increases in HIV services through public facilities (see section on counterpart financing compliance) are not factored in the 2009/10 spending levels.

The HIV response in Tanzania is overwhelmingly dependent on external resources. Findings of the latest available 'Public Expenditure Review' for fiscal year 2010/11 indicate that external resources contributed over 95% of the total HIV spending. Funding from non-Global Fund external resources indicated in the CCM request will contribute about 36% of the funding need and 64% of the available funding. Key non-Global Fund external resources identified in the CCM request for the next phase include:

1. US government agencies under the PEPFAR umbrella is the primary financier of the Tanzania HIV program contributing to nearly two thirds of the total funding in the previous phase (around USD 350 million annually). PEPFAR contribution is expected to decline from previous levels in the next phase (USD 290 million allocated in PEPFAR 2012 FY budget)

2. The governments of Canada (through CIDA) and Denmark (DANIDA) support a pooled NMSF Fund which provides support for district governments' nonmedical, multi-sectoral HIV and AIDS activities. DANIDA also supports capacity building of TACAIDS and MSD. CIDA is also supporting a multi-donor health workforce initiative as well as 10% of UNJP funds.

3. The UN agencies pools resources and technical expertise to all the NMSF thematic areas. Prevention is accorded priority (45 percent), followed by crosscutting issues (e.g. fighting stigma, discrimination, and advocacy). UN budget has declined by over half in recent years.

Other donor support for the HIV program not included in the CCM request includes the recently approved 'Southern Africa Trade and Transport Facilitation Program Project' for Tanzania financed by the World Bank that incorporates a sub-component for HIV services (USD 5 million). This sub-component will refurbish and extend priority lower level health centers, facilitate the purchase of essential equipment, such as CD 4 count machines, and provide technical assistance to develop the capacity of the staff in the local health centers, in HIV/AIDS awareness, counseling and testing, and the disposal of medical waste. The primary beneficiaries of the component will be the mobile population along Dar es Salaam Corridor. Other funders such as JICA and GTZ who have withdrawn from direct program financing may continue to support technical assistance activities.

The Global Fund through existing grants (Round 8) and the current consolidated request for Round 4 RCC Phase-2 and Round 8 interim funding, finances 12% of the funding need and 23% of available funding.

A clearer picture of the funding need and financial gap at program and intervention level will be available with the finalization of the NMSP 2013-17 and the ongoing 'National Health Accounts' exercise.

Compliance with Counterpart Financing Requirements

1) Availability of reliable data to assess compliance

The Government primarily finances the HIV program through central Ministry of Finance allocations to TACAIDS, MOHSW, Regional and Local Authorities and other MDAs. A smaller share is contributed through own resources of Local Councils and the National Health Insurance

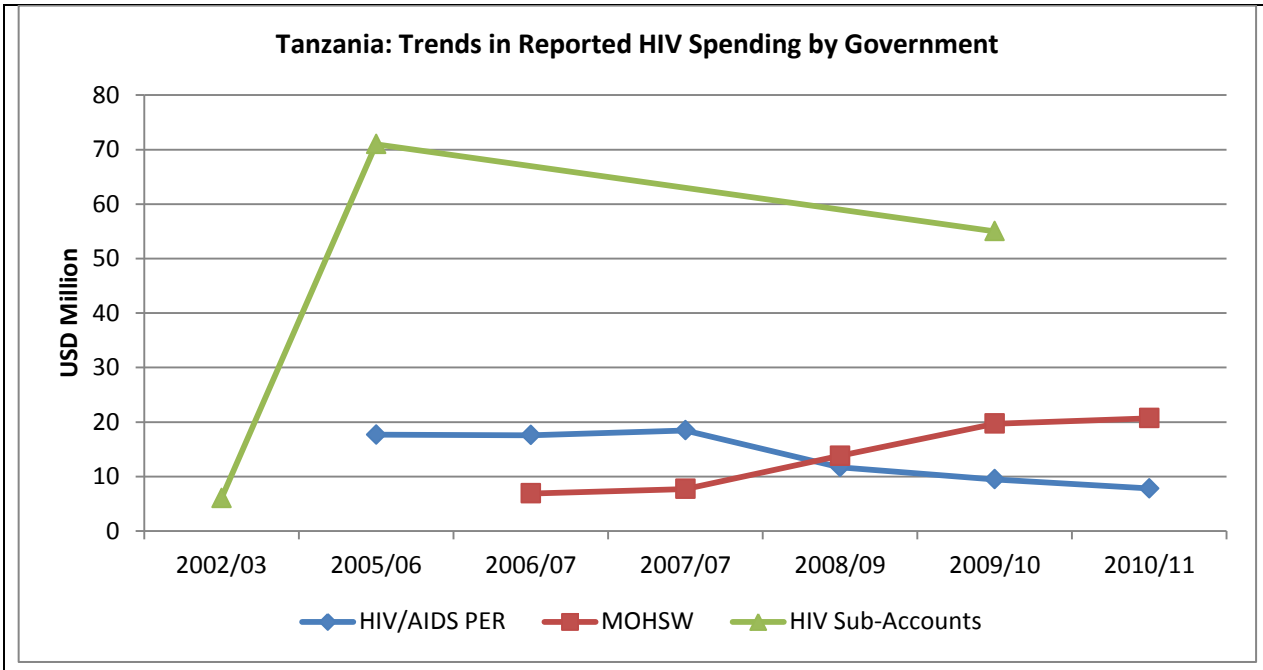
Fund. As per the 'Plan and Budget Guidelines' (PBGs) issued in the backdrop of the first Five Year Development Plan (2011/12 – 2015/16), all HIV and AIDs intervention should be coded as "Objective A" for easy expenditure tracking. While the detailed 'Medium Term Expenditure Frameworks' and annual plans are developed based on interventions, government allocations except for recurrent expenditure of TACAIDS are not earmarked in the national budget. Further, over 80% of donor expenditure is off-budget. HIV/AIDS spending is therefore tracked through annual 'Public Expenditure Reviews'. However, these reviews are limited to tracking direct programmatic spending and do not capture spending on service delivery that is integrated within facility budgets and accounts for a major share of government contribution. Total HIV spending is captured through periodic National Health Accounts (NHA) and its sub-accounts. Available data is sufficiently reliable to assess compliance with counterpart financing requirements. Nevertheless, time-lag and one-off nature of NHA exercises is a constraint in obtaining reliable data on current spending. To address this gap and ensure availability of data on a routine basis, the Global Fund through WHO is supporting institutionalization of NHA in Tanzania. The NHA 2011-12 with disease distributional accounts is expected to be available in October 2013.

2) Minimum threshold government contribution to disease program

Based on the CCM request and existing funding available from the Global Fund as well as 2009/10 level of government spending derived from the NHA, the counterpart financing share is 35% and meets minimum threshold requirement of 5% for low income countries. Tanzania will meet the minimum threshold requirements, even if only direct programmatic contribution by the government estimated by the PER is considered (above 7%).

3) Stable or increasing government contribution to disease program(s)

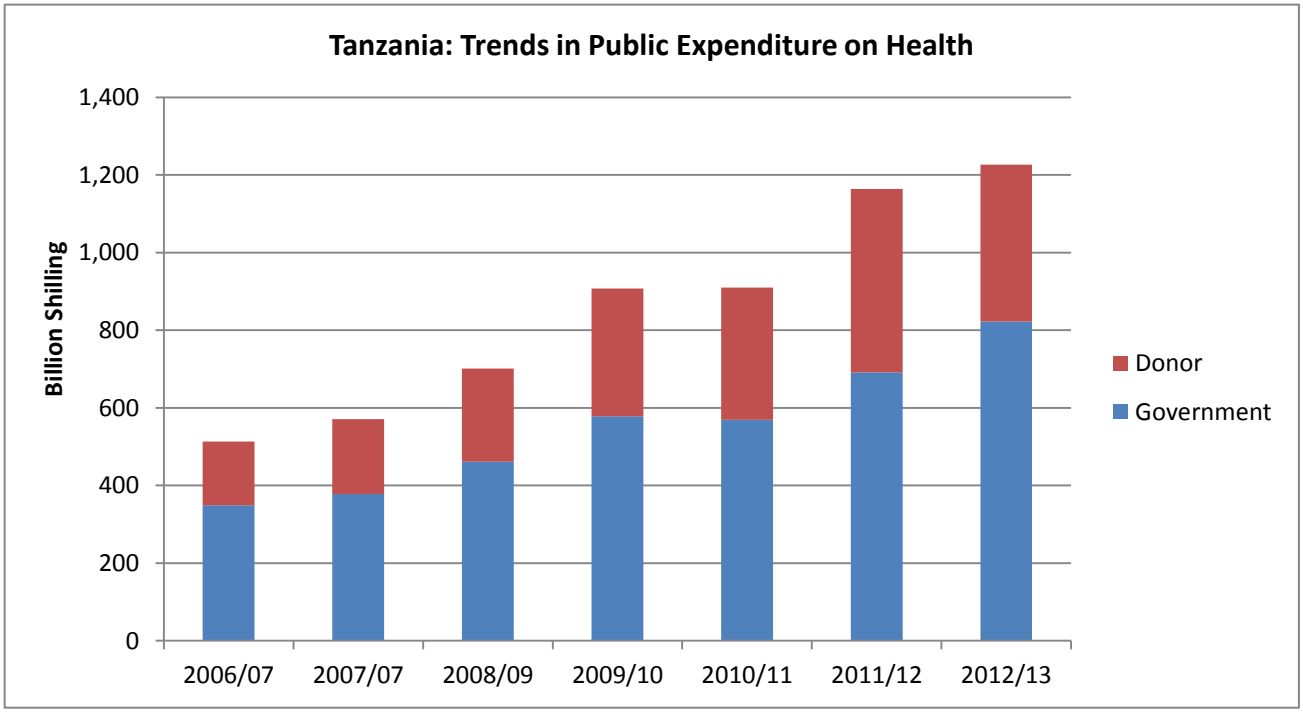
Available data from NHA-HIV subaccounts and HIV/AIDS Public Expenditure Review indicate a declining trend in government spending on HIV; whereas MTEF budgets tracked by MOHSW indicate an increasing trend in government HIV spending. Earlier, significant share of programmatic spending from government resources was routed through TACAIDS. With increasing focus on decentralization and mainstreaming, government resources increasingly was allocated through different MDAs. Poor absorption of fragmented allocations along with high levels of inflation and weakening of local currency against the US dollar is likely to have led to a decline in real government HIV spending. On the other hand, the difficulties of tracking actual spending through multiple channels of spending could have contributed to under reporting of government expenditure. With better mechanisms for tracking HIV spending, the results of the 2011-12 NHA and PER could provide a better sense of actual trends in government HIV spending. Nonetheless; the heavy dependency on donor resources that is now declining necessitates strong efforts to leverage domestic resources to sustain the HIV response. Initiatives to establish an AIDS Trust Fund for HIV and AIDS interventions are on-going; the process is at the level of the cabinet. The Trust Fund is expected to pool resources from the domestic revenues and earmarked levies. Other mechanisms include cost sharing schemes such as capitalization of Hospital Pharmacies, establishment of the Community Health Fund (CHF) and the National Health Insurance Fund (NHIF). In the current 'five year plan period, 'Objective A' for tracking HIV spending has been set as a default objective for government Ministries, Departments and Agencies (MDAs) which are required to put aside 5% of their recurrent expenditure for HIV and AIDS activities in the Medium Term Expenditure Review (MTEF). Further, the current request includes a commitment of counterpart funding of 28% of cost of condoms for targeted distribution (USD 8.5 million in the next phase. These initiatives and commitments are likely to increase government HIV spending in the next phase.



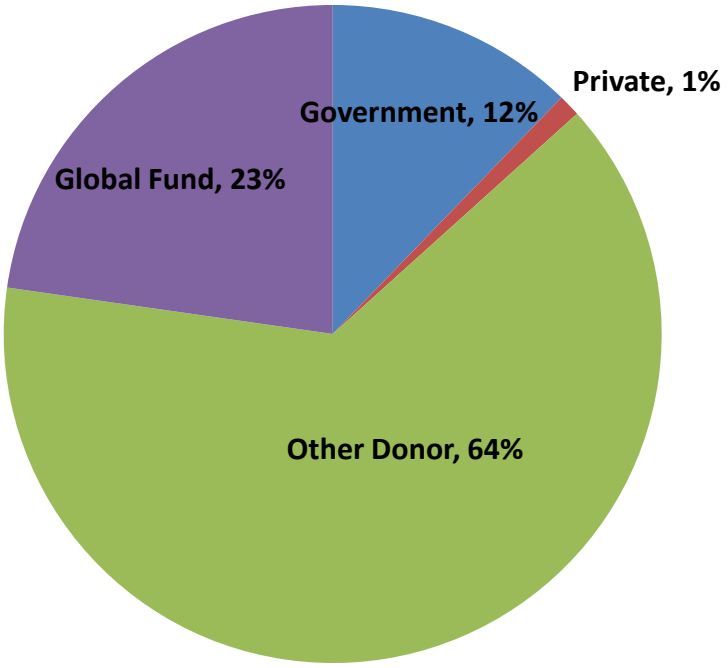
Source: HIV Sub Accounts- NHA (2003, 2006, 2010); PER- Annual Public Expenditure Reviews; MOHSW- CCM Request. PER and MOHSW data does not include HIV service delivery costs (HR, Infrastructure, and overheads) of out/inpatient care in public facilities.

4. Stable or increasing government contribution to health sector

General government expenditure on health of Tanzania was around 3 percent of gross domestic product (GDP) and about 11% of total public spending in 2011– in the median range of African countries. However, Tanzania is quite donor dependent with external resources accounting for about 40% of total health expenditure. Government contribution to the health budget has been increasing over time (see figure below). In 2012/13, while government contribution to the budget increased by 18%, donor resource declined by 14%. However, government expenditure on health has not kept pace with economic growth and share of health in budget has dipped to around 9 % in 2012/13.



Funding Landscape – Counterpart Financing 2013-2015

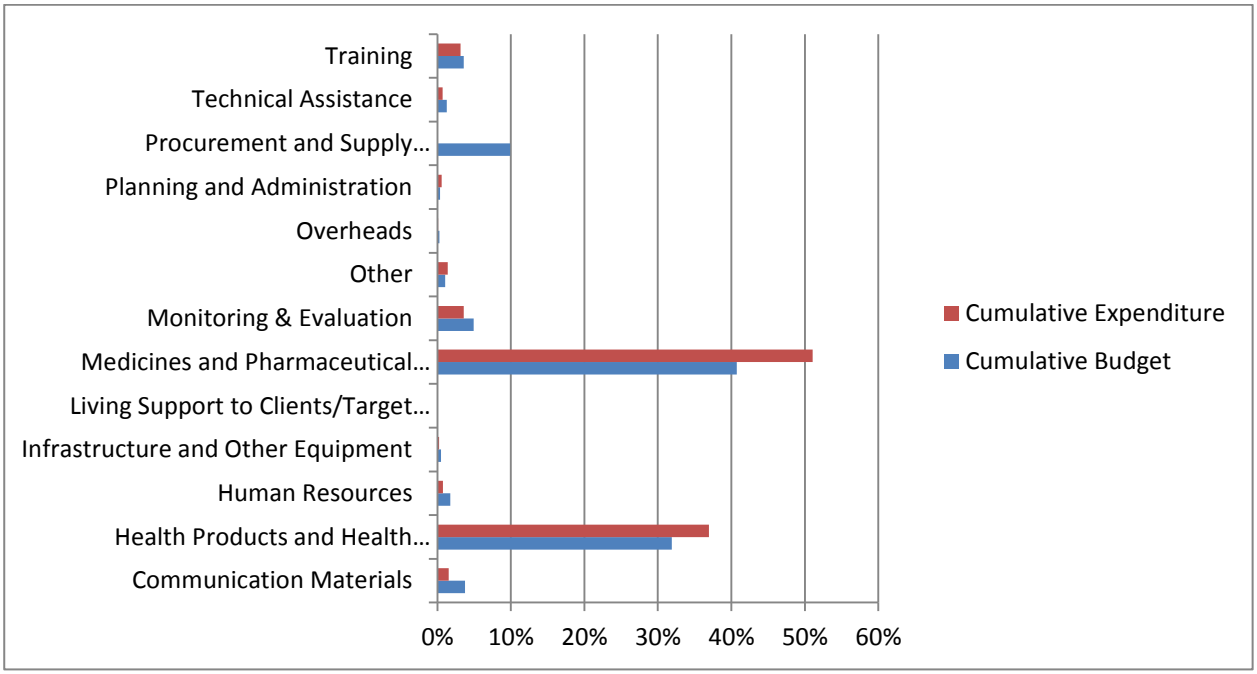


4: Funding Recommendation and Budget Analysis

PR: Ministry of Finance

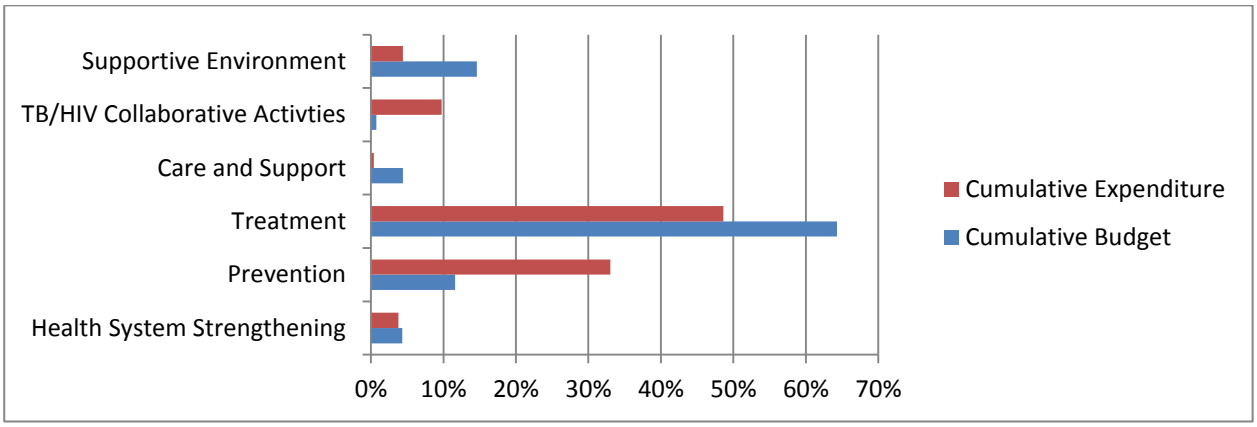
Budget US$ 209,228,941 vs. Expenditure US$ 137,709,178 (30 June 2013)

Per Cost Category



PR: Ministry of Finance

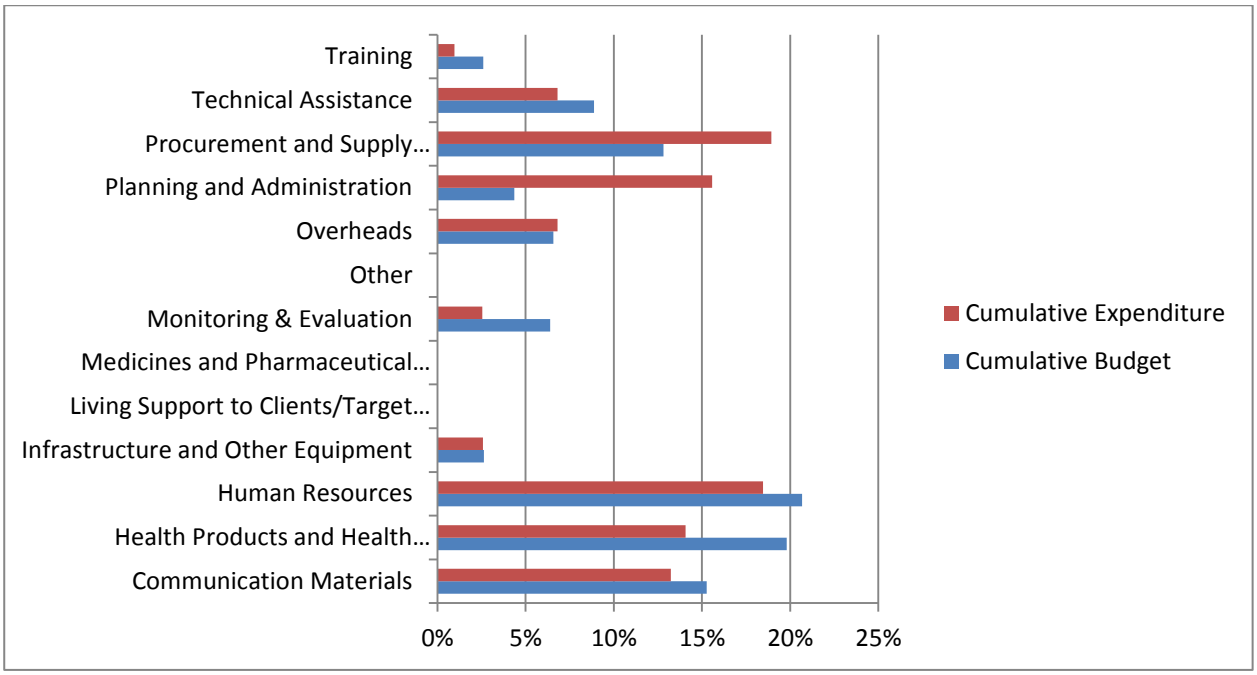
Per Activity



PR: PSI

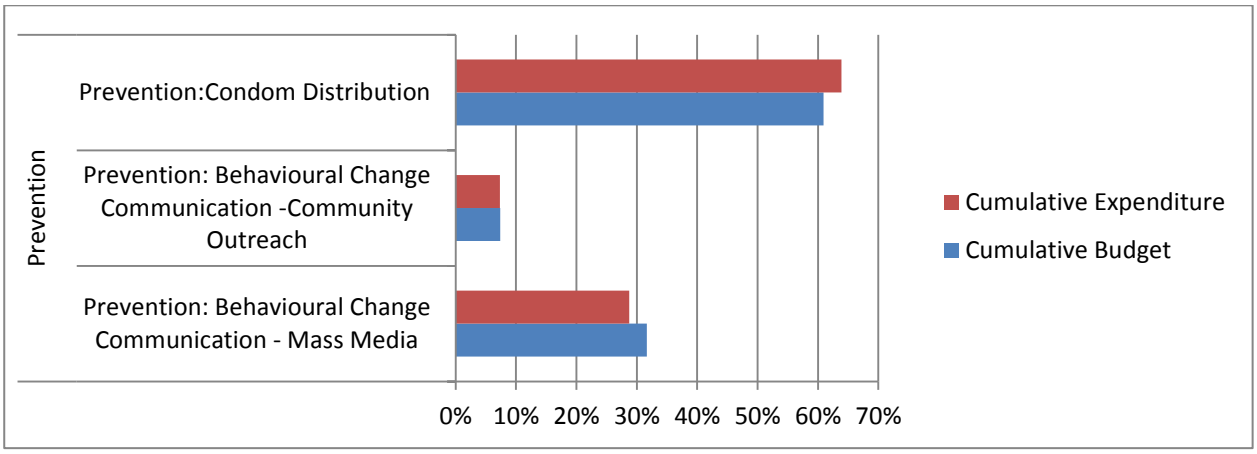
Budget US$ 9,344,965.70 vs. Expenditure US$ 3,474,959.08 (31 December 2012)

Per Cost Category



PR: PSI

Per Activity



Summary Budget Recommendation and Incremental Amount (for total program)

Human Resource	-39,465
Infrastructure & Equipment	-20,500
Budget Recommended by the Secretariat	
PR 1	
PR 2 *(add additional lines for other PRs, if necessary)*	
Total Budget Recommended	43,329,936.97
- Undisbursed amount at cut-off date	12,740,229.91
- Cash at cut-off date	2,295,529
PSI RECOMMENDED INCREMENTAL AMOUNT	**28,294,178.06**
MoF Interim Funding Recommended Amount	**51,000,000**
Total Recommended Incremental Amount	**79,294,178**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)	98.3%

For renewals and interim applicants: Please justify the recommended incremental amount in the context of the past performance, the funding gap, and the interventions proposed as well as expected impact to achieved taking into account value for money and risk mitigation measures.

An incremental amount of US$28,294,178.06 for PSI (TNZ-405-G06-H) is recommended. Adjustments have been made by the Secretariat in the Human Resources and Infrastructure & Equipment budget cost categories.

- The latest progress report for the period January–June 2012 showed the grant rating as A2. The recommended funding range is in therefore line with the grant performance.
- Before grant signing, the PR will need to provide the assumptions supporting the budget figures as currently, all unit costs are expressed as lumpsums.

5: Further contextual Information

Please add any other comments/ observations from the CT to bring to the GAC/ TRP's attention regarding the renewal/ funding request. Please summarize relevant conditions or management actions (if any).

The budget includes an inflation rate of 4% between year 4 and year 5 and 5% between year 5 and year 6. This will be subject to further review during budget negotiations and is an area of potential savings.

Condition: The Parties to this Agreement acknowledge and agree that the use of funds budgeted as protection against inflation is conditional upon prior review and approval of the Global Fund, as part of its annual commitment and disbursement decision. The Global Fund may decommit or decide to reinvest saving in the Program, in the event if the use of such funding is not approved.

ANNEX 1: PERFORMANCE BY PRINCIPAL RECIPIENT[3]

PRINCIPAL RECIPIENT 1

Grant Number	TNZ-809-G13-H
Principal Recipient	Ministry of Finance
Current Grant Start date	1 June 2010
Current Grant End date	30 May 2015

Programmatic Achievements

Overall Performance Rating at Cut-off Date 30 June 2013:

2010 - Dec 31 2010	Jan 1 2011 - Jun 30 2011	Jul 1 2011 - Dec 31 2011	Jan 1 2012 - May 31 2012	Jun 1 2012 - Dec 31 2012	Jan 1 2013 - Jun 30 2013
B1	**B1**	**B1**	**B1**	**B1**	**B1**

TNZ-809-G13-H

Service Delivery Area	Indicator Number	Top 10	Training	Indicator	Rated Target	Rated Result	%
Treatment: Antiretroviral treatment (ARV) and monitoring	1.1	Yes		Number of Adults and Children with Advanced HIV infection receiving antiretroviral therapy	933,334	880,415	**94%**
	1.2	Yes	Yes	Number of Health workers trained on ART Comprehensive Care and Treatment	200	0	**0%**

[3] This section needs to be repeated for each PR in the portfolio.

	1.8			Number and Percentage of Health Facilities providing Care and Treatment submitting reports as per set standards	N: 900 D: 1,100 P: 81.8 %	N: 1,019 D: 1,156 P: 88.1 %	**108%**
Care and Support: Care and support for the chronically ill	1.3			Number of Malnourished individuals provided with Ready to Use Therapaeutic Food (RUTF)	12,000	11,994	**100%**
	1.4	Yes		Number of adults and Children with HIV infection receiving care and support outside Health Facility	122,148	173,247	**120%**
	1.5			Number and Percentage of Civil Society Organisations that received TOMSHA supportive supervision in the past six months			
TB/HIV collaborative activities: Prevention of TB disease in PLWHA	1.6	Yes		HIV patients screened for TB (number)	675,556	852,637	**120%**
	1.7	Yes		HIV patients receiving DOTS	67,556	58,422	**86%**
Prevention: Counseling	2.1	Yes		Number of people who	480,500	1,983,32	**41%**

and testing				received testing and counseling services for HIV and recieved their test results	0	4	
Prevention: PMTCT	3.1	Yes		Number of Pregnant women who were tested for HIV and know their results	N: 865,318 D: 929,450 P: 93.1 %	N: 1,171,847 D: 158,938 P: 737.3 %	**120%**
	3.2	Yes		Number and Percentage of HIV positive Pregnant women who received antiretrovirals to reduce the risk of mother to child transmission	N: 54,165 D: 67,706 P: 80 %	N: 44,799 D: 69,937 P: 64.1 %	**80%**
	3.4	Yes		Number and percentage of infants born to women living with HIV initiated on Co-trimoxazole prophylaxis by 2 months of age	N: 43,947 D: 54,165 P: 81.1 %	N: 11,137 D: 28,090 P: 39.6 %	**49%**
	3.5			Number of Health Care Workers received Comprehensive training, Refresher training, and Mentoring training inline with the 2010 WHO	420	0	**0%**

				guidelines for PMTCT-EIT			
HSS: Information system & Operational research	4.1			Number of Local Government Authorities (LGAs) staff Trained on Tanzania Output Monitoring System for non medical HIV/AIDS services (TOMSHA), Monitoring and Evaluation Phase 2: Number of non medical of HIV/AIDS implementers trained on TOMSHA, Monitoring and Evaluation	70	62	**89%**
	4.2			Number of Health and Demographic Sentinel Surveillance (HDSS) sites strengthened Phase 2: Demographic Sentinel Surveillance report finalised and disseminated annually to stakeholders	1	1	**100%**
	4.3			Number of Supported operational	10	23	**120%**

				research and special studies conducted and cooordinated			

Cumulative Indicator Rating at cut-off date: 30 June 2013

Training Indicator Rating	0%
Average Performance on Top 10	79%
Top 10 Indicator Rating	**B1**
Average Performance All Indicators	82%
All indicators Rating	**B1**
Number of TOP TEN Indicators with B2 or C Rating	3
Renewals Indicator Rating	**B1**

ANNEX 1: PERFORMANCE BY PRINCIPAL RECIPIENT[4]

PRINCIPAL RECIPIENT 2

Grant Number	TNZ-405-G06-H
Principal Recipient	Population Services International, Tanzania
Current Grant Start date	01/01/2011
Current Grant End date	31/12/2013

[4] This section needs to be repeated for each PR in the portfolio.

Programmatic Achievements

Overall Performance Rating to cut-off date (*example below*):

Jan 1 2011 - Jun 30 2011	Jul 1 2011 - Dec 31 2011	Jan 1 2012 – June 30 2012	Jul 1 2012 - Dec 31 2012
A2	**A2**	**A2**	**A2**

Cumulative Indicator Rating at cut-off date:

Top 10 / Top 10 equ.	Training	#	Active Indicator Name	Cumulative Target	Cumulative Result	Percentage Achievement
Top 10		1.1	Number of male condoms sold through social marketing as recorded in PSI's Sales Management Information System (MIS). Phase 2: Number of male condoms sold through private outlets RCC Phase 1: Number of male condoms sold through private outlets	516,055,464	476,757,152	92%
Top 10		1.2	Number of female condoms sold through social marketing as a recorded in PSI, Sales Management Information System (MIS). Phase 2: Number of female condoms sold through private outlets RCC Phase 1; Number of female condoms sold	3,244,507.5	2,749,979	85%

			through private outlets			
		1.4	RCC: Percentage of rural enumeration areas where PSI condoms are sold	N: D: P: 84 %	N: D: P: 88 %	105%
		1.5	RCC: Percentage of "Hot Spot" outlets in High-Risk-Zones ("Hot Zones') where PSI condoms are sold	N: D: P: 90 %	N: D: P: 87 %	97%
		1.11	RCC Phase 1: Percentage of women and men aged 15-49 who both correctly identify condom use at every sex as a method to reduce the risk of HIV transmission	N: D: P: 73 %	N: D: P: 0 %	0%
Top 10		1.12	RCC Phase 1: Percentage of mobile men who identify condom use at every sex as a method to reduce the risk of HIV transmission	Not Found	Not Found	Cannot Calculate: S4
Top 10		1.13	Number of commercial sex workers reached with HIV prevention activities	Not Found	Not Found	Cannot Calculate: S4
		2.1	Number of Interpersonal Communication (IPC) sessions addressing the risks of anal sex conducted RCC Phase 1: Number of men who have sex with men (MSM) reached with HIV prevention activities	300	512	120% *
		2.2	RCC: Number of commercial sex workers reached with HIV prevention activities	3,500	3,371	96%

Average performance on Training Indicators	**N/A**
Average performance on Top 10/Top 10 equivalent indicators (including Training)	**88%**
Top 10/Top 10 equivalent indicators rating	**B1**
Average performance All indicators	**85%**
All indicators rating	**B1**
Number of Top 10/Top 10 equivalent indicators with B2 or C Rating	**0**
Renewals Indicator Rating	**B1**

*Based on analysis on performance analysis, quality of data and quality of services as well as compliance issues, adjust performance rating as necessary

RECOMMENDED PERFORMANCE RATING	A2

Financial Performance at Program Level

PR Type	No. of SSFs / Grants	Cumulative Signed Budget to cut-off date (Grant Agreement)	Cumulative Adjusted Budget to cut-off date (EFR)	Disbursed to cut-off date (Finance)	Expenditures to cut-off date (EFR)
NGO	1	$42,071,256	$42,691,054	$25,133,242	$22,651,982
PS	1	$2,704,527	$2,704,527	$3,269,287	$500,549
Grand Total	**2**	**$44,775,783**	**$45,395,581**	**$28,402,529**	**$23,152,531**

Disbursed vs. Adjusted Budget at cut-off date	**63%**

Expenditure vs. Adjusted Budget at cut-off date	**51%**
Current Implementation period % time elapsed	**48%**