United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 13th, 2021

INFORMATION MEMO FOR AMBASSADOR WRIGHT, TANZANIA

FROM: S/GAC Chair, Michelle Chevalier and PPMs Elyssa Finkel & Ashley Lima

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Wright,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries. As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of clients returning to care are needed to ensure that we are addressing critical, persistent and new structural barriers. In addition, focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not and these funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic also laid bare the depth and breadth of inequities still across the globe and clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all of our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, a number of countries have shown a level of resiliency were achieving epidemic control of HIV, and others are on the brink of epidemic control. With continued implementation, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are very excited about your progress in:

- Reducing over-testing and the scale-up of index testing
- Accelerating DTG-based regimen uptake across all age groups
- Steady improvement and achievement of 95% viral load suppression by the end of FY20

Together with the Government of Tanzania and civil society leadership we have made tremendous progress together. Tanzania should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue, and we again highlight 5 overarching issues we see across PEPFAR.

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services

3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed [net new on treatment and treatment current growth, (retention surrogate)]
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following specific key challenges in PEPFAR Tanzania:

1. Lagging achievement in VL testing coverage across all sub-populations
2. Adoption and scale-up of strategies for pediatric clients to enhance case finding, treatment, adherence and retention.
3. Ensuring treatment continuity for young adults and along geographic distributions

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 21 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016 PEPFAR and the Global Fund resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Tanzania has not achieved the 2020 goals but has made significant progress over the last year and is on track to achieve 2030 goals, which means sustaining the amazing gains will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Tanzania is $450,500,000 inclusive of all new funding accounts and applied pipeline. All earmarks and program direction provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Tanzania and civil society of Tanzania, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

We are hoping this approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden

of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC:
S/GAC—Michelle Chevalier, Chair;
S/GAC—Elyssa Finkel, PEPFAR Program Manager;
PEPFAR Tanzania—Jessica Greene, PEPFAR Country Coordinator

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

1. **Reducing over-testing and scale-up of index testing**. The Government of Tanzania (GOT) and PEPFAR Tanzania program continues to make significant strides in case identification through their improvements in case management and an intensified focus on targeted testing. These efforts resulted in sustained index testing yields >22% across Tanzania from FY19 Q3 to FY20 Q4—a 340-440% increase compared to FY18 Q1—and a 32% increase in HTS_TST_POS achievement during the same time period.

2. **Accelerating DTG-based regimen uptake across all age groups.** With the policy support from the GOT, Tier 1 facilities successfully transitioned by December 2019. In addition, as of September 2020, almost 90% of eligible women of child-bearing age and adults were on DTG-based regimens, which represents an approximate 350% increase compared FY19 Q4. Similar growth is seen in all age groups, including children (500% increase), where PEPFAR TZ is working with IPs to emphasize transition among eligible pediatric clients with real-time monitoring of client level data.

3. **Continuous improvement and achievement of 95% viral load suppression (VL) by the end of FY20.** With the support of the GOT, the PEPFAR Tanzania program has strengthened case management for PLHIV resulting in an increase of VL suppression from 88% in 2019 Q4 to 95% by Q4 of 2020, achieving >95% suppression in priority populations such as pregnant and breastfeeding women.

Challenges:

1. **Lagging achievement in VL testing coverage across all sub-populations**. Viral load testing coverage in Tanzania has steadily decreased from 86% to 74% from FY19 Q4 to FY20 Q4. Challenges in overall performance stems from a confluence of national policy issues, which has led to reagent stockouts and a VL sample backlog of over 155,000 by the end of FY20 Q4.

2. **Adoption and scale-up of strategies for pediatric clients to enhance case finding and retention**. Collaborations between PEPFAR Tanzania and GOT have led to improved pediatric case-identification as evidenced by the quadrupling of HTS_TST_POS yield from 0.9% in FY19 Q1 to 4.0% FY20 Q1. However, the number of positive children identified per quarter has steadily decreased to 3.2% in FY20 Q4 in both facility and community settings—a decline mirrored by the simultaneous decrease in index testing yield from a peak of 7.3% in FY20 Q1 to 4.9% in FY20 Q4. Similarly, quarterly retention proxy percentages for infants <1 yrs continues to remain depressed as compared all other age bands, reaching a low of 16% in FY20 Q4.

3. **Ensuring treatment continuity for young adults and along geographic distributions.** In FY2020, young women aged 20-39 and young men aged 25-39 were most impacted by interruptions in care as compared to adults of any other age band, with approximately 80% of losses a result of transfers or loss to follow-up at 3+ months. In addition, the Tanzania Program is

experiencing its highest volume of treatment interruptions in the Lake Region in the North, however, the highest volume of clients returning to treatment is concentrated in the Southern Highlands, thus highlighting that the clients experiencing care interruptions and subsequent returns are different. Ensuring strategic approaches for case management and longitudinal tracking along the borders to ensure treatment continuity remains a priority.

Given your country's status of continuing progress towards the achievement of epidemic control, the following priority strategic and integrated changes are recommended:

1. Scale-up index testing strategies to facilitate case-identification across Tanzania with a focus on pediatric and other priority populations.

2. Ensure the implementation of tailored linkage and retention interventions by client/population through real-time data analysis, targeted case management approaches, and population-specific health education/literacy.

3. Rapid clearance of viral load sample backlog and the development of a standardized process for monitoring and reporting on VL reagent stocks to enhance progress towards 95-95-95 goals in viral load coverage.

4. Continued focus on improving technical/partner performance through improved data quality and engagement in continuous quality improvement activities.

SECTION 1: COP/ROP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP/ROP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP21, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	$ 403,507,101	$ -	$ -	$ -	$ 500,000	$ -	$ -	$ -	$ 404,007,101
GHP-State	$ 365,888,351	$ -	$ -		$ -	$ -	$ -		$ 365,888,351
GHP-USAID	$ 35,000,000				$ 500,000				$ 35,500,000
GAP	$ 2,618,750				$ -				$ 2,618,750
Total Applied Pipeline	$ -	$ -	$ -	$ 46,492,899	$ -	$ -	$ -	$ -	$ 46,492,899
DOD				$ 2,278,510				$ -	$ 2,278,510
HHS/CDC				$ -				$ -	$ -
HHS/HRSA				$ -				$ -	$ -
PC				$ 3,101,300				$ -	$ 3,101,300
USAID				$ 27,955,867				$ -	$ 27,955,867
USAID/WCF				$ 12,586,369				$ -	$ 12,586,369
State				$ -				$ -	$ -
State/AF				$ 570,853				$ -	$ 570,853
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ -				$ -	$ -
TOTAL FUNDING	$ 403,507,101	$ -	$ -	$ 46,492,899	$ 500,000	$ -	$ -	$ -	$ 450,500,000

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $260,000,000 and the full Orphans and Vulnerable Children (OVC) level of $37,000,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$ 260,000,000	$ -	$ -	$ 260,000,000
OVC	$ 37,000,000	$ -	$ -	$ 37,000,000
GBV	$ 10,000,000	$ -	$ -	$ 10,000,000
Water	$ 2,160,000	$ -	$ -	$ 2,160,000

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks. **Only GHP-State will count towards the GBV and Water earmarks.*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	**$ 450,000,000**	**$ 500,000**	**$ 450,500,000**
Core Program	$ 398,800,000	$ -	$ 398,800,000
Cervical Cancer	$ 3,000,000	$ -	$ 3,000,000
Community-Led Monitoring	$ -	$ -	$ -
Condoms (GHP-USAID Central Funding)	$ -	$ 500,000	$ 500,000
DREAMS	$ 25,000,000	$ -	$ 25,000,000
HBCU Tx	$ -	$ -	$ -
One-time Conditional Funding	$ -	$ -	$ -
Surveillance and Public Health Respons	$ -	$ -	$ -
VMMC	$ 23,200,000	$ -	$ 23,200,000

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$ 240,052	$ -	$ -	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

Table 5. COP/ROP OU Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	59,727	74,006
TX Current >15	1,295,766	1,483,877
VMMC >15	309,883	707,986
DREAMS (AGYW PREV)	185,963	-
Cervical Cancer Screening	248,783	308,637
TB Preventive Therapy	408,444	545,194

Table 6. COP/ROP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	36,682,615	26,614,873	10,067,742
HHS/CDC	136,885,310	131,936,707	4,948,603
PC	2,823,746	1,650,491	1,173,255
State	1,502,313	365,680	1,136,633
USAID	232,691,008	215,697,660	16,993,348
Grand Total	**410,584,992**	**376,265,411**	**34,319,581**

These figures include only bilateral figures at present

Table 7. COP/ROP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level.

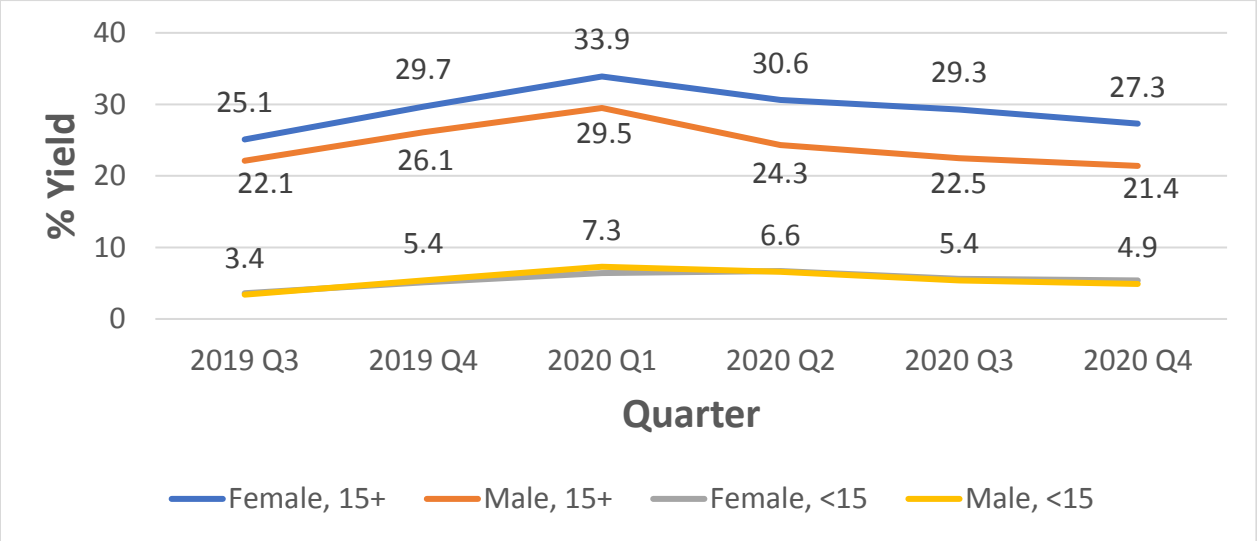
Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
102141		USAID	$13,172,641	$17,163,467	($3,990,826)
70358	Remote Medicine Inc.	USAID	$241,762	$2,398,839	($2,157,077)
18060	Elizabeth Glaser Pediatric Aids Foundation	USAID	$12,690,927	$14,464,803	($1,773,876)
18058	Abt Associates Inc.	USAID	$1,664,812	$2,261,252	($596,440)
17296	Cardno Emerging Markets Usa, Ltd.	HHS/CDC	$700,000	$1,195,590	($495,590)
18621	FREEDOM HOUSE INC	USAID	$380,000	$633,141	($253,141)
14698	Unicef	USAID	$902,687	$1,146,908	($244,221)
17316	Unicef	HHS/CDC	$500,605	$654,716	($154,111)
17992	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	HHS/CDC	$180,000	$259,272	($79,272)

These figures include only bilateral figures at present

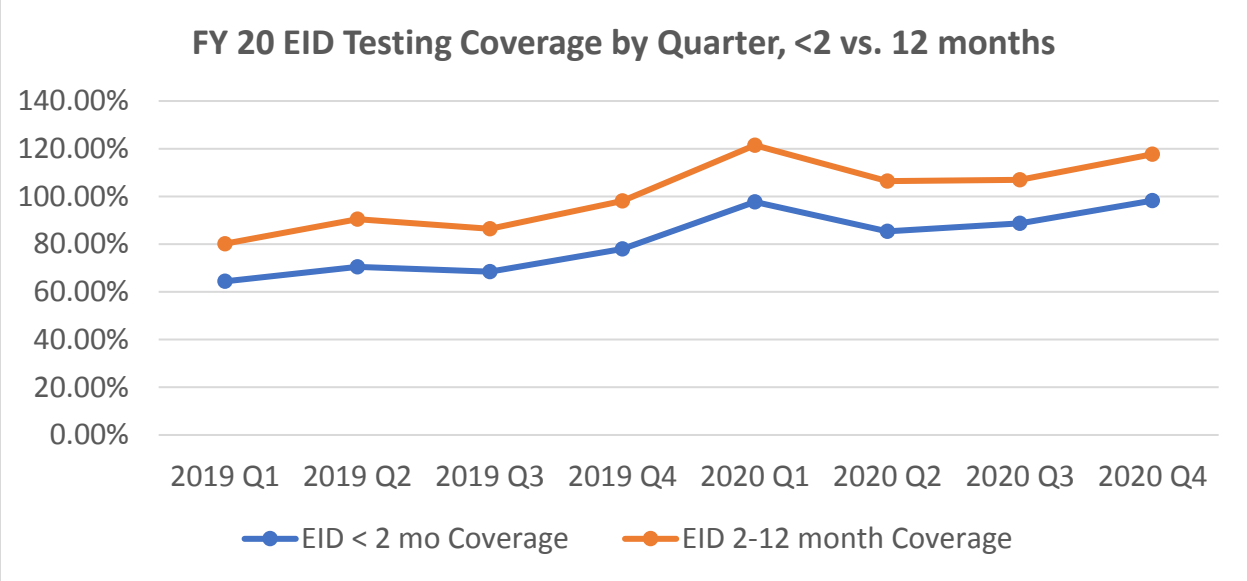
Table 8. COP/ROP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	1,817,908	1,618,447	89%	HTS Program Area	$ 15,557,766	72%
	HTS_TST_POS	142,759	162,260	114%			
	TX_NEW	145,619	167,587	115%	C&T Program Area	$ 54,813,192	36%
	TX_CURR	840,052	729,695	87%			
	VMMC_CIRC	331,680	299,967	90%	VMMC Sub-Program Area	$ 10,822,883	78%
	OVC_SERV	15,390	7,036	46%	OVC Beneficiary	-	
DOD	HTS_TST	465,002	731,703	157%	HTS Program Area	$ 221,588	100%
	HTS_TST_POS	26,601	27,047	102%			
	TX_NEW	24,333	25,517	105%	C&T Program Area	$ 13,404,742	96%
	TX_CURR	234,836	199,880	85%			
	VMMC_CIRC	243,959	165,031	68%	VMMC Sub-Program Area	$ 5,862,119	100%
	OVC_SERV	349	280	80%	OVC Beneficiary	$ 46,286	100%
USAID	HTS_TST	1,398,942	1,465,420	105%	HTS Program Area	$ 13,178,148	71%
	HTS_TST_POS	89,519	87,149	97%			
	TX_NEW	76,661	83,696	109%	C&T Program Area	$ 112,242,553	90%
	TX_CURR	518,657	428,256	83%			
	VMMC_CIRC	229,414	78,196	34%	VMMC Sub-Program Area	$ 6,184,018	100%
	OVC_SERV	852,634	844,823	99%	OVC Beneficiary	$ 25,171,290	95%
					Above Site Programs	$ 20,578,896	
					Program Management	$ 48,840,415	

Index Testing Yield by Age and Sex, 15+ vs. <15 yrs



Tanzania experienced a 440% increase in index testing yield between FY18 Q1 and FY20 Q1 among adults over the age of 15 years, however, improvements are needed to increase the index testing yield in clients below the age of 15 yrs. In addition, the gap in index testing yield positivity between males and females over the age of 15 continues to widen.



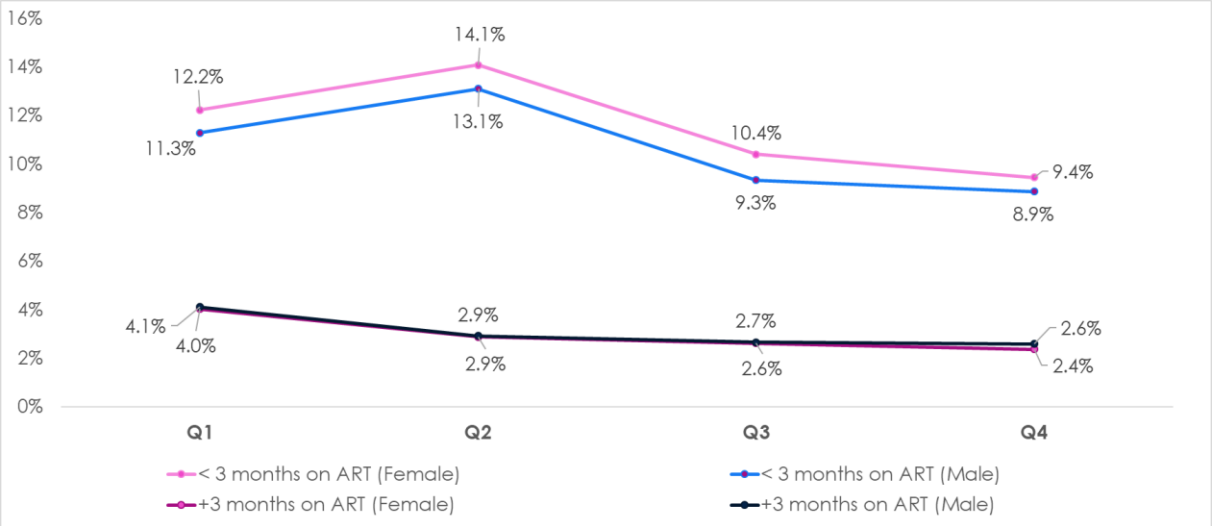
Tanzania has experienced substantial increases in EID from FY19 Q1 through FY20 Q4, achieving 98% 2-month EID testing coverage by FY20 Q4.

FY 20 Q4, Contributions to Tx_NET_New (25 highest volume SNUS)

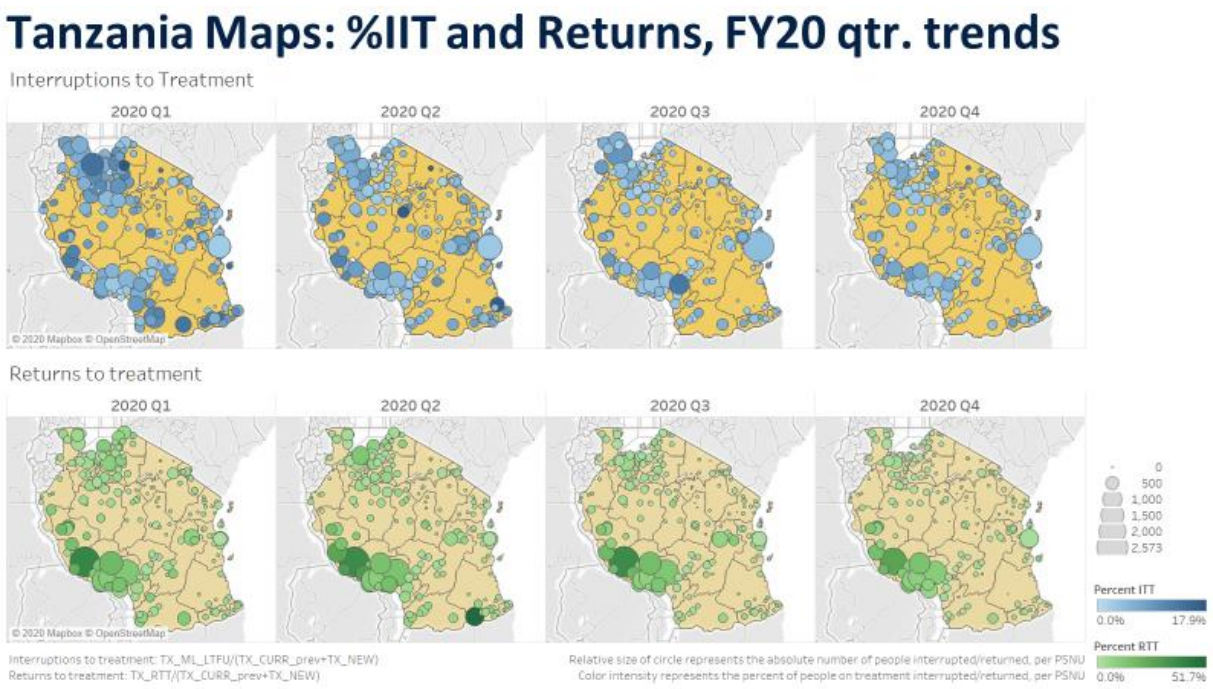
	Net New Deep Dive									
	TX_CURR FY20Q3	TX_NEW	TX_RTT*	IIT on ART < 3 mo	IIT on ART +3 mo	DIED	DECLINED/ STOPPED	TRANSFER OUT	TX_CURR FY20Q4	NET NEW
Dar es Salaam	166,102	5,123	2,947	889	4,377	359	30	2,393	167,598	1,496
Mwanza	104,652	5,564	836	154	1,261	278	29	1,639	109,265	4,613
Mbeya	100,976	2,991	9,288	245	3,577	222	8	1,689	102,623	1,647
Kagera	85,319	3,211	1,256	502	2,437	339	18	1,786	79,116	-6,203
Iringa	65,721	2,296	490	64	763	242	47	1,413	67,160	1,439
Tabora	65,832	2,696	1,093	597	1,566	207	62	1,396	66,801	969
Shinyanga	62,103	2,625	646	194	1,000	198	10	1,568	64,007	1,904
Geita	60,710	4,584	1,547	710	2,213	219	45	2,693	62,651	1,941
Morogoro	60,099	3,480	865	237	1,196	319	59	892	62,067	1,968
Njombe	55,373	1,816	947	240	1,914	197	79	1,590	55,307	-66
Ruvuma	47,818	3,691	990	226	860	191	12	914	50,976	3,158
Tanga	45,671	3,398	494	212	985	309	42	1,227	47,486	1,815
Mara	45,016	2,004	660	88	652	172	50	708	47,075	2,059
Pwani	40,870	2,375	1,363	302	1,094	157	17	947	42,699	1,829
Songwe	36,237	1,206	3,636	95	1,557	85	0	580	36,494	257
Dodoma	33,323	2,211	398	90	378	143	9	866	34,939	1,616
Kilimanjaro	31,849	1,276	371	112	674	144	19	540	31,749	-100
Simiyu	29,845	1,085	269	165	593	109	27	601	30,393	548
Mtwara	28,276	1,218	631	182	1,103	130	6	648	28,958	682
Arusha	27,003	1,387	418	149	655	95	19	594	27,424	421
Rukwa	24,728	1,089	4,474	92	1,359	74	11	435	25,345	617
Lindi	20,911	629	358	79	293	137	36	511	21,223	312
Singida	20,674	1,021	298	136	611	77	10	461	20,681	7
Katavi	18,820	948	1,833	84	792	57	9	588	19,465	645
_Military Tanzania	19,191	449	2,141	38	685	35	0	130	19,338	147

Tanzania is experiencing slowed program growth despite improvements in identification and linkage of positive clients. In FY20, Tanzania averaged an approximate quarterly loss of 30,000+ clients. Analysis of the absolute number of gains/losses for individuals on treatment (TX_CURR) from FY20 Q3 to Q4 shows the large majority of clients are lost through transfers or care interruptions at 3+ months with the highest losses in Kagera.

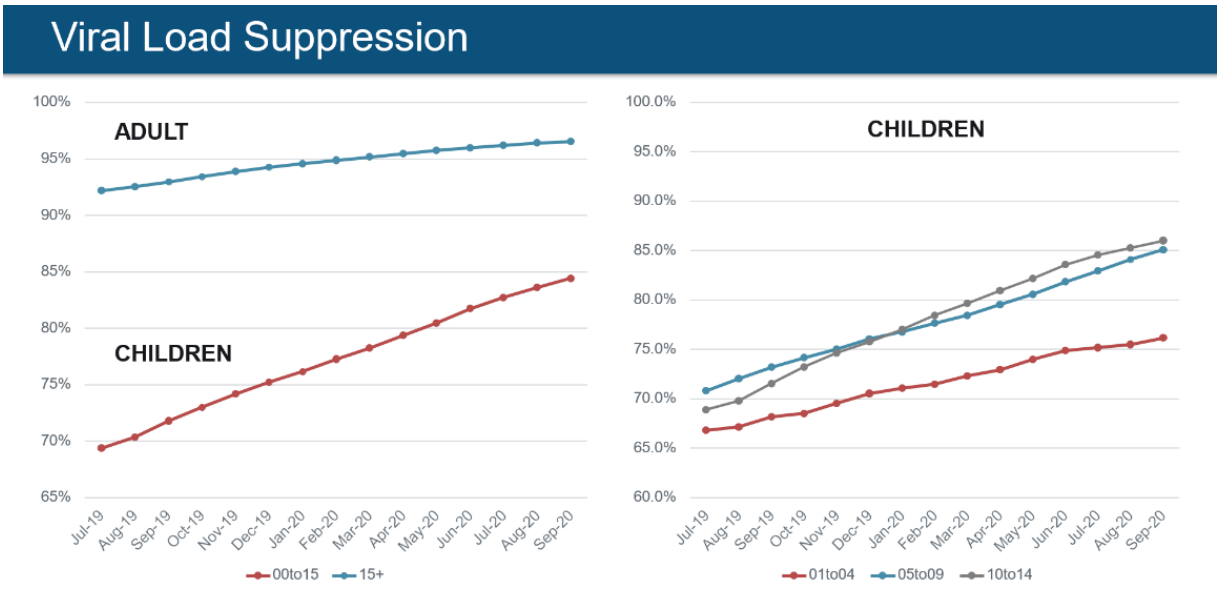
FY 2020 Interruptions in Treatment Percent Trends for <3 and + 3 months by Sex



In FY2020, the highest percentage of treatment interruptions for newly enrolled clients (TX_NEW) occurs at < 3 months for both males and females peaking at 13.1% and 14.1% in FY20 Q2, respectively. Young women aged 20-39 and young men aged 25-39 were most impacted by interruptions in care as compared to adults of any other age band.



In FY 2020, the highest volume of treatment interruptions occurred in the Lake Region and the highest volume of clients returning to treatment was in the Southern Highlands, thus highlighting that the population of clients experiencing care interruptions and subsequent returns are different.



VL suppression is improving in both adults and children in Tanzania, with adults now at >95% viral suppression by the end FY20 Q4. Children have experienced a substantial improvement in viral suppression between FY2019 and FY 2020 reaching above 85% by the end of Q4, however, there are significantly lower rates of VL suppression among children under 5 years of age.

Partner and Financial Performance

In FY20, CDC Tanzania tested efficiently, overachieving on their FY20 case identification target (HTS_TST_POS = 113%) while reaching just 89% of their testing target (HTS_TST = 89%). While they overachieved their new on treatment target (TX_NEW = 115%), they fell short of their current on treatment target (TX_CURR = 87%) and viral suppression achievement was low (TX_PVLS =6%). Despite COVID-related barriers, CDC did achieve their VMMC targets (VMMC_CIRC = 90%). Table 8a shows where CDC partners underperformed (highlighted in red).

Table 8a. CDC COP/ROP 2019 | FY 2020 Results & Expenditures

PARTNER/INDICATOR	FY20 RESULT	FY20 TARGET	FY20 % ACH.	Program Area	BUDGET	% EXPENDED
AMREF HEALTH AFRICA HQ						
HTS_TST	174,122	137,118	**127.0%**	HTS	**$1,362,500**	96%
HTS_TST_POS	12,526	13,473	**93.0%**			
TX_NEW	14,207	13,407	**106.0%**	C&T	**$4,340,000**	133%
TX_CURR	53,187	67,179	**79.2%**			
TX_PVLS	42,896	64,141	**66.9%**			
AGPAHI						
HTS_TST	483,948	477,225	**101.4%**	HTS	**$990,000**	90%
HTS_TST_POS	35,042	32,456	**108.0%**			
TX_NEW	49,265	45,981	**107.1%**	C&T	**$13,129,148**	107%
TX_CURR	247,706	268,484	**92.3%**			
TX_PVLS	133,305	256,602	**52.0%**			
INTRAHEALTH INTERNATIONAL, INC.						
VMMC_CIRC	186,014	203,590	**91.4%**	**VMMC**	**$4,814,774**	119%
MANAGEMENT AND DEVELOPMENT FOR HEALTH						
HTS_TST	703,449	922,654	**76.2%**	HTS	**$2,680,000**	213%
HTS_TST_POS	76,948	61,315	**125.5%**			
TX_NEW	104,115	86,231	**120.7%**	C&T	**$25,552,387**	109%
TX_CURR	428,802	504,389	**85.0%**			
TX_PVLS	350,549	481,732	**72.8%**			
VMMC_CIRC	113,953	128,090	**89.0%**	VMMC	**$6,437,242**	78%
ICAP						
HTS_TST	256,928	280,911	**91.5%**	HTS	**$19,044,872**	74%
HTS_TST_POS	37,744	35,515	**106.3%**			
OVC_SERV	7,036	15,390	**45.7%**	**OVC**	**$1,762,556**	58%

In FY20, DOD Tanzania over tested (HTS_TST = 157%; HTS_TST_POS = 102%). While they achieved their FY20 new on treatment target (TX_NEW = 105%), they underachieved on their current on treatment target (TX_CURR = 85%) and viral suppression and VMMC achievement was low (TX_PVLS = 68%; VMMC_CIRC = 68%). Table 8b shows where DOD's partner underperformed (highlighted in Red.

Table 8b. DOD COP/ROP 2019 | FY 2020 Results & Expenditures

PARTNER/INDICATOR	FY20 RESULT	FY20 TARGET	FY20 % ACH.	Program Area	BUDGET	% EXPENDED
Henry M. Jackson Foundation for The Advancement of Military Medicine, Inc., The						
HTS_TST	689,534	465,002	**148.3%**	HTS	$2,392,737	77%
HTS_TST_POS	25,398	26,601	**95.5%**			
TX_NEW	23,525	24,333	**96.7%**	C&T	$16,774,477	77%
TX_CURR	180,542	234,836	**76.9%**			
TX_PVLS	137,367	224,442	**61.2%**			
OVC_SERV	0	349	**0.0%**	OVC	$2,695,363	75%
VMMC_CIRC	158,326	243,959	**64.9%**	VMMC	$11,587,305	64%

In FY20, USAID Tanzania achieved their testing and case identification targets (HTS_TST = 104%; HTS_TST_POS = 97%) as well as their FY20 new on treatment target (TX_NEW = 109%). However, USAID Tanzania underachieves their current on treatment target (TX_CURR = 83%) and viral suppression and VMMC achievement was low (TX_PVLS = 63%; VMMC_CIRC = 34%). Table 8c shows where USAID's partners underperformed (highlighted in red).

Table 8c. USAID COP/ROP 2019 | FY 2020 Results & Expenditures

PARTNER/INDICATOR	FY20 RESULT	FY20 TARGET	FY20 % ACH.	PROGRAM AREA	BUDGET	% EXPENDED
ASSOCIATION OF PRIVATE HEALTH FACILITIES IN TZ						
VMMC_CIRC	2,598	121,033	2.1%		$548,087	9%
BAYLOR COLLEGE OF MEDICINE						
HTS_TST	8,694	6,365	136.6%	HTS	$1,782,624	83%
HTS_TST_POS	455	272	167.3%			
TX_NEW	431	466	92.5%	C&T	$1,497,733	89%
TX_CURR	2,732	3,496	78.1%			
TX_PVLS	2,225	3,332	66.8%			
DELOITTE CONSULTING LIMITED						
HTS_TST	719,945	619,255	116.3%	HTS	$3,747,370	114%
HTS_TST_POS	50,849	42,773	118.9%			
TX_NEW	55,002	44,471	123.7%	C&T	$12,965,238	96%
TX_CURR	281,433	314,811	89.4%			
TX_PVLS	189,687	301,044	63.0%			
Elizabeth Glaser Pediatric Aids Foundation (EGPAF)						
HTS_TST	485,546	378,391	128.3%	HTS	$5,385,715	107%
HTS_TST_POS	22,482	28,467	79.0%			
TX_NEW	24,755	28,447	87.0%	C&T	$7,168,517	95%
TX_CURR	127,695	141,343	90.3%			
TX_PVLS	106,589	135,184	78.8%			
Family Health International						
HTS_TST	179,990	280,680	64.1%	HTS	$20,012,200	88%
HTS_TST_POS	9,781	12,314	79.4%			
TX_NEW	2,578	1,755	146.9%	C&T	$1,944,954	48%
TX_CURR	16,396	20,372	80.5%			
TX_PVLS	10,598	19,495	54.4%			
OVC_SERV	53,121	37,621	141.2%	OVC	$25,723,182	93%
JHPIEGO CORPORATION						
HTS_TST	58,441	92,451	63.2%	HTS	$2,816,291	147%
HTS_TST_POS	2,950	4,250	69.4%			
OVC_SERV	0	24,047	0.0%	OVC	$134,632	99%
VMMC_CIRC	40,028	57,029	70.2%	VMMC	$13,439,195	83%
JSI Research and Training Institute, INC.						
HTS_TST	10,263	10,893	94.2%	HTS	$2,795,732	99%
HTS_TST_POS	629	720	87.4%			
TX_NEW	930	761	122.2%	C&T		
TX_CURR	0	16,358	0.0%			
TX_PVLS	0	15,665	0.0%			
VMMC_CIRC	35,570	51,352	69.3%	VMMC	$4,001,004	102%
Pact, Inc.						
OVC_SERV	791,702	790,966	100.1%	OVC	$44,960,216	81%
TANZANIA HEALTH PROMOTION SUPPORT (THPS)						
HTS_TST	0	10,907	0.0%	HTS	$645,000	17%
HTS_TST_POS	0	723	0.0%			
TX_NEW	0	761	0.0%	C&T	$320,000	109%
TX_CURR	0	22,277	0.0%			
TX_PVLS	0	21,330	0.0%			

- A large majority of PEPFAR Tanzania implementing partners were able to maintain previous gains despite tremendous programmatic challenges in FY2020. With the exception of global challenges with viral load testing reagent stockouts that affected all IPs, AGPAHI stands out for achieving HTS_TST, HTS_TST_POS, and TX_NEW targets and reaching 92% of TX_CURR targets. AGPAHI's performance exemplifies significant growth since FY2019 when the partner underperformed in HTS_TST_POS (79%), TX_NEW (83%) and TX_CURR (85%).
- Despite much progress over the past year, substantial gains are still needed to improve pediatric case identification and retention across all IPs.

- Performance across the cascade:
    - Case Identification
        - Similar to last year, MDH—Clinical Services leads the other partners in case identification with 126% of HTS_POS and 76% of HTS_TST, which demonstrates that they have sustained and scaled targeted testing strategies with fidelity.
        - ICAP achieved 106% of HTS_TST_POS while reaching 92% of HTS_TST
        - Deloitte achieved 118% of HTS_TST_POS while reaching 116% of HTS_TST
    - Treatment Growth
        - No IPs reached 100% of TX_CURR targets, however, 2 IPs did achieve greater than 90%: AGPAHI (92%) and EGPAF (90%).
        - Similar to last year, the gap between the total number of clients initiated on treatment (TX_NEW) and the total of number of clients retained on treatment (TX_NET_NEW) continues to exist across IPs thereby contributing to a net loss 30,000+ clients per quarter from the Tanzania program despite substantial achievements in case identification.
    - Viral Load
        - Achievement against VL suppression targets was under 75% for all IPs except EGPAF (79%).
- Remediation Measures
    - In FY2019 Kagera and Mwanza contributed to 31% of the treatment gap compared to FY2020 where Dar Es Salam alone contributed to 22% of the gap between PLHIV and TX_CURR. In addition, the Tanzania program continues to lose an average of 30,000+ clients from treatment programs despite substantial achievements in case identification. Ensuring strategic approaches for case management and longitudinal tracking of clients to ensure treatment continuity remains a priority. PEPFAR Tanzania must immediately develop site-specific remediation plans to enhance linkage and retention of clients. The remediation plans should include time-limited performance benchmarks and provision to adjust finding based on performance.
    - PEPFAR Tanzania is encouraged to review closely its partner performance data in a routine and standardized method, and to use these analyses to inform problem-solving discussions that can improve achievement against target.
    - As of the end of October 2020, there were 22 labs across all partners and agencies with 155,000+ VL sample backlogs (including EID) due to reagent stock-outs. The reasons are multifaceted, including GOT shelf-life policies and delays with port clearance. An interagency lab TWG was convened in November 2020, and as of December 2020, 41,000 samples have been cleared. Immediate remediation and clearance of the VL sample backlog is needed by the end of FY21 Q2.
- The Government of Tanzania and PEPFAR Tanzania agreed to halt VMMC for boys <15yrs in COP 20 discussions. As of FY20 Q4, 6 of 7 IPs discontinued services by FY20 Q3 with the exception of Henry Jackson Foundation performing 24,297 <15 yrs circumcisions in FY20 Q3 and FY20 Q4. Continuation of VMMC services in boys <15 yrs will result in removal of VMMC funding from any non-compliant IP.
- In FY20, Tanzania DREAMS IPs reached 185,963 AGYW compared to 154,137 in FY19. Despite implementation challenges, the proportion and number of AGYW that completed the primary package increased from FY19 (64%) to FY20 (82%).
- OVC Performance: In COP21, achievement of 90% or more children and adolescents on ART remains a priority.
    - Tanzania achieved 100% of OVC_SERV and 92% of OVC_SERV <18yrs achievement, however, there was variation across IPs for OVC_SERV: PACT (100%), FHI360 (86%), HJF (80%).

- Achieved 92% of OVC program proxy coverage of TX_CURR<15yrs in 81 OVC councils with coverage of 71-128% in regions with the highest TX_CURR <15yrs burden: Dar es Salaam, Shinyanga, Mwanza, Mbeya, and Tabora.
- The OVC_HIVSTAT known status proxy for FY 20 in Tanzania was 90% substantially improved from 84% in FY19.
- In FY20, Tanzania made progress in improving the number of OVC beneficiaries who exited the program without graduation, decreasing the number from 16% in FY19 to 7% in FY20.

SECTION 4: COP/ROP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP20 implementation (FY2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Tanzania has adopted and implemented a test and start policy which is aligned with WHO guidance.
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Circular released in Jan 2020 authorizing scale-up of DTG to remaining facilities. DTG transition has moved quickly to overall coverage of 88% of all eligible clients (including 87% of all eligible women of childbearing age) as of Q4 FY20. GF approved collection and destruction of legacy stock. GOT to collect

	NVP from facilities and to stop usage at facilities.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	3MMD scale-up continues (90% of eligible clients receiving). 6MMD started in Dar es Salaam in March 2020 and 74% of eligible clients received by end of September 2020. Based on stock analysis, 6MMD expansions is slowed pending stock arrival in Q3 2021.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	On track to complete TPT by end of COP 20. By FY20 Q4, 67% of eligible clients either were receiving or completed IPT.
5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	VL scale-up remains strong with high capacity. National lab TWG re-established. Multiplexing for VL, EID, and TB started. 52 POCT sites doing EID testing. Sample Referral Guideline and Procedure Manual developed. Integration of VL data with CTC2/3 complete. Business process for VL/EID, EQA, IDSRS, NBTS, and TB developed.
Testing	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Index testing at scale with fidelity. National index testing AE tool in use, national CTC2 chart incorporates elicitation form to track IPV, monthly portal updated to include pediatrics and community index testing monitoring as well as IPV tracking. Self-testing HAPCA amendment signed and regulations endorsed by the GOT, and national HIV self-testing framework approved.
Prevention and OVC	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	National PrEP scale-up has begun in alignment with the target groups identified (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices.) Awaiting official letter to be released from PORALG to proceed with implementation.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively	OVC packages have been aligned.

facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	
Policy & Systems	
1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	The GOT prohibits user fees for HIV, TB, and MCH services in public and private settings. There is no evidence of informal user fees.
2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	CQI is core component of site level management and partner workplans.
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	VL scale-up remains strong with high capacity. National lab TWG re-established. Integration of VL data with CTC2/3 complete.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Tanzania is on track towards is contribution to local, indigenous prime partner funding
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	GOT has established an AIDS Trust fund and is exploring an HIV levy and partnerships with private sector entities to channel funds.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR currently supports implementation of routine death (and birth) surveillance in multiple regions. Assessment is ongoing to optimize for national scale-up and sustainability
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Use Case testing of two matching algorithms within the National Health Client Registry (NHCR) has been successfully conducted. Recommendation for biometric use has been shared with eGOV agency for final approval. Testing of fingerprint module in NHCR has been conducted. Requirements for the

	functionality of connections between multiple health-related systems have been developed.

In addition to meeting the minimum requirements outlined above, it is expected that Tanzania will consider all the following technical directives and priorities:

Table 10. COP/ROP 2021 (FY 2022) Technical Directives

OU –Specific Directives
HIV Testing
1. Focus on expanding HIV self-testing beyond key populations and leveraging best practices of the faith and community initiative to reach individuals currently being missed via traditional testing approaches.
2. Collaborate with NACP to validate HIV risk screening tools to reduce over-testing, increase case-identification and reduce missed opportunities for diagnosis.
3. Focus on the scale-up of case identification strategies for children under 15 yrs leveraging OVC platforms in high burden SNUs, where available.
4. Increase 2-month EID testing coverage through the expansion of POC testing, mentorship to improve the quality of DBS samples and integrating EID testing into pediatric service delivery platforms.
HIV Treatment
1. Focus on reducing interruptions in treatment in young women and men through rapid assessments of these subpopulations. Leverage MenStar approaches and utilize male peer to peer support programs/coach programs to enhance treatment linkage in men 25-39yrs.
2. Continued focus on pediatric cascade to improve treatment coverage, retention and viral suppression, and leverage OVC platforms in high burden SNUs (where available) to enhance performance.
3. Conduct in-depth regional/SNU analyses to understand retention trends and develop targeted strategies to address losses.
4. Strengthen linkages between clinical and community partners to increase retention and VL testing coverage for KPs.
HIV Prevention
1. Collaborate with Government of Tanzania to facilitate the authorization and implementation of the new PrEP policy to ensure rapid scale-up.
2. Strengthen linkages of AGYW identified in communities to DREAMS safe spaces. Engage in demand creation to increase PrEP uptake among AGYW and expand PrEP availability in DREAMS districts.
3. Ensure VMMC partners achieve full compliance with PEPFAR age guidance.
Other Government Policy or Programming Changes Needed
1. Government of Tanzania and PEPFAR Tanzania must work together to standardize processes to manage, monitor, and report on VL reagent stocks in real-time to improve VL testing coverage.
2. Continue implementation of 2018 PEPFAR HRH transition plan, assess for gaps in implementation, and continue to develop the capacity of local partners to build HRH resiliency.

COP/ROP 2021 Technical Priorities

Client Centered Treatment Services

COP21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an

adult population that is asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 21, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptoccal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP21 DREAMS implementation include systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental consent as dictated by local laws. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance and report into the cervical cancer MER indicators. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

Condoms and Lubricants

Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues This funding is in addition to funds allocated

for condom programming and additional condom/lubricant procurement in each country from COP21 country funding as determined during the COP planning process.

Tanzania will have access to $500,000 from the Condom Fund in COP21/FY22, contingent upon adequate justification of need. Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP21 guidance. Among other items, this justification should include an outline of how Tanzania will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR Tanzania should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country

capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)
Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact", OUs with continuing FCI investments should continue implementing best practices in accordance with FCI and COP21 Guidance. Priorities for COP21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices
There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP/ROP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings. .

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2021 development, finalization, and implementation. As in COP/ROP 2020, the draft Strategic Direction

Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): OU's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): OU's COP/ROP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be

Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: **community mobilization, behavior, and norms change** (all populations)

+

50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY21 and must meet 40% by FY20. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY21 as appropriate through their COP/ROP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP/ROP 2021 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Tanzania should hold a 3-month pipeline at the end of COP/ROP 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the

event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain a 3-month buffer. Any agency that anticipates ending COP/ROP 2020 implementation (end of FY 2021) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2021, decreasing the new funding amount to stay within the planning level.